EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
TUESDAY, 25 AUGUST 2009

SESSION THREE

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 2.31 pm

PATCHETT, DR STEVEN JOHN REUBEN
Executive Director, Mental Health, Department of Health,
examined:

The CHAIRMAN: Welcome Dr Patchett. On behalf of the Education and Health Standing Committee, I thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into a review of Western Australia's current and future hospital and community health care services. You have been provided with a copy of the committee's specific terms of reference. At this stage I will introduce myself and the other members of the committee who are present today. I am Janet Woollard; next to me is Mr Peter Abetz; Mr Peter Watson, who has just left the room for a few minutes; and Lisa Baker. Dave Worth, our principal research officer; Tim Hughes, research officer, and Hansard are with us.

This committee is a committee of the Legislative Assembly of the Parliament. This hearing is a formal procedure of the Parliament and therefore commands the same respect of proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard is making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to your presentation and hopefully some questions from the committee today, I need to ask you a series of formal questions. Have you completed the "Details of Witness" form?

Dr Patchett: Yes, I have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Dr Patchett: Yes.

The CHAIRMAN: Did you receive and read an information for witnesses briefing sheet provided with the "Details of Witness" form today?

Dr Patchett: Yes, I did.

The CHAIRMAN: Do you have any questions relating to being a witness at today's hearing?

Dr Patchett: No.

The CHAIRMAN: Dr Patchett, we are obviously very pleased to have you here looking at and hopefully talking to us about mental health in terms of the hospital structure and the community structure. We are rather hoping that you might also come back at some point when we are looking at our review on alcohol and illicit drugs and assist us with that review as well. Would you like to perhaps give us a brief description of the tertiary cum secondary health care in the hospital sector and then the community sector with what you see as, I guess, both the successes within the structures and the areas where there are room for improvement?

Dr Patchett: Yes, thank you. I will start by telling a bit of a story about mental health itself and the direction that mental health has been heading in since the 1960s and 1970s really. I think I speak for the whole western world that we all made mistakes in relation to mental health; we got the message wrong. I often talk about the discovery of chlorpromazine (largactil) in 1952, which while it led to wholesale improvement in mental health care, it also I think set us back because it then rolled mental health into the medical model, basically, that mental illness is another brain disease and we

just have to wait now for the clever drug companies to come up with the right drug or the right manipulation of the molecule and everything will be fine. The whole world did that. As I said, I think it is pretty obvious to us all now that we made a mistake in that mental illness is a disorder of the mind and social functioning as much as biochemistry in the brain. I guess that is where we stand now; we are left with a legacy of care that was based on the medical model and a particular emphasis on biological approaches, and as we plan for the future the realisation is that we really need to do a lot more. The hope in the future is that by doing a lot more and caring for the whole person, people can actually recover and that is the message now in 2009-10.

Like the rest of the western world, we have traditionally had mental health services up until the last 10 years anyway that have been based around large psychiatric hospitals; the asylums—Graylands and Heathcote, and then Heathcote disappeared. I guess we need to give credit to the national mental health strategy that began in 1992—17 years ago. The four policies and plans that have fallen out of that have really pointed mental health services around the country to follow the lead of the enlightened world; that is, designing mental health services that best meet needs.

To summarise, it is important that what is now realised about mental health is that what, in a sense, mental health services have abided by but not given true emphasis to is the bio-psychosocial understanding of human beings. It was put to us beautifully by a visitor from the United States last year, it might have even been the year before, who was talking about deinstitutionalisation in the United States with chlorpromazine (largactil), that mental health care is a three-legged stool and all legs are needed for it to be solid and to hold up—that is, specialist mental health care and medication when required or psychotherapy; stable accommodation, which is absolutely essential; and psychosocial support, and that is really the social inclusion agenda that has taken over in recent times. The mistakes we all made were providing specialist mental health care and not doing the psychosocial support; providing accommodation and then the revolving door was all about people failing in that accommodation and mental health services making the mistake of believing the failure was about the accommodation but the failure was about putting the social system of support around somebody so that they could recover those functions that get affected by mental illness. Therefore, I really say that all that we are doing nowadays is to move much more towards that kind of recovery-focused mental health care, the whole spectrum, and decreasing the emphasis on inpatient beds, which are still vitally important, but having the whole range right out to independent but still supported accommodation in the community.

I have been in this fortunate position to lead mental health for two and a half years now. From the time that I took over the job, I have been fighting for what we are getting at the moment; that is, a modern strategic plan that is really going to tell that story and put that story before all of us. With the support of the Minister for Mental Health, cabinet and the Premier, it is really putting mental health before all of us as an agreed plan. We have embarked upon this nine-month, strategic planning exercise and engaged the international consultancy firm PricewaterhouseCoopers to really do this very extensive community consultation with stakeholders in getting the story right or as right as possible. That plan will come down in early next year and I am really optimistic that it will be the blueprint; it will be the way forward. We will all be able to look at it and proudly say, "Yes, that is where we have to head for the next 10 years in mental health."

[2.40 pm]

The CHAIRMAN: How does that plan differ from the review that was done by the health department into mental health services?

Dr Patchett: It extends that significantly.

The CHAIRMAN: For the benefit of members of the committee, would you please elaborate on how it extends that?

Dr Patchett: Yes. In the past there have been a number of plans and planning forums on continuing care. For example, a planning document was prepared called "Partnerships Creating Good Outcomes". The "WA Mental Health Strategy 2004-2007", under the previous government, was another very important document in the planning jigsaw. Each of those has not looked at the whole picture with the modern, contemporary story around recovery and bringing consumers into the primary focus of mental health care. It is a mistake that everyone in the western world has made. We have overlooked our consumers.

The CHAIRMAN: What did the previous plan focus on?

Dr Patchett: Probably mostly on state government-funded mental health services.

The CHAIRMAN: Is that beds?

Dr Patchett: Yes, beds.

The CHAIRMAN: Was it beds rather than psychosocial support or accommodation?

Dr Patchett: Stable accommodation. The "WA Mental Health Strategy 2004-2007" is really important in terms of accommodation. It focused on that. We had very little, and we are still behind the rest of the nation in terms of stable accommodation with high level support. What is required—I am hopeful our strategic planning exercise will identify this because it is the way the rest of the world is going—is that mental health services need to be organised around districts; an identifiable region. We need a full range of services available in regions.

I prefer to talk about our beds as intensive care beds. People in hospital for a mental illness, require intensive care. People in that circumstance are seriously unwell. We should be aiming for as short a stay as possible, but then having the full range of step down and supported accommodation options or brief stay and quick resolution of psychosis back to original accommodation.

The CHAIRMAN: In relation to that, I know that the tertiary hospital in Fremantle is meant to have short-stay accommodation. I have actually taken patients to the casualty department there who needed to be admitted because of problems associated with mental health. I have been made aware that some patients in that hospital have been there for 100-plus days.

Dr Patchett: Yes, that is right.

The CHAIRMAN: Yes, we need accommodation in the community. I have had meetings with many people in the community in relation to mental health. I worked in Southport in the United Kingdom, which was then, I think, called an institution and a lot of people wanted to move away from its being called an institution. I still meets with family members of people who have mental illness. I believe that there is a role for some people in the community who are perhaps unable to live in a smaller unit with three or four others to be cared for—I do not know what you want to call it, because "institution" has a bad name and I am not so sure that "asylum" is the right term. Will the current review look at accommodation? Do you think it is likely to consider maybe having some of those larger accommodation places for long-term patients?

We know from the experience in the eastern states that between 70 to 80 per cent of prisoners are in prison because they have a mental illness. I do not have the statistics for WA, but I am sure the figures are just as high.

Dr Patchett: It is very similar.

The CHAIRMAN: Maybe we can look at the three areas—treatment, accommodation and psychosocial support. Would you give us your views on the direction you think we should take to seek an improvement in those three areas? There are eight people in this room; therefore, two of us will suffer from mental illness.

Dr Patchett: It is probably half of us now—47 per cent is the latest in terms of a diagnosable mental illness, including anxiety.

Ms L.L. BAKER: Does that include menopause?

Dr Patchett: Yes, and male menopause.

It is a simplistic way of putting it, but the idea of three legs of a stool appeals to me. That is the bear bones of it. If you think about it, in any setting you need those three. To illustrate intensive care, the most acute ward in Graylands Hospital is where the specialist mental health care is. That is where you need your psychiatrists, nurses, OTs and psychologists really concentrated. Obviously you need a building as well. There is less emphasis on psychosocial support there.

Under the "WA Mental Health Strategy 2004-2007", 150 beds have almost been completed in the metropolitan region and 50 in rural regions for that very intensive psychosocial support, not so much clinical in-reach, but very intensive psychosocial support and stable accommodation.

The CHAIRMAN: These are the three or four-bed homestay-type accommodation.

Dr Patchett: Yes.

Mr P. ABETZ: Are they connected to the hospitals or are they in the community?

Dr Patchett: Some of them are in the hospitals and some are in the community. They are called community supported residential units. There are 30 beds of community options, which are to replace the very long-stay beds at Graylands Hospital and Murchison ward. I will tell you, in a moment, a good story that has come out of that. The latest figures from the surveys at Graylands show that at any one time 40 per cent of patients could be discharged from the hospital if there was a stable accommodation option for those people.

The CHAIRMAN: For rehabilitation?

Dr Patchett: Yes, and then we could move the specialist care with them. It is for the want of a stable accommodation option. That is where a huge amount of work is being done and the strategic plan will have a very big story around that. We have to move into the community. We have to surround people with those. Deinstitutionalisation failed because people were discharged and forgotten about. We have to follow them with individualised care plans, case management and psychosocial support at a level that is required.

Ms L.L. BAKER: I think I missed the approximate percentage of the gap that you gave.

Dr Patchett: About 40 per cent of people in Graylands at any one time.

The CHAIRMAN: Therefore, 40 people at Graylands could be in the community.

Dr Patchett: Yes, but for want of support.

Ms L.L. BAKER: I am aware, because currently we have a victim of this in Maylands, that people are discharged from Graylands in very poor condition and end up on the street, particularly Aboriginal people and people with coping issues. I do not know why people are released by the psychiatric institutions when they are clearly not capable of coping. Is that about bed pressure?

Dr Patchett: Yes.

Ms L.L. BAKER: So they are sent out because they have to move on for other people. That is appalling.

Dr Patchett: It is mostly about bed pressure. The beds that we have—between 600 and 700 beds—are filled all the time to 98 per cent capacity. It is about bed pressure. You can prevent that. That is what we really need to do and I think that what the strategic plan will strongly recommend is not only building early intervention centres but also assertive community care in the community. We would have teams of people to follow and case manage.

Ms L.L. BAKER: There would need to be a significant investment in the non-government sector to provide community care.

Dr Patchett: Yes.

Ms L.L. BAKER: Have you done any work on what kind of funding model you might be looking at, such as what DSC does for funding of disabilities? Have you started that work yet?

[2.50 pm]

Dr Patchett: Yes, we have, because we have to align the department's support to a separate portfolio, a minister for mental health. We are currently identifying the mental health budget and then identifying a resource allocation model that takes into account the more sophisticated community care model. There is a kind of rough formula that the world is heading for. Whereas, 10 years ago 70 per cent of state government money on mental health was spent on inpatient facilities and 30 per cent in the community, the ideal is probably the reverse: 30 per cent to inpatients and 70 per cent in the community. We are about 50-50 at the moment, so we are heading that way. The strategic plan will complete that story for us of how to invest in the community.

The CHAIRMAN: You said before that the funding may be regional based.

Dr Patchett: Yes.

The CHAIRMAN: We have had discussions with other people about how services need to be interrelated. I know that we had the psychiatric emergency team north of the river, but there were problems south of the river. Would you see that regional-based model linking the north metropolitan and the south metropolitan regions, and the existing regions?

Dr Patchett: Yes. For example, I would hope to have that full range of services in the four southern regions: Fremantle, Bentley, Armadale and then Peel-Rockingham, and having inpatient beds. We are almost there, which is what the clinical services plan is all about. For example, the Rockingham General Hospital will have 30 mental health beds. That is the nucleus for the Peel and Rockingham-Kwinana Health Service. There will be the inpatient beds, intermediate care and then the community and emergency response team. We do not have, and what we really need to invest in, is the assertive case management teams that do not just facilitate an admission to an authorised bed overnight, but also follow that patient: they go back the next day, treat in the home, escalate into intermediate care when required for more intensive care for a few days, and then back out to the accommodation. We need that kind of more dynamic community-based care.

The CHAIRMAN: I refer to that regional picture. At the moment I have people calling me because beds, maybe at Bentley, are occupied with patients who have been transferred up from down south, where there are not the psychiatrists on call to care for those patients who are at the acute stage of their mental illness. Whilst I can see the regional model fitting into the metropolitan area, how are you going to address the problems in the outer or rural areas? I do not know if there is a big difference and whether the statistics are the same, but we know there are a lot of people outside the metropolitan areas who are also suffering from mental illness, and I believe that not only is the staffing of psychiatrists very poor but also staffing of psychiatric nurses for caring for people both inpatient and outpatient as case managers in the community is poor. This looks at treatment, accommodation and support, but we need the staff for those three things.

Dr Patchett: Yes, indeed.

The CHAIRMAN: Where does the staffing mix come in with this three-pronged review?

Dr Patchett: Good question. Quite clearly, the work force is a big story in this as well. Capacity, competency, skills, training and education are very important messages. It has to do with the fact that because we follow the outdated model in mental health care, we thought that mental health services should do everything. They were not very good at doing some aspects of that; for example, in psychosocial support. The NGOs have developed great skill in delivering psychosocial support skills. It is not just the government-funded menial health services and staff work force but the whole continuum of the work force, and we really need a strategic plan that pulls together; and it will.

In terms of regional areas—of course, the member for Albany knows this—there is an inpatient unit in Albany; there is one in Kalgoorlie, a large inpatient unit in Bunbury, and there is soon to be—it has been delayed—the 14-bed inpatient unit at Broome; and Geraldton is obviously the next. But we need to provide the range of services throughout the rural and remote areas as well through the Western Australian Country Health Service, as it exists at the moment. There is a disparity between the amount of mental health funding that goes into the metropolitan region and the amount that goes into regional and remote regions. Our strategic plan will have a very important story to tell about that, too.

Ms L.L. BAKER: Will you be reviewing the act? Is that one of the recommendations?

Dr Patchett: Yes.

Ms L.L. BAKER: The sooner the better!

Dr Patchett: The act is being reviewed, which was one of the new government's election commitments and which has been done—the D'Arcy Holman review embarked on this in 2002-03—but it needs to be closed off.

Ms L.L. BAKER: Yes. There are a lot of gaps and inefficiencies in reporting between agencies and individuals and who is responsible for what. Particularly, parents and carers get extraordinarily let down by the system the way that it is.

The CHAIRMAN: You said that we are looking at this three-legged stool. Will the new strategy have a formula for staff-patient or staff-client ratios to ensure that the problems that we see now with the lack of staff, both medical and nursing and other allied health professionals, can be identified and then hopefully addressed in future budgets? Where will this fit? Are you looking at that?

Dr Patchett: Yes. The 10-year strategic plan will still be high level, so it will not drill down to the nursing hours per patient days kind of formula about how much specialist mental health care is needed from a psychologist, nurse, psychiatrist, whatever. It is looking into each of those areas at the level of care required, which will then define the number of specialist mental health professionals and will define for community supported residential units and other supported residential living in the community, the amount of NGO --

The CHAIRMAN: Like within the age care sector with high dependency and low dependency care?

Dr Patchett: Yes, like that. I mentioned before the NGOs. They are very good now, and mental health services are provided on a needs-based assessment that identifies what a person needs. That is the other big movement, which I mentioned before. Mental health care needs to be individualised. Everybody needs a care plan that needs to be coordinated. Individualised care plans will identify how much of each of those things are needed at each stage, and then will continually change as the person recovers and from time to time inevitably relapses.

The CHAIRMAN: Do we have statistics about funding provided to NGOs to assist in this?

Dr Patchett: Yes.

The CHAIRMAN: Can we ask you to provide details of those funding statistics?

Dr Patchett: Indeed. Currently, for example, I control about $40 million of NGO funding for something like 80 NGOs in mental health care. The area of mental area services also have --

The CHAIRMAN: Can we have that broken down into who the NGOs are and what services they are providing?

Dr Patchett: Yes.

The CHAIRMAN: That would be wonderful.

[3.00 pm]

Ms L.L. BAKER: If you were to approximate the shift in capacity to NGOs—I am just hypothesising—would it be about one-third, or would it be more? Can you make a guess? Ideally, what would be the perfect situation?

Dr Patchett: I think it would be at least 100 per cent at the moment—a doubling.

Ms L.L. BAKER: Really? That is outstanding—and a big emphasis on the prevention and primary stuff as well?

Dr Patchett: Yes, early intervention.

Ms L.L. BAKER: That is really good to hear.

The CHAIRMAN: Again, going back to staffing, because that is a big problem, we do have a shortage, as we said before, of psychiatrists and registered and enrolled mental health nurses. I know that in the private sector recently, one of the private hospitals—St John of God—has been successful in putting together a program for enrolled nurses. That is very much a stepping-stone diploma for them to be able to move on to become registered nurses—degree-based nurses. What are you doing at the moment in mental health, because it is currently a post-graduate qualification, whereas years ago we had enrolled mental health nurses and registered mental health nurses?

Dr Patchett: When we had the emphasis on workforce two years ago, when Peter Flett came into his position, the strongest message that he starting talking about at the beginning was workforce and the workforce crisis. You may recall that the Assistants in Nursing program was applied to mental health as well. So we had a really good look at it. The problem is actually that it is hard to break down the tasks in mental health in the same way that you do in health. Intensive care is an easy one, for example—you can think of how you can break those tasks down and match the competencies around those tasks. It is different in mental health. That is because what we are trying to stress in mental health is the relationship between the carer and the consumer. Assistants in nursing would be no different in that regard or in that dimension from an enrolled nurse or sometimes even a registered nurse. We saw the assistants in nursing as a pipeline into gaining some qualifications and then going on to usually cert III or IV and then on to enrolled nursing and then on to specialist registered nursing. Enrolled nursing is actually a shell of nursing professional that really lends itself well to mental health, because you can build into enrolled nursing special functions—for example, psychotherapy and cognitive behaviour therapy. You can relatively quickly train people in the basics of cognitive behaviour therapy. You can have an enrolled nursing diploma in cognitive behaviour therapy, for example. So we are exploring that. At the registered nursing level, we find it hard to attract graduate nurses into mental health. The number of graduate nurses is much lower than you would expect. So we have embarked upon an investment in that regard. We are paying upfront—we are essentially investing into scholarships to allow nurses to come into mental health, and we are subsidising that move for them.

The CHAIRMAN: You are subsidising the qualification, but there is no extra salary at the end of the qualification.

Dr Patchett: That is right.

The CHAIRMAN: So I wonder what the uptake will be for that.

Dr Patchett: It has actually been surprisingly good. We are paying their postgraduate fees, yes.

The other big message that I alluded to before is really getting our workforce roles and responsibilities right, because in the past a mental health nurse, for example, was expected to do calming and restraint, and to give medication, and to then go over to the kiosk or maybe even go on a community visit. Community mental health nurses were doing a whole lot of functions. We have been able to differentiate those roles more clearly and concentrate on psychosocial support. Psychosocial support at one end is actually getting somebody out of bed and to the table so that they

can eat food. The really basic activities of daily living is the beginning of psychosocial support, right through to being able to attend the tennis club and the health club and being a fully-functioning member of society. There is a huge spectrum there. I guess the realisation that we have come to in mental health is that mental health professionals are not well trained in that. NGOs do it a hell of a lot better. It is recognising that and buying that expertise—investing in that expertise. It really has to be very much a partnership model. The other big risk, too, of course, is that in terms of partnerships, mental health is absolutely a whole-of-government issue. There is a huge story around accommodation and around our relationship with the Department of Housing. Now with the National Affordable Housing Agreement there is a lot of commonwealth funding for the sorts of clientele that we look after, including the homeless. So we are developing those relationships. There is a policy and strategic plan, very much as an up-front story about how we really have to get a commitment from the whole of government to this mental health problem in our society.

The CHAIRMAN: We were made aware as a committee recently of the problems in relation to children who have mental illnesses, particularly in terms of the lack of accommodation for children who may come from a broken home, or whatever. Can you explain to us what is happening there, and maybe the link with PMH and the link with community services for children with mental illnesses?

Dr Patchett: Yes. I will start by saying again—and I am hoping that the strategic plan will have a big message about this—that there is very good evidence that we are intervening in mental illness at the wrong stage in life. There is really good evidence now that we should be concentrating mostly on infants—not even children; on infants. The kinds of traumas they may suffer—broken families, and sexual, physical and emotional abuse—leave a very deep mark on the psyche at an early stage. Increasingly, the world is heading that way. Now in mental health services, instead of talking about child and adolescent, we are talking about infant, child, adolescent and youth. We are also focusing very heavily on youth, because there is this sudden ridiculous cut-off at the age of 18 where the child one side of that is an adult and on the other side is a youth. It is recognised that that is the most dangerous time for mental illnesses, the severe ones—15, 16 and 17, through to the early twenties. So to have that disruption in care and lack of continuity of care across that important age range is part of the story as well.

The CHAIRMAN: Have you had some input into the register that has been developed by child development services for children at age three or four in trying to identify problems?

Dr Patchett: Not centrally in the mental health division, but child and adolescent mental health services may have, yes.

The CHAIRMAN: We would be interested in your comments on that. I am trying to think what the name of the register is. There is some screening that they are rolling out across WA. It comes under child development services. We will try to follow up, because from what you are saying now in terms of having that early intervention, those questions that are asked early on to try to identify any problems are obviously very important.

Dr Patchett: The other important message or point to stress in relation to child and adolescent services is where mental health has to go—that is, we need much more collaboration with other government departments. Obviously the Department for Child Protection is a very important player in that, as is the Department for Communities. There is a very good program—in fact, we had our monthly meeting this morning—that is sort of emblematic of the way we need to be delivering sophisticated mental health services in our community.

[3.10 pm]

That is called PECN—people with exceptionally complex needs. That sprung out of trying to develop services to get a young Aboriginal man out of Casuarina Prison and back to the NPY lands and how the Department of Corrective Services, the Disability Services Commission, the police,

mental health services and drug and alcohol services really got together and, instead of saying, "It's your problem, not ours", formulated a joined-up government plan that got him back to where he had to go. Out of that has come this PECN—people with exceptionally complex needs. That is really where child and adolescent mental health services need to reside too. For example, I am not sure whether you have heard about the Headspace initiative, which is a commonwealth initiative. There is a Headspace program down in Fremantle. That is very much about pulling together all possible community agencies into a coordinated wraparound service.

Mr P.B. WATSON: And down in Albany.

Dr Patchett: And in Albany, yes.

The CHAIRMAN: If some parents decide that they no longer wish to care for their child who has had a mental illness for years, would you say that the onus falls on Child Protection services?

Dr Patchett: I would be saying that a lot of work needs to be done to identify what happens there.

The CHAIRMAN: Who are the people on the bottom line who should be looking to ensure that that child is not left on the street?

Dr Patchett: It is kind of like the problem for us in Mental Health and why Graylands has 40 per cent of people who cannot go anywhere else. We are trying to separate those functions but work together on them. For example, housing—a stable roof over the head of that child—is at the moment, of course, Child Protection's responsibility, but it is probably better rested in the hands of housing experts like the Department of Housing, and Child Protection and the mental health services then put in the services around that person that allow them to stay in that accommodation, to grow in that accommodation and to improve again.

The CHAIRMAN: That is long term.

Dr Patchett: Yes.

The CHAIRMAN: I am asking about in a crisis.

Dr Patchett: At the moment, it is Child Protection's responsibility and it is Mental Health's responsibility. What we really do need, though, is those accommodation options, and a range of them. In Child Protection, they need to be from secure right through to just living in the community, like we do in Mental Health—secure right through to independent living in the community—and have that range available to services to then put what is really essential—that is, those remedial services and support services—around them.

The CHAIRMAN: The federal government has identified in WA the approximate number of beds required in the general health-care sector. Whilst you are saying that you are hoping that the onus will move from the use of acute tertiary and secondary beds for patients who could be housed in the community, do you have—we are not going to hold you to a specific number—a rough idea of what is required at, I guess, a hospital level and a community level? What is available now in both those areas, and, just as an estimate, how many additional beds would be required in both areas, or maybe in the three areas—not the institution, but the asylum or whatever care you want to call it? How many beds do we have now and how many would we need to meet the demands that we have now?

Dr Patchett: The first clinical services plan came out with a magical 777, but that included from acute right through to long stay.

The CHAIRMAN: Seven hundred and seventy-seven?

Dr Patchett: Yes, 777.

The CHAIRMAN: So 777 beds; and this was when?

Dr Patchett: That was when the Reid report —

The CHAIRMAN: That was in 2004-05.

Dr Patchett: Yes. We have been —

The CHAIRMAN: That is when we thought that 20 or 25 per cent of people had mental illnesses.

Dr Patchett: Yes.

The CHAIRMAN: Now when we know it is 50 per cent —

Mr P. ABETZ: Is that what we have, or is that what it ought to be, according to the Reid report?

Dr Patchett: At the moment it is less than that. I will take that on notice and I can get to you the bed numbers right at this moment, on this day. Add to that, though, 600-odd people in licensed psychiatric hostels right at this moment, 200-odd people in community supported residential units—the new units and community options that came out of the mental health strategy 2004-2007—and also independent living programs in the community. There was a program that we had in conjunction with the Department of Housing and Works, as it was then, called independent living, whereby the Department of Housing and Works identified houses and we put in wraparound services. That has gone into abeyance, but the new relationship we have with the Department of Housing now is really identifying, and we are trying to earmark, if you like, 100 houses—100 placements—immediately and then start work on them. What you will see in the clinical services framework is the projection of the original 777, with the Hardes model as it is called, into the out years, I think until 2015 or 2016.

The CHAIRMAN: From that modelling, how many beds are we short now in the metropolitan area and in the outer metropolitan area?

Dr Patchett: I would say that we probably have, in terms of hospital beds, too many, but we need them because we do not have those community services. What we have tried to put into the clinical services framework this time is trying to pre-empt the big story that will evolve over the next 10 years. That ultimately will see far fewer inpatient beds, I will say here.

The CHAIRMAN: Going back, how many community service beds are we deficient at this time? What is that figure?

Dr Patchett: It is probably hundreds. I could not really put a —

The CHAIRMAN: If you said it was 777 in 2004-05, is it hundreds or thousands now?

Dr Patchett: It is probably a lot of hundreds, yes.

The CHAIRMAN: A lot of hundreds. Is that hundreds or thousands?

Mr P.B. WATSON: You make a good politician!

Mr P. ABETZ: Multiple hundreds?

Dr Patchett: It is very difficult to do. The modelling that the clinical services framework is based on is looking at Victoria and then comparing. We do know that, compared with the other states, we have far fewer supported residential units in our community. We run at a much lower rate than New South Wales with our modelling, and Victoria. I think that the problem is that the modelling around 777 has clearly included in it a lot of beds that should be more appropriately in the community.

The CHAIRMAN: Are you able to provide to the committee by way of supplementary information the number of beds that the department feels are needed within the community now to care for the number of people who have mental illnesses and who are not housed at home and do not have accommodation and require accommodation?

Dr Patchett: I would say yes, but just mention, obviously, to members that it is a rough calculation.

The CHAIRMAN: That is fine. I will hand over to Peter in a moment. I appreciate that you are going to give us information on the valuable role that the non-government organisations are now playing in mental health, but could we also have the statistics for current government employees in mental health—clinicians, nurses and allied health professionals—and, I guess, the needs in those

areas? How many additional staff would be needed in each of those areas to possibly be able to cope without the wonderful job that the non-government organisations are performing at the moment?

Dr Patchett: Yes.

The CHAIRMAN: I will allow Peter to ask some questions now.

Mr P. ABETZ: This is just a slight change of direction, or a different area of focus. Having worked in community care as a pastor for 25 years, and having worked on rehabilitating drug addicts and having worked with dysfunctional families and all that sort of thing, my impression is—I am just wondering how this fits in with mental health and where it is going—that a very large proportion of the crisis-type admissions to psychiatric hospitals are actually drug related. Would that be a fair comment or not?

[3.20 pm]

Dr Patchett: Yes, I think it is. I think that nobody really knows the extent, but, being realistic about it, here in Western Australia I think we are doubly disadvantaged because we have not seen mental health services and drug and alcohol services closely aligned for a long time. I see you are going to be talking to Neil Guard. I hope he will give the same message as I do, that we are really coming together much more closely now and doing much more joint service planning, seeing the two as inextricably mixed. As a clinician, I was director of the forensic mental health service. Close to 100 per cent of our clientele were comorbid—drug and alcohol, and mental health.

Mr P. ABETZ: I guess part of the way for government to reduce the cost of mental health to the community would actually be to devise more effective drug use prevention programs to keep people out of the illicit drug scene. I guess that is an area on its own. I am an amateur kind of person but my experience suggests to me, having seen kids grow up in dysfunctional families, that there must be some real predictors in terms of a dysfunctional family—there is abuse and all that. Those kids growing up end up having far greater mental health issues than, say, kids growing up in a stable mum and dad kind of home situation. Is there a section of mental health or is there any government department that really is trying to address that issue to try and reduce the mental health issues? The church communities that I provide pastoral care to, they are fairly functional families and mental health issues are extremely rare; but, where they do occur, they generally do not need long-term hospitalisation. There is poor social support and so on. Mum and dad care, so they can actually be nurtured back to health in the home environment. They do not take up much hospital time; whereas out of the "dysfunctionalness" they tend to be much more the long term or severe situations. What sorts of programs are there to try to address that?

Dr Patchett: As I mentioned, in mental health there are those programs aimed at identifying infants in the first six months to first year of life who are really seriously at risk. There are very, very good and robust methods of identifying those kids now and remedying it; turning it around.

The CHAIRMAN: That is the first six months?

Dr Patchett: Yes.

The CHAIRMAN: You said "tools" or "programs"?

Dr Patchett: Programs or tools.

The CHAIRMAN: Can you send us, again by supplementary information, some information on those tools and programs?

Dr Patchett: Yes. But really the other story, in terms of intervening, that is what pure mental health does. But the message really has been that no government agency or human service should be doing that on its own. It really is joined up. It needs to be joined up. I think that is going to be the message, increasingly. That is what we are promoting and advocating. That is where the policy has to have that joined up at the beginning. You can see child protection and mental health services

working collaboratively, together with housing, to identify the at-risk kids and put them in programs around them.

Mr P. ABETZ: Programs like Families at Work?

Dr Patchett: Yes, that is right.

Mr P. ABETZ: That kind of program where kids who have major behavioural problems are brought in from Monday to Friday, or whatever it is, then they go back home for the weekend. Knowing some of the staff who work there, they have indicated that when the kids come back after the weekend, it takes them to Wednesday to get them back on track again and then they go back into dysfunctional homes. Is there more emphasis on actual family home support? With that particular program, I wonder whether sometimes you need to take kids out of a family situation for a time, provide intensive family assistance to try to lift the parenting skills to reduce the mental health issues of their kids. Is that part of the scene?

Dr Patchett: Yes, it is. There are positive parenting programs. But, again, it is just scratching the surface. Mental health services have concentrated on the severe end of the spectrum, in the past as well.

Mr P. ABETZ: Is there sufficient funding for that whole area? Every health area pours bucket loads of money into it, but realistically, in terms of benefit to the community and recognising the budget constraints, what sort of increase in funding would you consider to be desirable to really try to address that issue? If we deal with those kids, they are not going to end up in jail, they are not going to cost us money, they are not going to end up as much in mental health crisis—all things which cost us bucket loads of money. If we invest it at that level, what sort of doubling, tripling do you think is needed?

Dr Patchett: I could not hazard a guess, I am sorry. There is a program in the United States around early intervention in infancy that demonstrates those benefits. It has been going for a number of years now. It demonstrates that if you really target those very vulnerable infants, identify them for a start and then target them, you can prevent all those things you mentioned and hugely prevent those things in the future.

Ms L.L. BAKER: Following on from Peter's comment, I think the definition of "family" and what is functional and what is not functional is something that we have not got time to explore today. If I am not right, please tell me, because I am happy to be corrected—I do not think that a functional family is necessarily a mum and dad unit in our society today. I think functional families can take a lot of different forms. What goes wrong is whether the parents have the skills to nurture and raise that child effectively. I know it is a debate for another day, but Peter said it three times—mum and dad is not necessarily a modern definition of what is happening in our community at the moment. Would I be right in that assumption, that a family unit can change? The construct of the family unit is not necessarily a pre-determinant to mental health or other issues; it is more likely to be things like advantage or social exclusion or poverty.

Dr Patchett: Yes, indeed.

Mr P. ABETZ: There was a very interesting paper presented at the World Congress of Families in Amsterdam last week, which my wife attended. There were some fascinating statistics on that issue, that kids that grow up with their biological mum and dad, in terms of their likelihood of having mental health issues, I think is one-sixth of those that do not. There is a whole lot of physical health, likelihood of getting into drugs and all that. They live in a broken world where there are broken families; that is all part of the reality of life. But the longitudinal study that these people presented really indicates that we do not live in an ideal world but if we were able to provide a situation where kids were able to grow up with mum and dad as the biological parents, the outcomes are just so much better for the kids. Part of what we need to do, too, is help families stay together and, where

they have not been able to stay together, provide that extra support, training and help so that we can get it as close as possible to those outcomes.

Ms L.L. BAKER: I have got no argument about the need to invest in families to ensure the health and wellbeing of children, Peter, but my argument would be that mum and dad is one unit within today's society—it might not be the only unit—so we have to deal with that reality as well.

Mr P. ABETZ: Absolutely, yes.

Ms L.L. BAKER: Sorry, it is probably not a question for you, Steve. We are just discussing things amongst ourselves!

The CHAIRMAN: Can I ask what you would see as the biggest gap in both the hospital and the broader health care system in terms of mental health?

Dr Patchett: It is not in the hospital; it is in the community. I believe we have got good emergency community response in the community emergency response teams, north and south, but the biggest gap is in the more assertive, continuing care. We do not have a great resource in the community for that. That is where our investment really should be.

[3.30 pm]

The CHAIRMAN: I guess in relation to that continuing care, you were able to tell us earlier that the budget you are responsible for is somewhere in the region of $400 million. How many staff do you currently have in mental health?

Dr Patchett: I can give the precise figure for you, but it is about 3 500.

The CHAIRMAN: Could we have that breakdown of where those staff are? What would you see as the unfunded priority? If the government gives more funding in next year's budget, what is the major priority for that funding in mental health?

Dr Patchett: I believe it is in assertive community care teams.

The CHAIRMAN: You mentioned the services at some of the hospitals—Joondalup; Broome coming on board; Geraldton. Where else is there a big need outside the metropolitan area for mental health? Is there an area across the state where the need has been identified as greater than in other areas?

Dr Patchett: Yes. I would say generally in response to that question that it is in rural and remote areas. Really, with Rockingham coming on next year, the metropolitan region is pretty well covered; that is, inpatient units at Sir Charles Gairdner, 30 beds; Graylands, of course, those beds; at Joondalup, an increase to 15 beds recently; at Swan Valley at the moment Swan District Hospital has psychiatric beds; the new Midland hospital, when built, will have 56 in total, so that is okay; Armadale has an inpatient unit; Bentley, of course, has an inpatient unit and a step up, step down rehabilitation unit; Alma Street in Fremantle; and then Rockingham-Kwinana. We have Fiona Stanley coming on in whatever year that is. So the metropolitan region is pretty well covered. Maybe you could say that that kind of north eastern corridor out to Ellenbrook may require particular investment in inpatient beds at a later stage. But it is rural and remote; nothing in fact north of Perth at the moment. There are no inpatient beds in Geraldton, none in Carnarvon. The Broome unit is the first. The Pilbara is an obvious area although, of course, Broome is coming on as large enough to hopefully cover. The emphasis in Broome of course will be Indigenous. It will be predominantly an Indigenous inpatient unit. That is going to be exciting, because it is building a special building with special requirements. Kalgoorlie struggles, but there are inpatient beds that kind of drop beds and increase, depending on staff. Albany works pretty well, I think because you have got good, stable staff—people living in Albany who want to live there and want to work in the local unit. There are plans, of course, to expand Albany hospital. Bunbury is a very good and functional unit. It is certainly the Kimberley and the Pilbara at the moment, the north and the mid-west as well. I think those are the major areas of shortage at the moment.

The CHAIRMAN: Are you able, by way of supplementary information, to provide the committee with details in relation to the statistics for prisoners with mental health problems?

Dr Patchett: Yes.

The CHAIRMAN: And possibly the statistics of the number of prisoners and for all prisons, the full-time equivalent staff members that you have in those prisoners caring for those prisoners with mental health?

Dr Patchett: We do not actually have the staff. The prison health services are run by the Department of Corrective Services.

The CHAIRMAN: W would appreciate the statistics in terms of the prisons. What role do you have and who coordinates the care of those patients in prisons and the care of those prisoners who have a mental illness? How are they being supported so that when they return back into the community they are able to possibly cope?

Dr Patchett: I have got a particular interest in this, having directed the forensic service. We did a very big offender mental health business case in 2004-05 that really mapped out what is required in courts, in prisons and in detention centres, and then back in the community. A few catch phrases came out of it. The first one is that the prisons are our largest psychiatric hospital in the state. If you look at really serious mental illness, and I mean psychosis, it is 10 per cent of prisoners at any one time. We have not actually done the surveys here but there are plenty comparable in New South Wales and New Zealand and around Australia. The muster is about 4 200 in prisons at the moment, so about 400 of them at the moment will be seriously mentally ill.

The CHAIRMAN: You are saying it is much lower than the statistics coming from the prisons in New South Wales.

Dr Patchett: I am talking about serious mental illness, which would probably need hospitalisation. Through the Department of Corrective Services health services directorate, they manage all primary care, including primary mental health care in prisons. There are a number of mental health nurses, for example, who are employed. The State Forensic Mental Health Service provides specialists in reach of the prisons.

The CHAIRMAN: Specialists?

Dr Patchett: Psychiatists in reach and psychologists in reach. Of course, you will be aware, too, of recommendations that health take over health services in prisons, as has happened in other parts of the world. Most notable, the NHS took over prisons health services in the UK about four years ago. The Inspector of Custodial Services had been recommending that for a long time. There was a review chaired by Greg Joyce the year before last that revisited the possibility of health services here and the Department of Health taking over the health of prisoners. That has been placed on hold.

The CHAIRMAN: Can I ask you for your 2004 review report by way of supplementary information, and also a copy of the Greg Joyce review.

Ms L.L. BAKER: While you are scribbling that down, could I ask a supplementary question? Did the report by Greg Joyce also look at recidivism rates and the correlation between recidivism and mental health?

Dr Patchett: Not really, no.

Ms L.L. BAKER: I am aware that report was done as an internal working document, I think. I cannot remember how long ago, but it would have been several years ago. I had been led to believe it was very high around 80 per cent recidivism. I do not know if the report is available. I think it may be an internal document that never saw the light of day. I am really not sure.

The CHAIRMAN: Who would have that.

Ms L.L. BAKER: The Department of Corrective Services.

The CHAIRMAN: I think that might be someone that we might want to ask to come and give a presentation to the committee in relation to this area. Because time is moving on, could I once again apologise for starting late. Dr Patchett, would you like to summarise anything or is there something that we have not asked you that we should have asked you that you would like to bring to our attention?

Dr Patchett: I suppose I was thinking in my own mind of all we have covered today. Probably the big message is that we are missing suicide prevention—state suicide prevention strategy is about to be released based on the national suicide prevention strategy—and the sub-agenda in that around Indigenous suicide clusters. I think the other thing that I probably have not stressed enough is Indigenous mental health and the importance of that and how really we are under-investing in mental health generally but we are far under-investing in Indigenous mental health. There is a huge story there, as you aware, in terms of suicides and all the communities of Narrogin and Albany recently.

[3.40 pm]

The CHAIRMAN: The member for Albany has actually brought it to our attention on a regular basis; that is, that we should be doing something in that area next. However, we are finishing off our reviews and then—

Mr P.B. WATSON: There are huge problems.

Dr Patchett: Yes, there are huge problems and huge concerns.

The CHAIRMAN: But you said that a review is about to be released—a state review.

Dr Patchett: Yes, a suicide prevention strategy is about to be released; the state government's suicide prevention strategy, one of its election commitments, is going to be released on 10 September, which is World Suicide Prevention Day.

The CHAIRMAN: Wonderful; we will be sure to get a copy of that.

In that case, I would like to thank you very much for all your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be introduced via these corrections and the sense of your evidence cannot be altered. However, should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript.

We are very much looking forward to your briefing for our other review, because your contribution today has been very welcome.

Dr Patchett: Thank you.

Hearing concluded at 3.40 pm