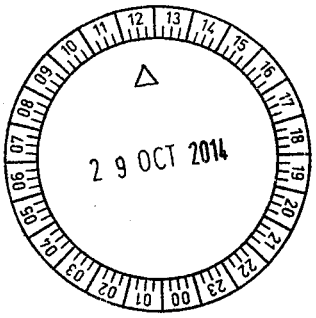
Deputy Premier of Western Australia
Minister for Health; Training and Workforce Development

Our Ref: 25-42284



Hon Simon O'Brien MLC
Chairman
Standing Committee on Environment and Public Affairs
Parliament House
PERTH WA 6000

Dear Mr O'Brien

Thank you for your letter of 16 September 2014 and your request for further information regarding access to acute inpatient mental health beds for young people.

There is one dedicated children's hospital in Western Australia which is Princess Margaret Hospital (PMH) located in Subiaco, Perth. Children under the age of 16 years old are treated either at PMH or at another hospital. Persons aged 16 and over are treated at other hospitals. By "appropriate children's facility", I presume you are referring specifically to PMH.

I will reply to each of the questions highlighted in your letter.

1. What is the waiting time for access to an inpatient bed in an appropriate children's facility?

The response received from Child and Adolescent Health Services (CAHS), Child and Adolescent Mental Health Service (CAMHS) only pertains to the waiting time in Princess Margaret Hospital (PMH) and the under 16 age group. Children over the age of 16 are required to present to the emergency department of another hospital.

There are also children under the age of 16 who present at other hospitals across the State.

In terms of mental health admissions from PMH Emergency Department:

PMH Emergency Department (ED)	FY 2012/13	FY 2013/14
Median length of episode in ED for mental health admissions	219 minutes	198 minutes
90th centile length of episode in ED for mental health admissions	407 minutes	363 minutes

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CAMHS have implemented numerous measures to reduce the waiting time in an emergency department, including:

- A 24 hour, 7 day a week Psychiatric Liaison Nurse and a 24 hour, 7 day a week on duty Social Worker to the PMH Emergency Department.
- A 24 hour, 7 day a week CAMHS Bedflow Coordinator who works collaboratively with the Adult Mental Health Bedflow Managers, in determining the safest outcome for the young person, which may include not being admitted.
- An assertive emergency mental health response team, the Acute Response Team (ART), who act as an Emergency Department diversion service by offering mental health assessments in the community.
- A shared care arrangement between Paediatric Medicine Clinical Care Unit and CAMHS, to allow mental health admissions to medical beds under joint bed-cards in PMH (children under the age of 16).
- Development of guidelines on how to manage young people under the age of 18 presenting with mental health conditions or concerns in non-CAMHS settings.

2. Is the government committed to providing 70 dedicated youth beds in Perth, and if so, what is the expected timeframe for this to occur?

This question will have to be addressed to the Minister for Mental Health.

3. What is the total acute inpatient bed-days per annum for patients transferred from regional Western Australia?

Due to the current configuration of mental health clinical services, data is reported for children up to the age of 18, and adults over the age of 18.
CAHS CAMHS have provided the following data for the financial year 2013-2014:

CAHS CAMHS admissions from rural Western Australia (FY 2013/14)				
	Bentley Adolescent Unit		Ward 4H (PMH)	
	admissions	Bed-days	admissions	Bed-days
Under the age of 16	9	71	22	150
Age 16 - 17	20	502	9	61

4. How does the committee reconcile anecdotal reports and government assertions about "turn-away" rates?

To understand the anecdotal reports of young people being unable to access a mental health bed, and to reconcile this with clinical process and appropriate outcome, I need to refer to a statement made by Dr Aaron Groves (transcript page 1 and 2):

> *"...children should not be admitted to hospital unless that is completely the last resort. Removing a child from their home and going to hospital is often very traumatising and something that should really occur when all other options have failed."*

It is with this principle in mind, that CAMHS Bedflow assess each individual case and determine if treatment can be offered safely in the community as opposed to admission to an inpatient unit.

Community treatment is recommended to the referring service, and only if acceptable to all parties, will community treatment be offered in lieu of admission to the inpatient unit. If any party fails to accept the alternative, then an admission is offered.

There are occasions when wards are at 100% occupancy. During these times, the young person remains in an emergency department or other medical, surgical or mental health ward/observation area, and is placed on a waitlist for admission to a CAMHS bed.

CAMHS ART assist the treating service in offering appropriate treatment and care, and CAMHS bed capacity is assertively reviewed by the CAMHS inpatient units in order to facilitate an early transfer to the inpatient unit. The waitlist for a CAMHS bed is reviewed daily by the on call CAMHS Psychiatrist and patients on the waitlist are prioritised according to age, clinical presentation, risk level and suitability of the current facility in which the young person finds themselves.

The offer of community treatment may not be what the parent/carer or referral service originally wish for, and may be subjectively experienced as "turn-away".

5. Does the figure of 60% represent the average shortfall of acute inpatient beds for young people?

Referring to my previous letter to the Committee (dated 7 July 2014), and referring to the data regarding young people not admitted, for the first 6 months in 2014:

- 104 out of 325 bed requests were not offered admission (32%).
- 67 out of the 104 (65%) were offered ongoing clinical intervention through a CAMHS community program, whereby it was deemed safe to provide treatment in the community.
- 22 out of the 104 (21%) who were not offered admission, did not require specialised mental health services and their needs were sufficiently met through ongoing primary healthcare services (General Practitioners) or non-governmental organisations.

The 67 out of 104 young people who were offered follow up through CAMHS in the community, in lieu of admission, is not a reflection of the shortfall of acute inpatient beds, but rather that treatment, where possible, could be delivered in the community, as was deemed to be clinically appropriate.

A review of bed occupancy between January and August 2014 revealed:

- BAU at 100% occupancy for 48 out of 243 days (20%) or 1:5 days.
- Ward 4H at 100% occupancy for 81 out of 243 days (33%) or 1:3 days.

- Whole CAMHS system at 100% occupancy (both wards full) for 17/243 days (7%) or 1:14 days.

The issue of sufficient bed stock to address the needs of the population needs to be reframed to address the issue of adequate resources in the community to support the inpatient units. I quote Dr Groves (transcript page 2):

> *"...there has always been pressure on beds for children because of that underinvestment."*

and Dr Caunt (transcript page 2):

> *"...there is such an under-resourcing in the community of mental health services that that puts pressure on beds."*

The responsibility rests, not only in the area of health, but also with social services, housing, child protection, disability services and other agencies.

I hope that this information has satisfactorily answered your questions.

Yours sincerely

Dr Kim Hames MLA
DEPUTY PREMIER
MINISTER FOR HEALTH

27 OCT 2014