STANDING COMMITTEE ON ENVIRONMENT AND PUBLIC AFFAIRS

PETITION NO 23 — MENTAL HEALTH BEDS FOR ADOLESCENTS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 2 JULY 2014

SESSION ONE

Members

Hon Simon O'Brien (Chairman)
Hon Stephen Dawson (Deputy Chairman)
Hon Brian Ellis
Hon Paul Brown
Hon Samantha Rowe

Hearing commenced at 9.46 am

Dr AARON GROVES
Chair, WA Branch, Royal Australian and New Zealand College of Psychiatrists, examined:

Dr JULIE CAUNT
Chair, Faculty of Child and Adolescent Psychiatry, WA Branch, examined:

The CHAIRMAN: I would like to welcome you to this hearing this morning on behalf of the committee. You will have both signed a document entitled "Information for Witnesses". Have you both read and understood the document?

The Witnesses: Yes.

The CHAIRMAN: Thank you. These proceedings are being recorded by Hansard and a transcript of your evidence will be provided to you. To assist the committee and Hansard, if you are quoting from a document, can you give us the full title of the document to identify it for the record. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session, and if the committee grants your request any public and media in attendance will be excluded from the hearing. Please note also that until such time as the transcript of your public evidence is finalised, it should not be made public. We have a number of questions for you, but do either of you wish to make an opening statement to the committee?

Dr Groves: Yes, first of all we would like to thank the committee for giving us the opportunity of addressing this really significant issue. I would also like to start by acknowledging that with meet today on the lands of the Whadjuk people of the Noongar nation and acknowledge the committee and the Parliament's commitment to acknowledging the indigenous heritage of this land, which the college also finds an extremely important issue. We want to acknowledge that this issue is of utmost importance to the college of psychiatrists. Child and adolescent mental health is a significant problem for the Australian community. I think the committee would be aware of the magnitude of the problem of severe emotional and behavioural disturbance and mental illness within the national committee, and we had a national survey of the prevalence of that in the last part of the last millennium. It may be of importance to the committee to know that that child mental health survey has recently been repeated and, whilst the data in relation to the prevalence of mental disorders is not yet out, the preliminary evidence shows that it is at least the same, if not more than it was more than a decade ago, something which I think should be of collective concern to the Australian community.

[9.50 am]

Within that context, it is important to perhaps paraphrase the words of a former Australian of the Year Professor Patrick McGorry who said, "Why would we ever intervene late when we can intervene early?" That is particularly the case with child and adolescent mental health. The view of the college for some decades has been that there has been a sizable underinvestment throughout all of Australia in addressing child and adolescent issues. Whilst that has been addressed over the last 15 years or so, we believe there is significant progress to be made in this area—probably more so than any other part of mental health, and that is the importance that we place on it. We know that the committee is focussing particularly on acute beds in relation to children and the new children's hospital. What we would like to make really clear to the committee is that children really should not

be admitted to hospitals unless that is completely the last resort. Removing a child from their home and going into hospital is often very traumatising and something that should really only occur when all other options have failed. It is in that regard that planning and thinking about the number of beds needs to be taken into consideration. What is the optimal amount of all the other sorts of services needed to get by with the least number of beds? Our concerns throughout Australia, and in particular in Western Australia, is that that suite of all the other options that allow for a child and their family to go through treatment and interventions at home that mitigates them ending up in hospital is vital. Whilst over the last 30 years in this country there has been the development of an array of services that help in that regard, we believe that this is the area in mental health service development in Australia that has had the least amount of development, the consequence of which is that there has always been pressure on beds for children because of that underinvestment. They are the sort of opening remarks we would like to raise. I will throw it open to Nadine if there are any other additional comments that she would like to make that I have forgotten about.

The CHAIRMAN: Dr Caunt, would you like to add anything?

Dr Caunt: The crux of the matter is that there is such an under-resourcing in the community of mental health services that that puts pressure on beds, which then leads to early discharge to the community so the community is stuck in an acute cycle as well. The substantive work to prevent that acuity, and not just the costs of going to hospital, but all of the morbidity associated with that, and the social cost of that lack of investment, is the biggest concern to the faculty. Within the context of mental health, there is pressure outside of youth and adult services are very constrained so there cannot be much of an overflow into adult services, which is traditionally, if there are not youth beds, they have been able to go into adult beds, but the adult beds are in crisis as well so there is that pressure back again.

The CHAIRMAN: Those opening remarks are very helpful in the context of our inquiries at present, which do flow from a petition that was received. The petition itself, whilst specific, does open up the sorts of issues of which you are providing us with a very beneficial overview. Thank you for that. There are some questions that I would like to put to you. Firstly, in what circumstances do children and adolescents need acute inpatient care? Perhaps in your response you can canvass whether certain psychiatric conditions are more prevalent and whether a particular age group is more needy. To what extent are the family and other background/social conditions a factor; and, does that influence the need for acute inpatient care? That is probably enough for now! The broad question is: in what circumstances do children and adolescents need acute inpatient care?

Dr Groves: I will ask Dr Caunt to start to answer that question.

Dr Caunt: Do you want me to answer about acute inpatient care?

The CHAIRMAN: Yes.

Dr Caunt: Acute inpatient care is when the community supports are overwhelmed by the acuity of a risk factor. That might be the risk of suicide, the risk of violence, the risk of deterioration in a social context, such as acute school refusal or something like that where they want to get the kid back to school very quickly. Because of that, it is about the risk overwhelming the capacity of the community to contain it. There are social factors, of course, so the more things you have in the community to contain that, both health services and mental health services, but also within schools and child protection and disabilities and those sorts of areas, if they have the capacity to contain it, they will not need acute mental health beds. There are also the family resources as well. In situations in which there is family disarray there is lesser risk usually to lead to inpatient admission. About diagnoses, I know that some of the focus in the investment in youth has been around low prevalence disorders, such as schizophrenia, bipolar disorder, the psychosis, the severe end of depression. Probably in a child and adolescent inpatient unit those disorders increase with age. So those would be found with more frequency in admissions of children who are older. In the younger age group, there are more likely to be things like anxiety disorders, depression, acute crisis

and adjustment problems, such as a child feeling suicidal, but they may not have a diagnosis of a severe mental disorder. Talking to colleagues, a lot of this is developing personality disorder which, if you can invest in early, you can turn around and the person's coping mechanisms can be increased such that they are able to function more within the community. The vast majority of inpatients would be adolescents and adolescents at risk of suicide.

The CHAIRMAN: We phrased that first question with the term "acute inpatient care". Is that the correct term to use or is there "inpatient care" and "acute inpatient care"?

Dr Caunt: In an acute inpatient unit, the majority would be about containing risk, which is what people do acutely; they get admitted because there is some risk. But in inpatient units as well, sometimes the risk is about medication, side effects or a medical risk. The thing that acute inpatient care has that a more slow-stream care or residential care does not have is 24-hour access to medical care. If the risk comes to fruition, such as you hurt yourself, medical staff are immediately available. Other things might be, for instance, a change in medication that might lead to a medical risk. A person might have to go into acute inpatient care for a short-term admission. Sometimes in children, because of the lack of servicing, I suspect, in disabilities, there are children who have significant developmental disorders are on medication and the community becomes overwhelmed trying to look after those children and they need acute inpatient care. Some of that is around the social thing of whether it is right for the parents to maintain the continuity of their supports in the community. It is not always risk, but there is some risk, and might not just be to the person or another person, it might be to relationships.

Dr Groves: If I can add to that, the issue about the petition and the new children's hospital as we understand the policy issues is that the new children's hospital is to focus on acute care. That means, as Dr Caunt indicated, that other levels of care less acute than that need to be addressed as well for any sensible planning to consider whether 20 beds is sufficient for acute care for the new children's hospital. In that regard, there are a couple of important issues. Firstly, the new children's hospital has a focus on children between zero and 16, being 15 years and 364 days and 16-year-olds and 17-year-olds will ultimately move towards services that are specific to youth.

[10.00 am]

That is a deviation from current practice because currently child and adolescent services usually see children up to 18 years, and that is an issue that needs to be handled very carefully. Children aged 16 and 17 clearly have different developmental needs than 12-year-olds and very different developmental needs than 25-year-olds, and as we move towards having youth-specific services, we need to make sure that those interfaces are handled very clearly and thought about. The planning that we understand has occurred in relation to youth services suggests that we need a lot of youth beds in this state, and so considering the adequacy of acute beds at the new children's hospital without understanding the very large number of youth beds that we need is a very important consideration. As Dr Caunt has already indicated, it is inappropriate for a child ever to be in an adult unit; it may on occasion be appropriate for them to be in a youth unit, but without any youth beds currently, the situation needs to be addressed.

The CHAIRMAN: That is something we will be exploring—the mix and the rearrangement of those categories—later today, you will be interested to know. I just have a couple of quick ones before I hand over to Steve. Can I just ask, what percentage of children generally occupying inpatient beds are involuntary patients?

Dr Caunt: I do not know that statistic offhand. I do know that the per cent that end up in the Mental Health Tribunal are relatively small—of under-18s that come before the Mental Health Tribunal. It is probably in the region of, say, maybe 150 to 200 a year, so that would be the amount that are involuntary. Some people are involuntarily referred, and that is why it is difficult for me to answer the question, and I do not know what the statistics would be, but the amount that remain involuntary

is relatively small considering the number of inpatients. We have involuntary beds at the Bentley adolescent unit presently—they are at 12—and they are generally full.

Dr Groves: Mr Chair, just to add to that, the Chief Psychiatrist of the state would be aware of that information; it is actually provided to him. That is something that could be addressed that way and perhaps a submission given. My understanding from having previously been in a similar situation in Queensland is that the proportion of admissions of children to children and adolescent units is smaller in terms of how many involuntary compared with the adults sector, so I agree with Dr Caunt's comments that whilst it occurs, it is less frequent than, for example, in youth and in adults.

The CHAIRMAN: Thank you for that, both of you. We will be sourcing statistics from the relevant government agencies, of course. It was just useful to get an anecdotal view of people who are experienced in the front line.

Dr Caunt: There is an added complexity, of course, because under 16, and certainly under 14, children might not want to be there, but the adult might be consenting for them to be there, so there is a number of people who, depending on how the practice of the new Mental Health Act pans out, might be more or less—I am not sure how that will impact on the number.

The CHAIRMAN: I am going to seek the benefit of your anecdotal experiences one more time. How many inpatients would be first-time patients or is it the case that most inpatients are hospitalised on numerous occasions?

Dr Caunt: Completely anecdotally, I have no statistics to back this up, I would say that when I have worked on that inpatient ward, say there are 10 inpatients, one or two of those, or one to two per cent, would be people who come and go for a period of time, so they have an illness or a development problem that is quite severe and recurrent and they come and go over a year or two, but the vast majority, if you can establish good after-care, they may have acute episodes, but the idea of the inpatient bed admission is to set up the community support such they can be managed within the community. But that proportion may be one or two out of 10, which is actually 10 per cent, 20 per cent, who actually need that ongoing relationship with the hospital.

Dr Groves: Mr Chair, if I could just add to that. It may be worth me now raising the national mental health service planning framework. I would love you to give you the source for this document; however, it is yet to be publicly released. Perhaps if I can quickly give you its background: it was an undertaking of all governments when they endorsed the fourth national mental health plan to develop a national mental health service planning framework. The commonwealth government tendered to the New South Wales and Queensland governments to develop this framework and a number of experts were involved in its development over two years until October last year, when that project completed. Its task was to give us an indication of what should be being provided to meet the needs of the mental health community. During that project I am aware that one of the issues that was looked at were issues such as what would be expected readmission rates of all people of all ages. In that regard it is helpful to note that the readmission rate of adults would be expected to be within a range of about 30 to 40 per cent in any one year. The rate of readmissions of children is much lower than that; it is in the order of 10 to 15 per cent in an optimal system. So, it might be expected, as Dr Caunt has said, that there will be readmissions—that is, people coming back in for a second or third occasion in the 12-month period—but more often than not it is people presenting for the first time, which is a bit different from what you see in adult mental health services, and partly that is because the nature of the problems are quite different.

Dr Caunt: I just would add too, because there is one thing I did not say, that when I say that, of course, I have not worked in an inpatient unit for a number of years and anecdotally from the members of the faculty, from the feedback I get from them, there is an increasing tendency to readmission, particularly with young people with self-harm and this is because there is a difficulty in establishing a support within the community that can contain that self-harm, mostly within

mental health services, like getting a plan of that. People debate whether that is because of an increasing acuity and an increased frequency of self-harm per se, which might be through lack of funding of many years so that those problems are not addressed earlier—the mental health problems that lead to that tendency. But yes, from the membership, they say that there is an increasing proportion of young people who re-present, particularly to acute services—there are now acute services in the community as well.

Hon STEPHEN DAWSON: I have a couple of questions. Thank you for coming this morning. Dr Groves, there has been a number of media articles over the past year in particular about mental health beds and the perceived shortage of those and you are quoted in July last year in, I think, an article in *The West Australian* in which you said there was unrelenting pressure on both child and adolescent mental health beds. A direct quote says —

> "The beds are never unoccupied because as soon as someone is discharged another is admitted and the number of children and adolescents on the waiting list is close to 10 and that is usual," …

How many beds are needed? Granted, I heard your comment that we need more funding across the system, but if we do not get that, if a bed is the last resort, what do we need at the moment; how many more beds?

Dr Groves: Mr Chair, if I can preface these remarks, because it is actually a fairly significant issue. I represent the Western Australian branch of the college. My previous role included being a senior clinical planner to the Mental Health Commission around its ten-year plan. I am no longer involved.

The CHAIRMAN: How recently were involved with it?

Dr Groves: Until 31 March this year. Therefore, I am privy to certain pieces of information that are protected by the relationship I signed with the Mental Health Commission about not releasing them; however, I have had intimate involvement in the national mental health service planning framework, which informs my views, and so have a number of members of the branch of the college. So we have a collective view that is separate from any other planning processes. I just will preface that remark so it is very clear that it is not based on work that is going before government. In that context, perhaps if I can explain that the national mental health service planning framework, which I have indicated has not been publicly released, is probably the most comprehensive planning process that has been undertaken in mental health anywhere in the world. It is the only undertaking in which the exact known epidemiology for a country—that is, how many people with what types of mental disorders need what types of care—has been planned through.

[10.10 am]

What it told us was the number of beds and services we would need to meet the population need. What we can then extract from that is what the Western Australian population would need. If I can start at the very youngest age group and work my way forward. There would be the need for a number of beds for what we generally refer to as perinatal or mother–baby type units. They are important because whilst the mother is usually experiencing a significant mental disorder, such as postpartum psychosis which is incredibly risky for the mother but also for the child, it is a very, very disturbing thing for an infant not to make that bond with their mother. It means that the mother and the baby are both admitted. There is a clear need for those beds in this state. The planning for beds for this state is around about what will be available once the mother–baby unit is open at Fiona Stanley. The college's position is that is about right for those babies. I am going to concentrate on babies. What perhaps has not been done is the establishment of those inpatient services for the very small number of babies who have other forms of severe disturbance and need intensive care that is not related to the mothers at all. There is this other separate little group that needs to be considered. That is modelled in how many beds we need for zero to 15.

Then there was the process of building up. Let us look at all of those diagnoses, whether they are eating disorders, behavioural disturbances or school refusal, and how many of them would need that small amount of inpatient care if all of the other services were available to prevent the person needing to go to hospital unless absolutely necessary. What it would say for the Western Australian population in 2014 is that we would need somewhere in the order of about 20 beds, which is the number for the new children's hospital, but contingent on a number of things being present; for example Hospital in the Home of around about five beds. That allows those children who have been in hospital to go home with a high level of intensive support and treatment earlier to allow the turnover to run 20 beds. Without it, it actually means you would need to add that number of beds into the total count. It also would establish that we need somewhere in the order of 70 beds—that is a number that I would need to have confirmed because it depends on a number of factors but it is pretty close to 70 beds—for youth; that is, people between the ages of 16 and 24. At the moment a number of those youth are getting their inpatient care in Bentley Adolescent Unit. My remarks in July last year were very much around the pressure on the Bentley Adolescent Unit, which has been relentless, and the backflow in that regard. We have not got any dedicated youth beds apart from the Bentley Adolescent Unit, which are not specifically youth; they are actually all of the adolescent time periods—13, 14 and 15-year-olds are admitted there as well as 16 and 17-year-olds.

The other important thing to establish is that the planning framework identifies that there are certain children who have severe amounts of family disturbance and significant morbidity, which means they need high levels of residential care that are the equivalent of an inpatient service where those lengths of stay are for many, many weeks, sometimes months. That is a really important thing because whilst those numbers of beds are very small, if you do not have them and they therefore have to be in the acute system, they block those beds for a very, very long period of time.

The other thing that was important to note from the service planning framework was the level of need for all of the community specialist child and adolescent services that Dr Caunt was referring to. Our current estimate from the branch is that nationally we have about half the number of those staff that we should have. That is a very, very significant shortfall. The adult sector nationally is probably about 70 per cent of where it needs to be, which is not too bad when you are looking at 50 per cent in the child and adolescent sector. Again, it reflects those opening remarks: the child and adolescent sector has had the least amount of development. There is also one other aspect to the planning framework: it assumes that there is sufficient primary mental health care; that is enough care from general practice in schools and in various other places that are appropriate for the child. This state has—I am sure the committee is aware—one of the lowest rates of general practitioners in the country per capita. The impact of that is that the GPs who are very busy see less mental health than they would otherwise see. That has an effect on the state's specialist system. The state's specialist system is actually doing things that it would not otherwise do. As you would be aware, the provision of primary mental health care is generally considered the responsibility of the commonwealth government, not the state, but the state's services are impacted when there are less GPs than there would otherwise be.

Dr Caunt's comments about the need, particularly amongst children, for a very broad approach to what are the needs in schools and what are the needs in various other places that children are at to provide services that mean that they are picked up, their problems are identified early, that interventions are early, to mitigate this late development and this late presentation of problems which is what often ends with hospitalisation is the basis for that plan. If we are not doing all of those particular aspects, the number of beds we will need will be much higher. So 20, according to that planning framework, is about right. But you need all of those other things. Without it, 20 will not be enough.

Dr Caunt: The other issue that I wanted to raise as well: I think from a systems perspective there is a number of inpatients that come who actually have developmental disorders. There is a lack of acute residential care for children with developmental disorders. Those with severe behavioural

disturbances fall between the gaps for a long time and do not get adequate management and end up in inpatient mental health units because there is nowhere else to contain them. It is not just community and health, it is also other sectors. In the welfare sector, the lack of input to mental health services there results in an increase in prisoners in the prison system. There is an inadequate child and adolescent mental health service as well. It is not just about inpatient beds, it is about all sorts of other services pressing on those. That feeds back into more and more beds within the acute units for mental health.

The CHAIRMAN: In processing the information that you are providing, part of what I am taking away from it is that the prospective availability of beds is about right in the metropolitan area at least, if we have relief in the other areas. Conversely, if we do not have other aspects of earlier care, or primary care, that is when that will show up an increased demand on the beds that are available—is my reading of it about right?

Dr Groves: Yes, that is correct, as at the population in 2014. Perhaps that is the other thing I wanted to add: clearly when planners do planning, one of the things they do is look to a forward horizon because it takes time to construct any new beds if there is a shortfall. If you look at the number of children and adolescents up to the age of 15 come 2025, the population projections suggest we need 28 beds. At some time in the next little while there has to be the planning around an additional eight beds on the basis of still having everything else there. The number might be right for this year, but it is not right if you look at the ABS series B population projections for this state in 2025. I know there is debate about whether the state's population will grow at that rate or otherwise, but in any case whether the net overseas migration or the net interstate migration continues at a lower level, 28 is the number we are going to be looking at in 2025.

One last point: the new children's hospital acute mental health beds for those children are actually for the state. One of the things that disturbs us substantially is that whilst about 80 per cent of the population could be considered to be in and around the metropolitan area or within easy access of the metropolitan area, such as from the south west, that is not the case when it comes to that large part of the state that is north of Perth. It would make no planning sense to ever establish inpatient beds for example in the Kimberley or the Pilbara because there would not be the type of professional resources there to do them, yet relocating somebody thousands of kilometres with their family to Perth for care is a significant problem. The state needs to think about how it works around those types of issues.

Hon STEPHEN DAWSON: Dr Groves, we are running out of time, but can you explain to the committee what happens in the case of somebody from a regional area at the moment who needs acute care—how do they get treatment?

[10.20 am]

Dr Caunt: Depending on the problem some will be attempts to manage in adult units if they were older adolescents. So there might be an attempt to manage them in adult units where they would not get specialised child and adolescent care because often in the remote areas in particular there is one worker working over multiple communities, so they would be out of their communities; they would not get much CAMHS input and most of the child psychiatry input is intermittent or flown in. There is no established person who goes there. It is all done through tele-psychiatry, which is very under-resourced. If that is not available or not practical for some reason, they are flown to Perth and then they are inpatients—either adult or adolescent inpatient units. They are usually adolescents because very small children it is difficult to get—people worry about the risk. Then the transport of family members and the accommodation of family members is quite difficult, particularly as most people transferred are not people who have access to a good deal of funds, and so the care is suboptimum because they are trying to link in with the families.

Hon STEPHEN DAWSON: I want to get back to the waiting list. We have 20 new beds in the new Perth Children's Hospital, but I think we are told that six of those beds will go across from Bentley

and some of the Princess Margaret hospital beds are also going to shift across to the new Children's Hospital. So, I just do not know how that is going to be enough when you are quoted in the media as saying there is a waiting list of close to 10 at the moment and there is always a waiting list of 10. Are you sure? Will this be enough beds if we do not get the support or the money for those allied services outside?

Dr Groves: The issue from the branch's perspective is we are unaware, because we have been uninformed by the government, how it actually plans to do all of that. So, we recognise that there are a huge number of youth beds. Youth are not in scope for the new children's hospital, which is why, if all the other things are right, we understand 20 at the new children's hospital. Our biggest concern is the 16 and 17-year-olds. That is when we start to get a big kick-up in utilisation of beds. If we are saying they are actually going to be taken out of the acquisition, that is how we can establish the 20 beds in the new children's hospital being right, but that is only because the youth are being looked after somewhere else. If that does not happen—and, as I say, we need about 70 and we have zero—that is where you can start to see where our concerns are.

Dr Caunt: The other concern is that 20 might be right, but we are not aware of any plan how the other things can be right. If the five Hospital in the Home beds—are they going to be there? If they are planned for, yes, 20 is right. If they are not, 25 might be right. If there is inadequate community services —

Dr Groves: Acute response teams, for example.

Dr Caunt: If there is inadequate community services, then again, there will be some more additional beds to that. So without knowing the more global plan, yes, that is the minimum all things being right.

Hon BRIAN ELLIS: I think my questions have been answered in the process, but tell me if I am wrong just summing up from your opening statement, it is better that the children are cared for at home rather than going to hospital. If all the resources and funding that you require for at-home care were provided, do you believe that the overall cost to government would be less?

Dr Groves: Yes. It is much more cost-effective as well as better for the family for the care to be provided at home rather than at inpatient unit. Running a child and adolescent inpatient unit is amongst the most expensive beds we have in the mental health system.

Hon SAMANTHA ROWE: Does that apply to youth as well? You include the 16 to 17-year-olds in that?

Dr Groves: Yes, absolutely, in that same statement.

The CHAIRMAN: That is a fairly clear remark, too, on behalf of the Royal College of Psychiatrists, WA branch. Is that the same attitude that is exhibited by the Mental Health Commission?

Dr Groves: We are in not in a position to comment about the Mental Health Commission.

The CHAIRMAN: I think our time has expired. Dr Groves and Dr Caunt, on behalf of the committee I want to thank you for your evidence and the benefit of your advice today, which has been very, very helpful.

A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections need to 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 simply deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. However, should you wish to provide supplementary information or elaborate on particular points, we would be very pleased to receive a further submission from you along with your returned transcript of evidence. So, with that we would just like to say once again thank you very much for your participation and attendance and we bid you a good day.

Dr Groves: On behalf of the college, we would like to thank the committee very much for allowing us to address you.

Hearing concluded at 10.26 am

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