

Queensland Mental Health Planning

Premier's Policy Issues Seminar

6 July 2006

Dr Aaron Groves
Director of Mental Health



WHO: World Health Report 2001

Mental Health: New Understanding, New Hope

“In devoting *The World Health Report 2001* to mental health,

WHO was making one clear, emphatic statement.

Mental health ...is crucial to the overall well-being of individuals, societies and countries and must be universally regarded in a new light.”

“There is no health without mental health”

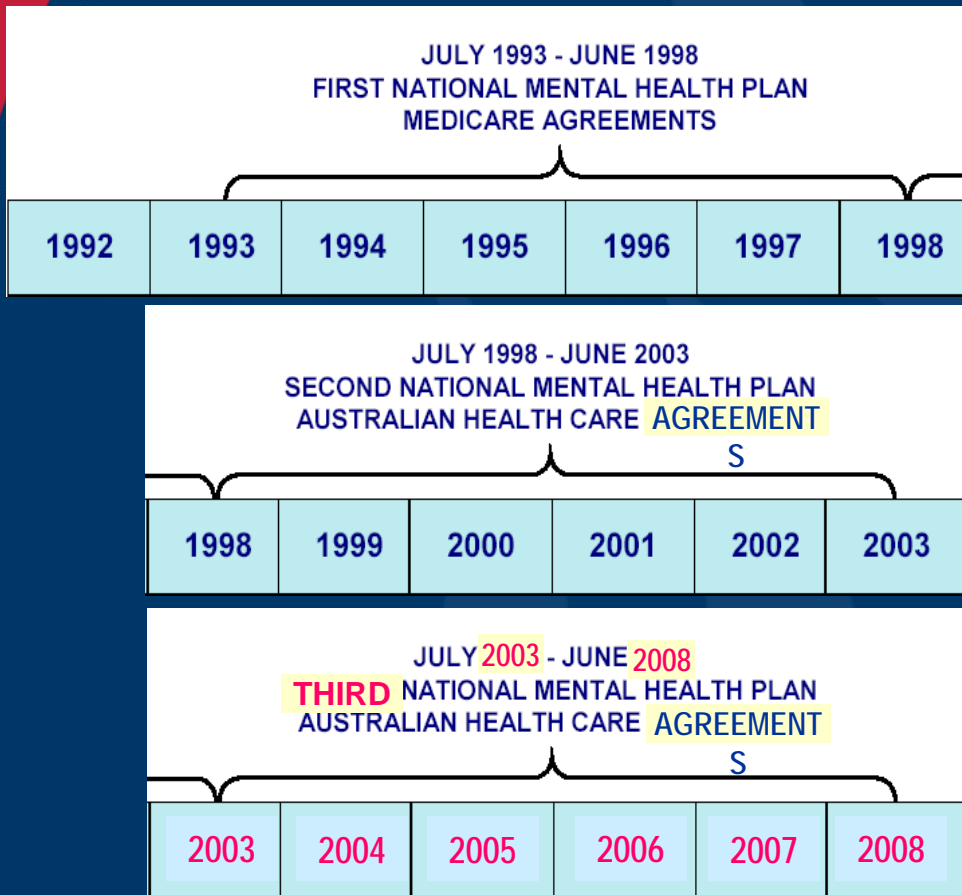
Source:

<http://bookorders.who.int/newaccess/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=24&codcch=2001#>

National Mental Health Reform

- Mental Health Statement of Rights and Responsibilities 1991
- National Mental Health Policy 1992
- National Mental Health Plan 1992 - 1998
Medicare Agreements 1993-1998
- National Mental Health Plan 1998 - 2003
Australian Health Care Agreements 1998-2003
- National Mental Health Plan 2003 - 2008
Australian Health Care Agreements 2003-2008

The history of National Mental Health Plans



■ Mainstreaming, Community MH

□ Designated MH budget, program

□ Promotion, Prevention

□ Partnerships in care

□ Quality & Effectiveness

□ Consolidating Reforms

□ Whole of Government

Growing public concern

- The achievements have not kept pace with increased community expectations and demand
- Broad concern that mental health reforms requires a renewal of effort
- Daily headlines on how and where the system is failing

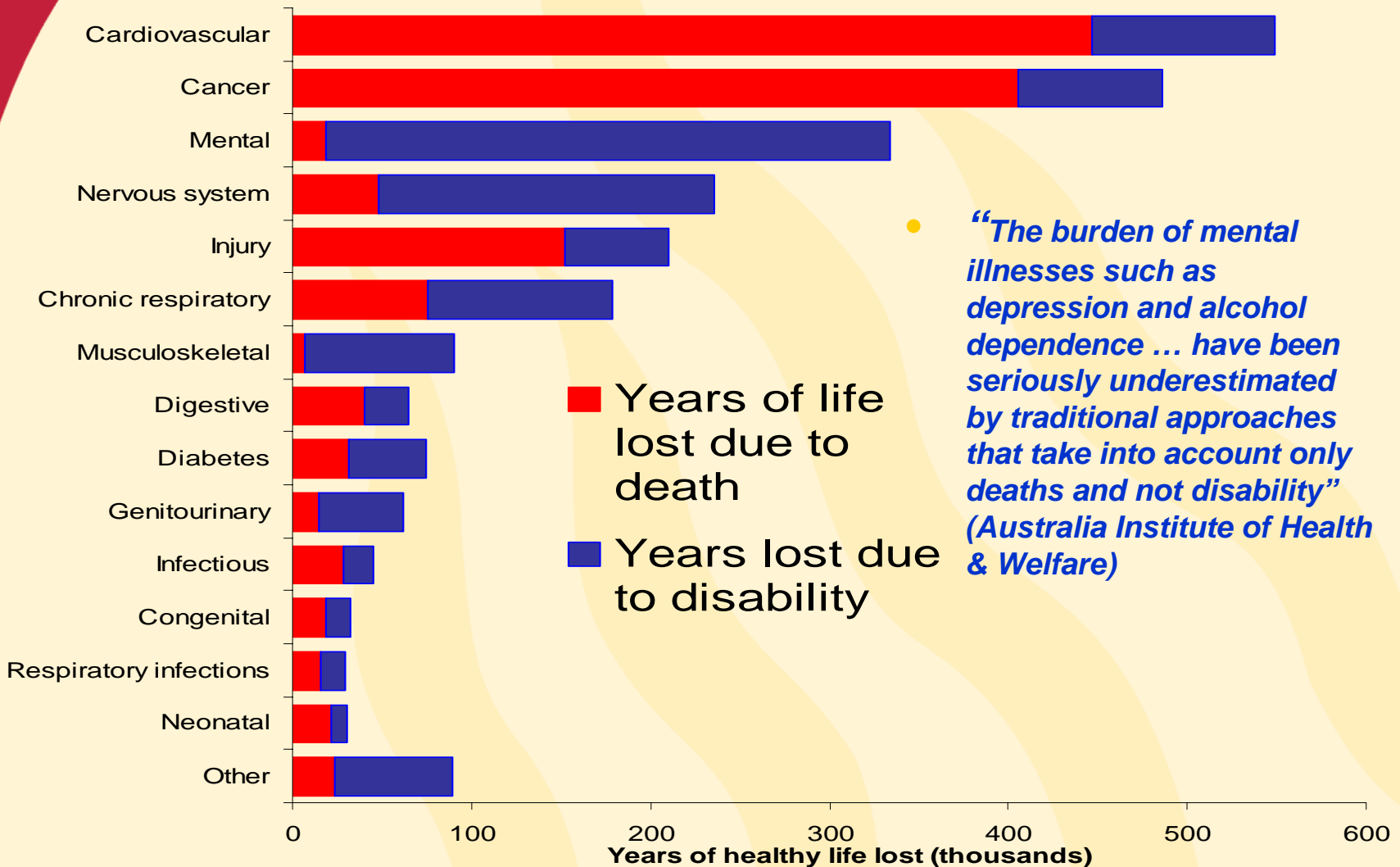
Recent reports

- Recent reports of nation-wide consultations on mental health further made the case for reform:
 - Mental Health Council of Australia's *'Not for Service'* Report
 - Senate Select Committee on Mental Health *'From Crisis to Community Report'*

Why? - The underlying problems

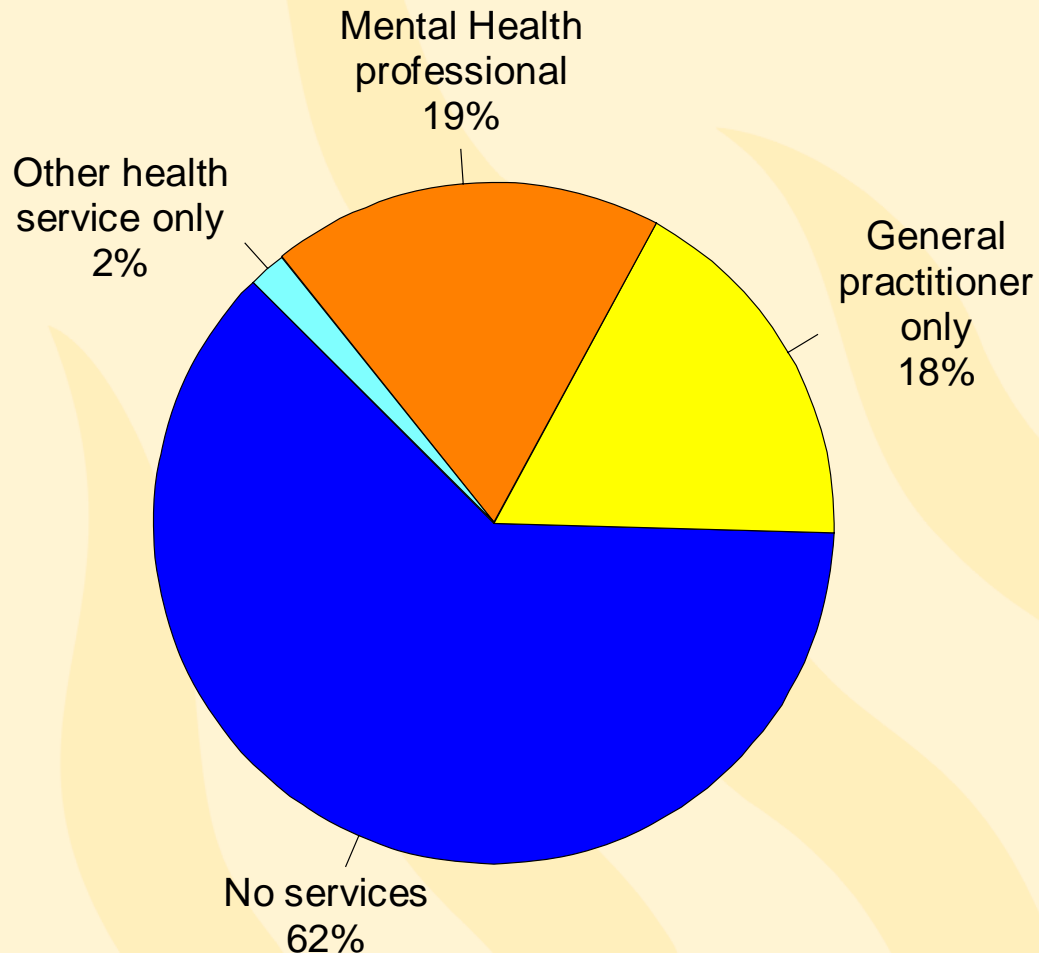
- Low treatment coverage
 - Two thirds of Australians with a mental health disorder receive no treatment
 - Only half the treatment rates of those with comparable physical disorders
 - Unmet need, previously not expressed, is now presenting as new demand
- Quality and effectiveness of services for people with severe mental disorders is not acceptable
- Poor service integration
- People have forgotten about the three legged stool

The 'burden' of mental health disorders on Australian society



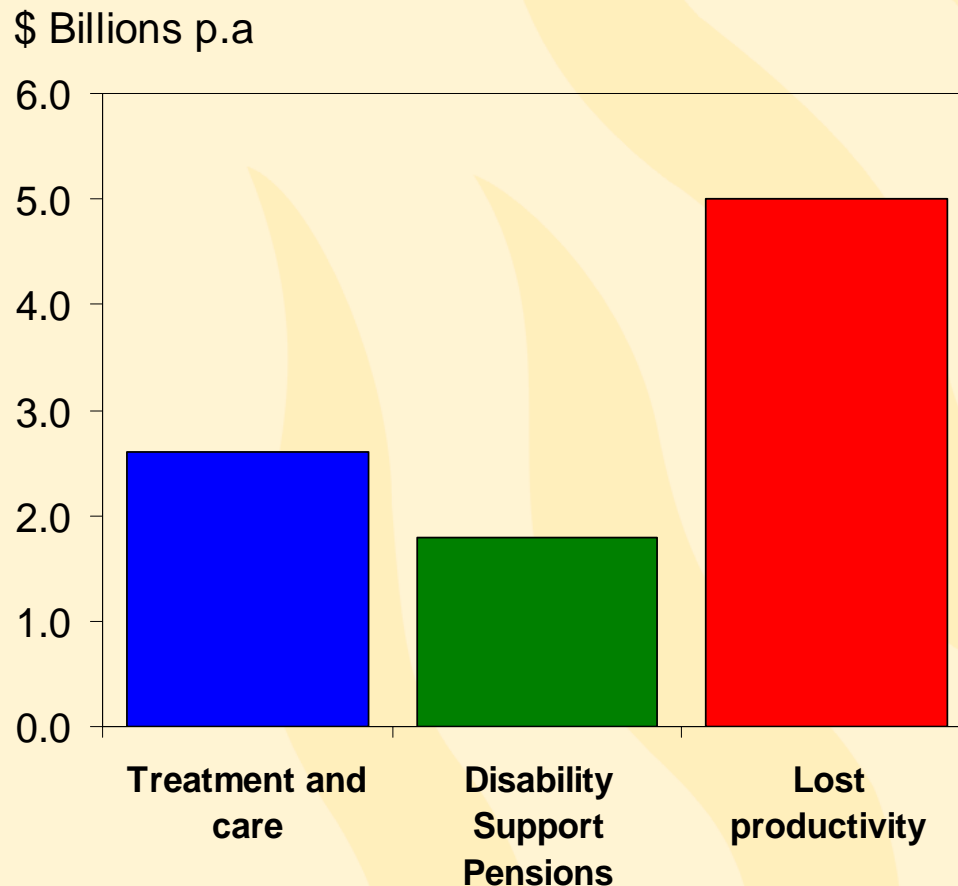
Need greatly exceeds supply

Who provides treatment?



Over half of Australians with a mental disorder receive no treatment (Source ABS 1997)

Mental disorders impose high health costs but much higher productivity losses



The Australian Government alone spends over \$ 3.9 Billion on welfare payments to people identified as having a mental illness. (Australian Government submission 476 to the Senate select committee on Mental Health 2005.)

It has been estimated that annual cost of mental illness in Australia is \$ 21.5 Billion health

WHAT IS THE PREVALENCE OF MENTAL ILLNESS IN AUSTRALIA?

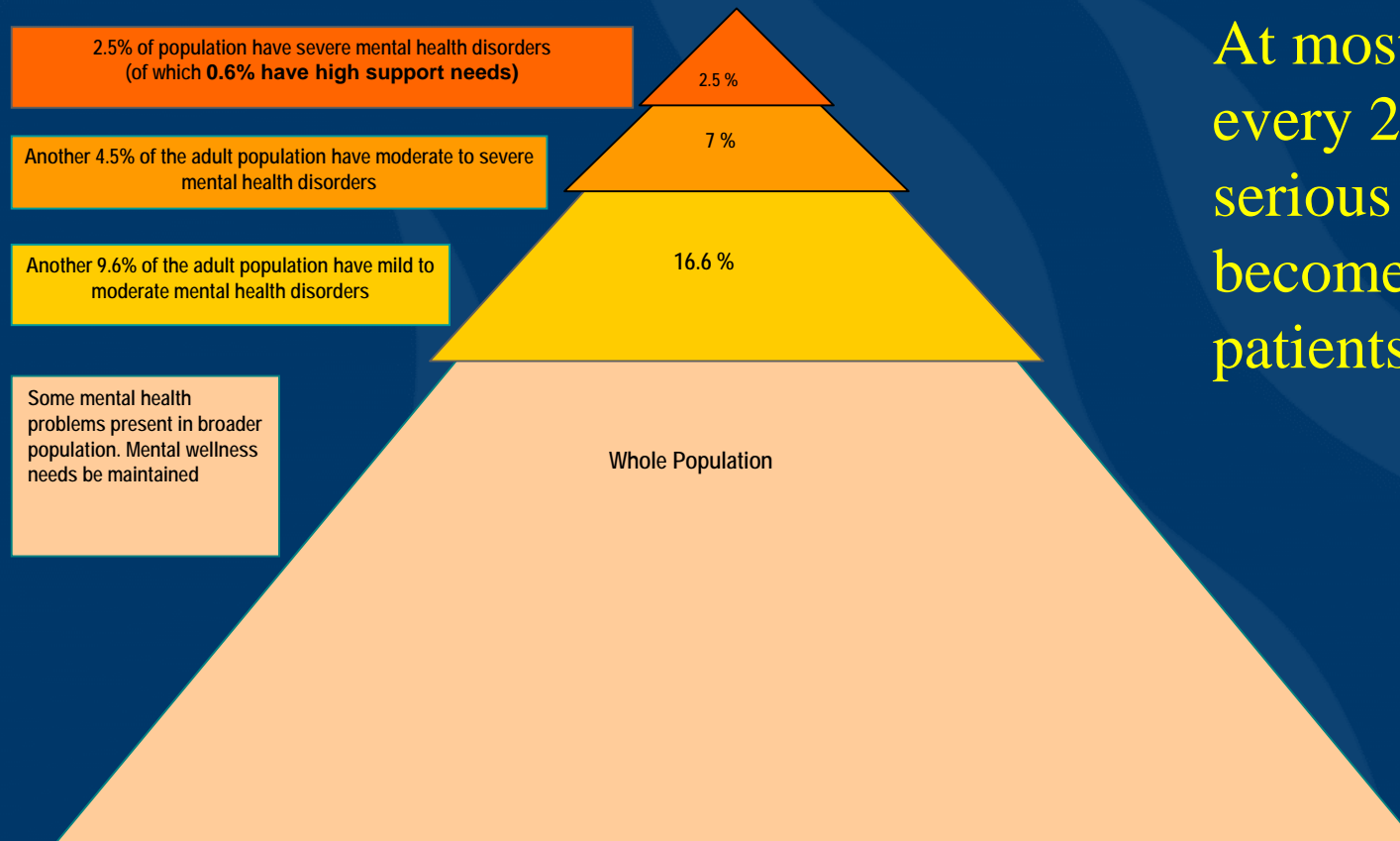
Prevalence	WELL	MILD	MODERATE	SEVERE	ILL
Age 0-17	84.6%	7.9%	5.4%	2.0%	15.4%
Age 18-64	82.2%	10.8%	4.2%	2.8%	17.8%
Age 65+	87.1%	6.7%	4.2%	2.0%	12.9%
All Ages	83.4%	9.6%	4.5%	2.5%	16.6%

Pop 2003-04	WELL	MILD	MODERATE	SEVERE	ILL
Age 0-17	4,062,720	379,728	259,344	98,208	737,280
Age 18-64	11,097,000	1,458,000	567,000	378,000	2,403,000
Age 65+	2,178,625	167,000	105,000	49,375	321,375
All Ages	17,338,345	2,004,728	931,344	525,583	3,461,655



12- MONTH PREVALENCE OF MENTAL ILLNESSES, AUSTRALIA, 2003-04

Prevalence of Mental Health in Queensland

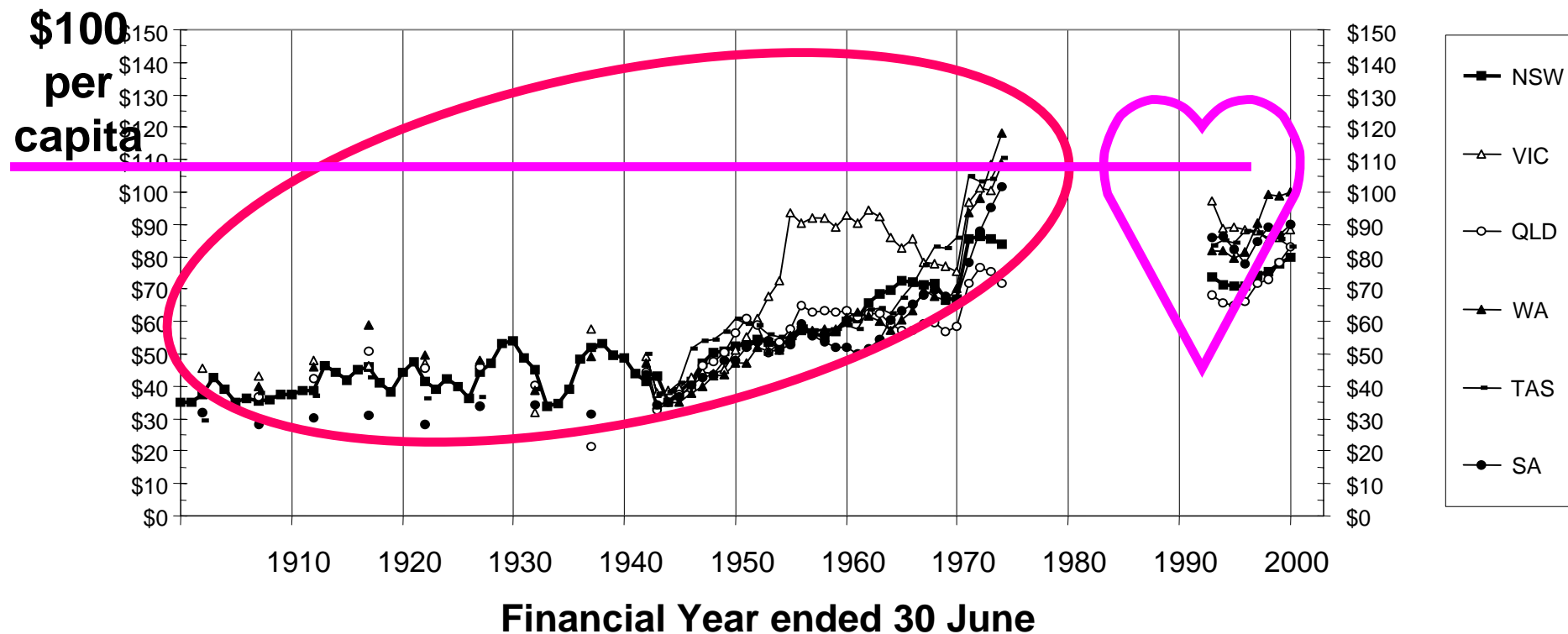


At most, only 1 in every 250 people with serious mental illness become forensic patients.

A BRIEF HISTORY OF DEINSTITUTIONALISATION

Estimated Expenditure on "Mental Health" per capita,
by State, 1900-01 to 1973-74
and
Expenditure on Mental Health under the National Mental Health Strategy

Note: All expenditure has been adjusted to Average Adult Male Weekly Earnings = \$900

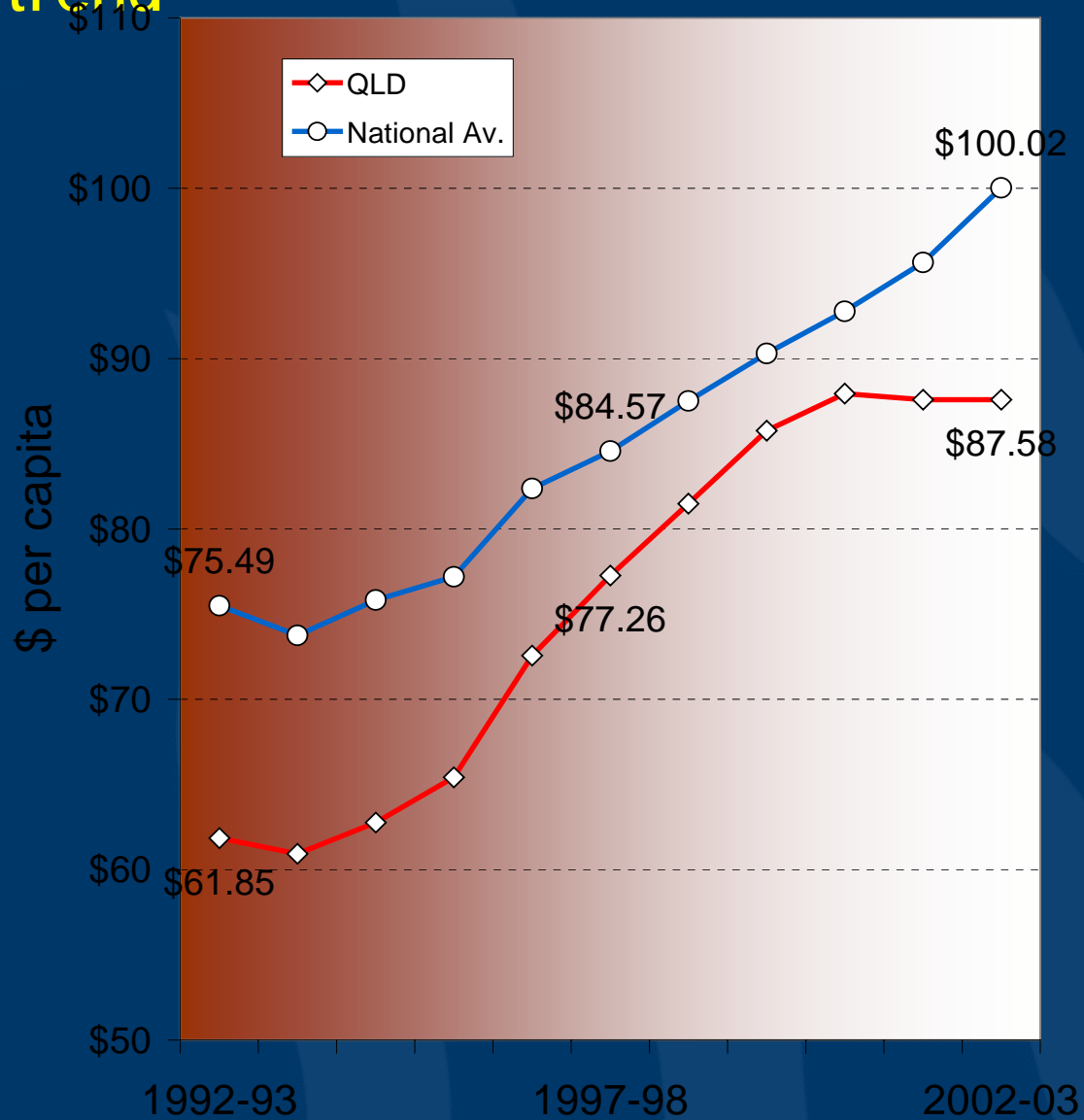


So why do we have a problem with mental health services in Queensland?

- Expenditure
- Community Mental Health services
- Inpatient Mental Health Services
- Non Government Sector
- Promotion, Prevention and Early Intervention
- Primary Care and the Private Sector
- Collaborative Across Governments Approach

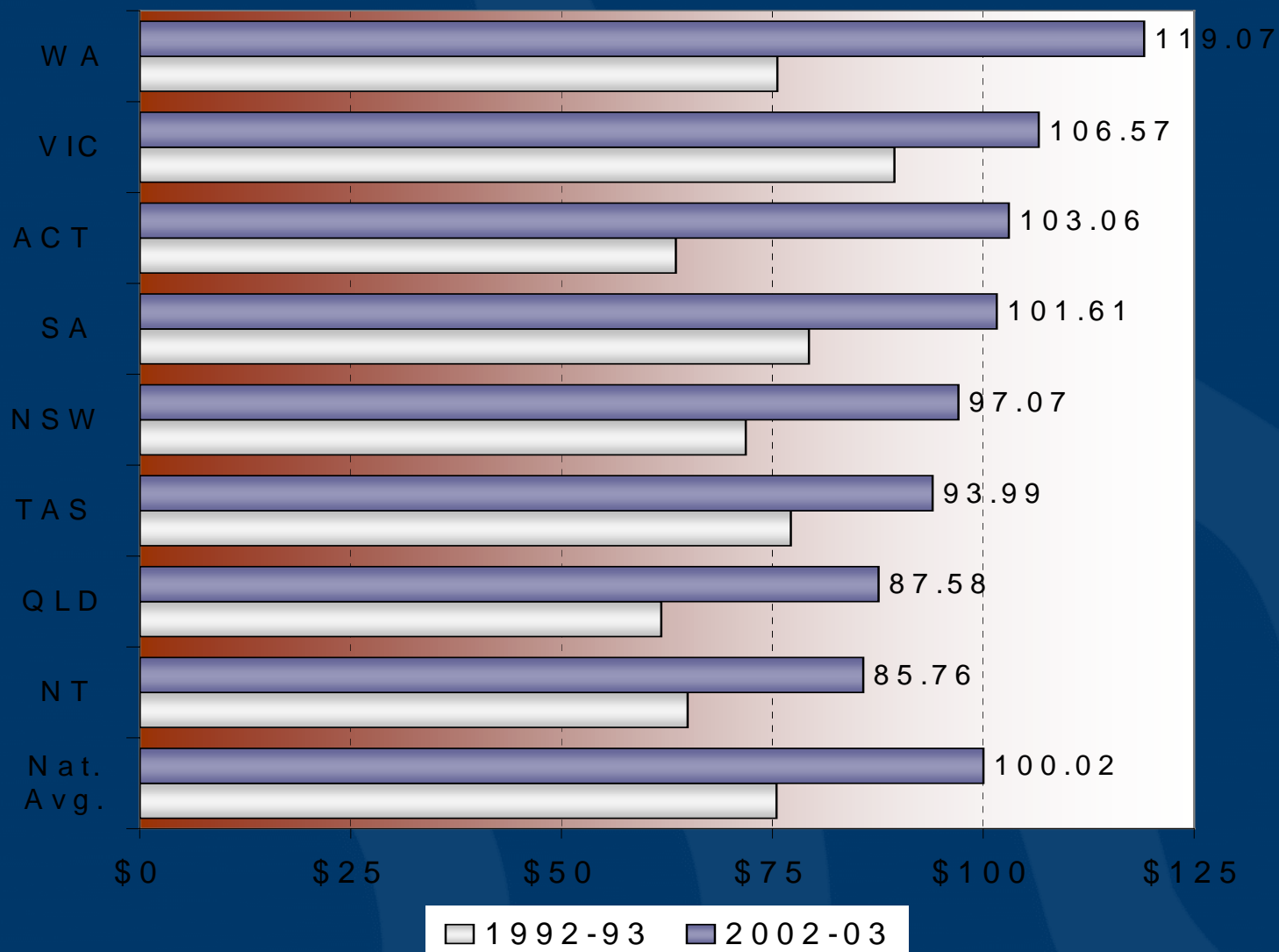
1. Expenditure

Queensland funding compared with National trend



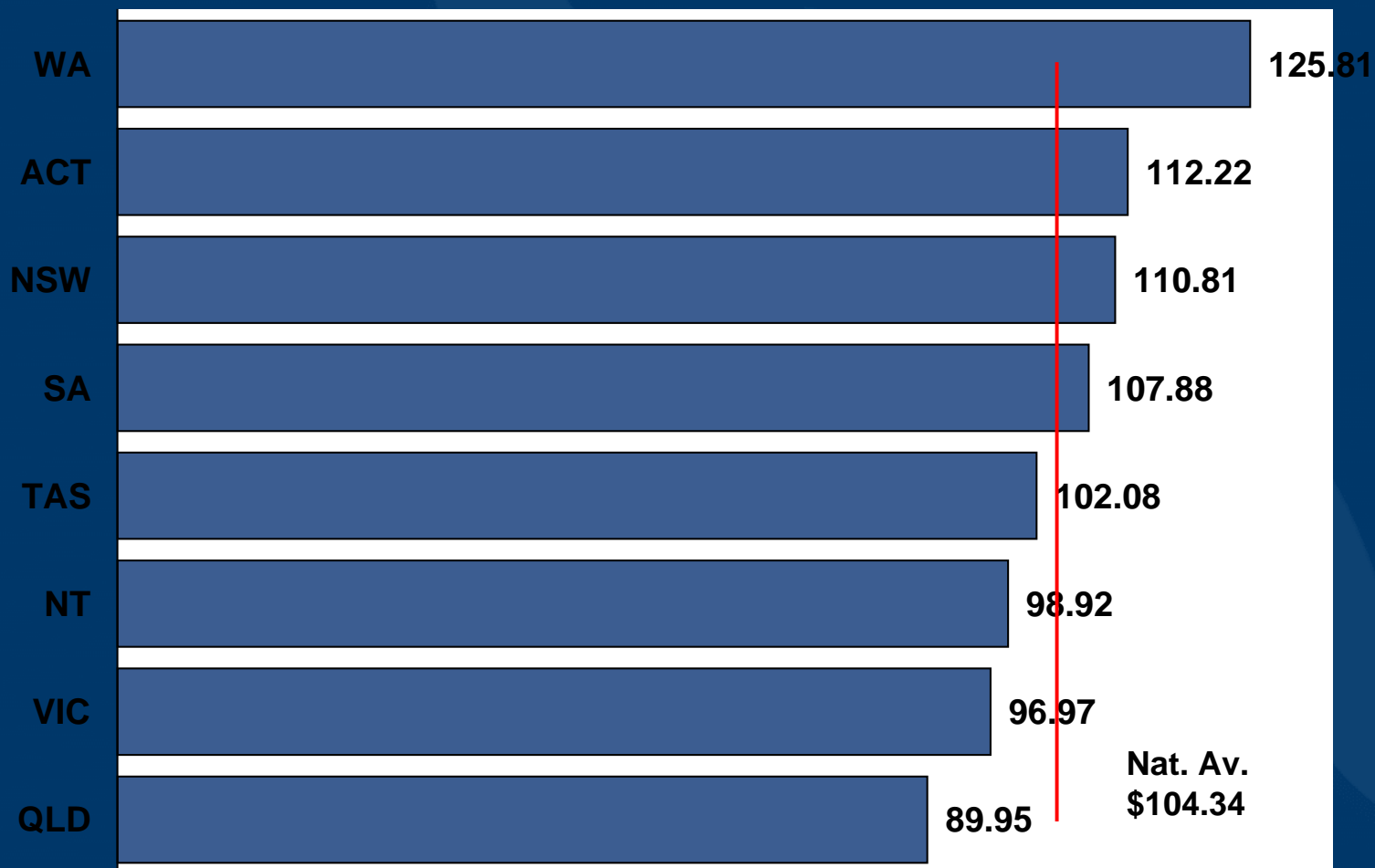
1. Expenditure

Per capita expenditure on specialised mental health services by states and territories, 1992/93 and 2003/03



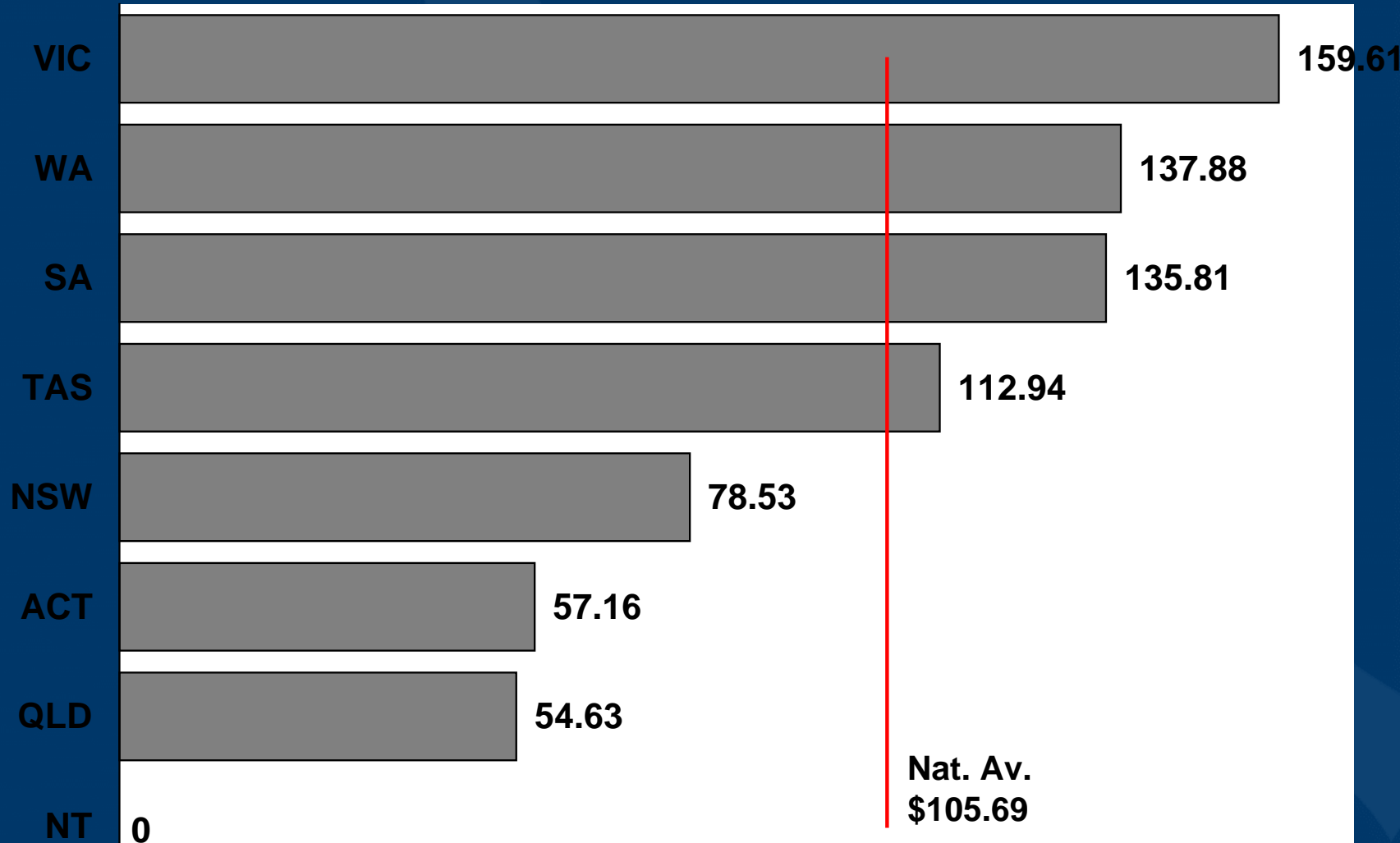
1. Expenditure

Per capita expenditure by states and territories on general adult mental health services 2002-03 (dollars)



1. Expenditure

Per capita expenditure by states and territories on older persons mental health services 2002-03 (dollars)

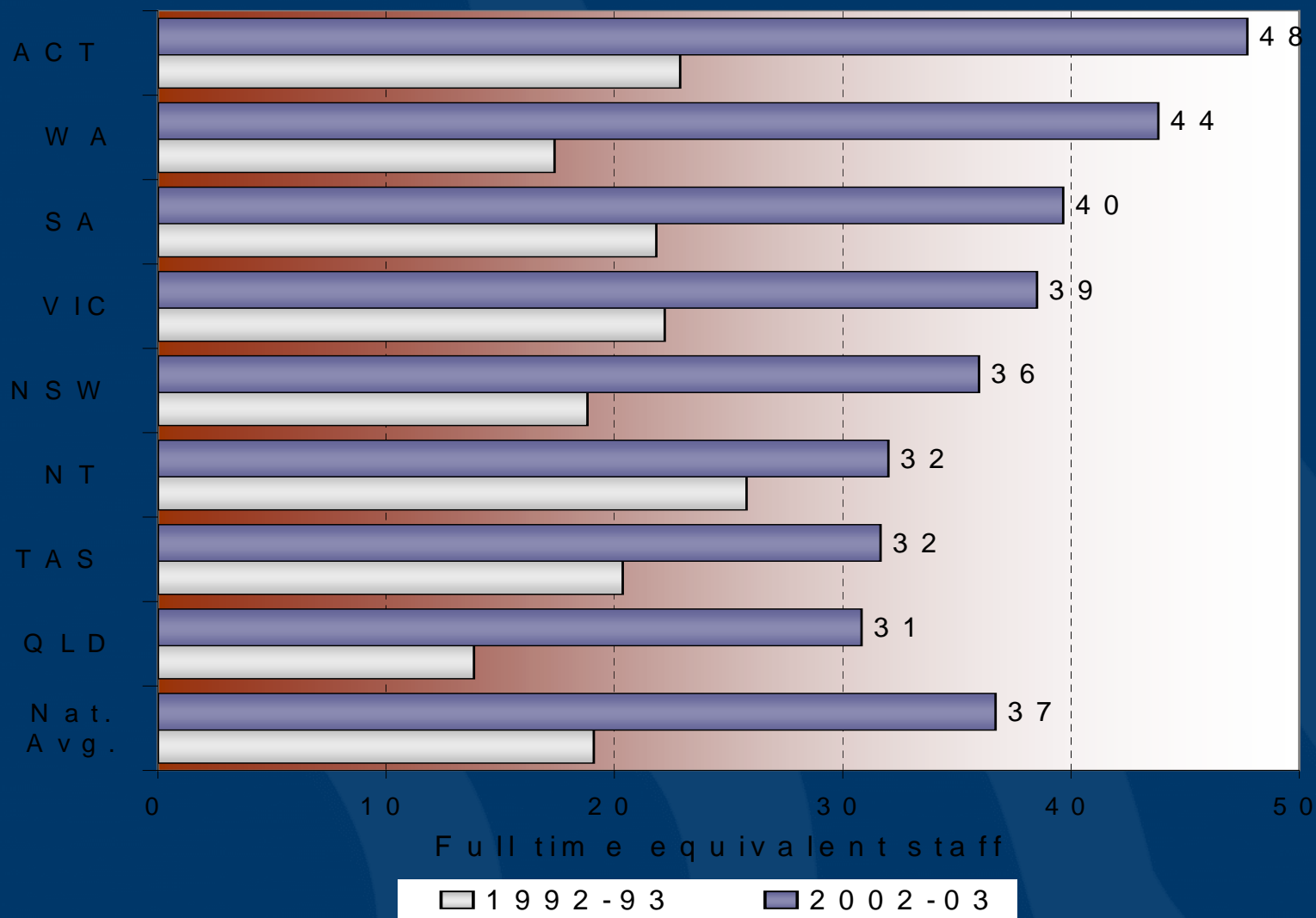


1. Expenditure

- Queensland started the National Mental Health Strategy with the **lowest per capita** spending on mental health
- It essentially retains that position
- Some areas of investment in mental health in Queensland appear considerably more **disadvantaged** than others

2. Community Mental Health Services

Number of FTE Community Mental Health staff per 100 000 population



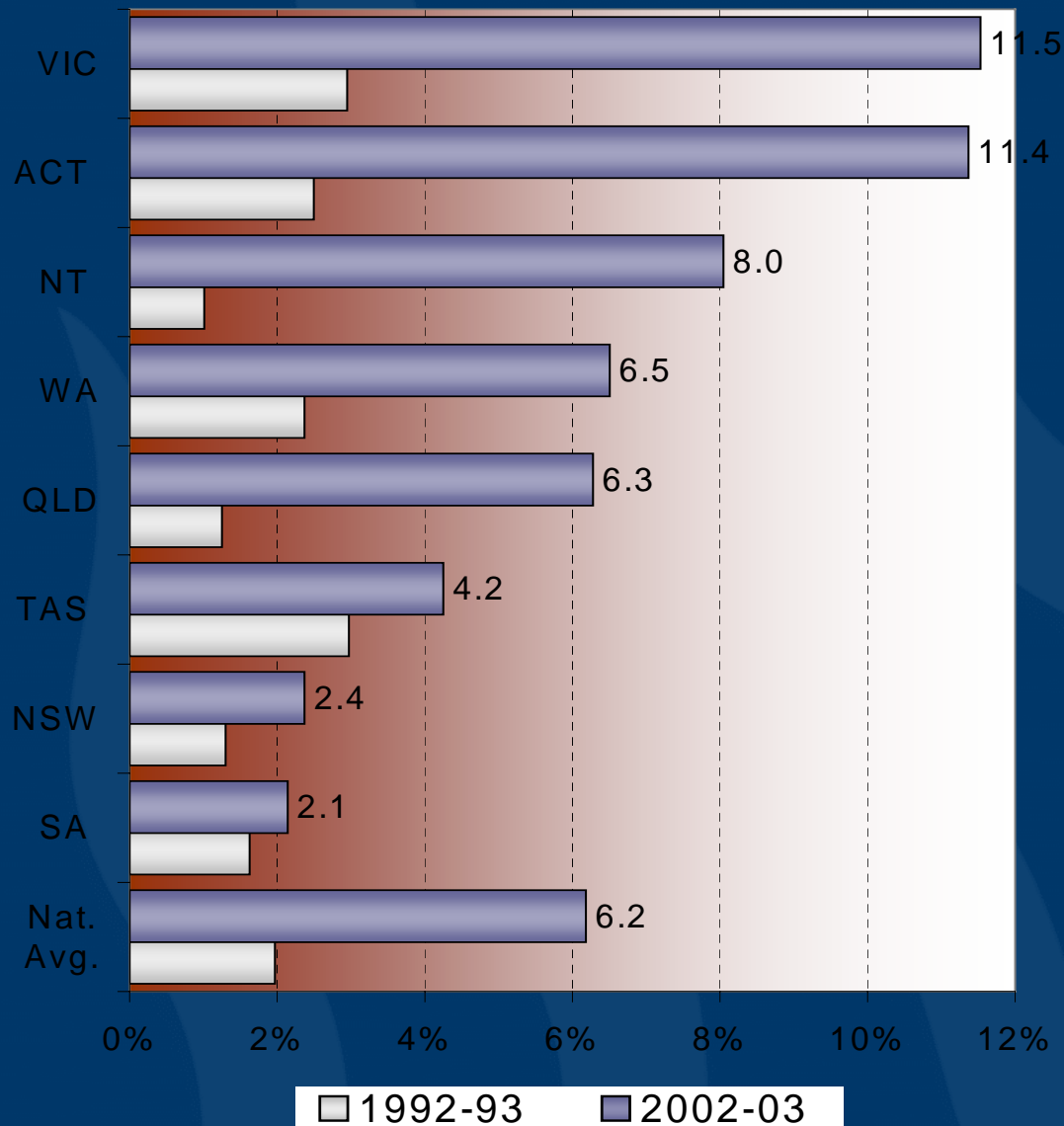
2. Community Mental Health Services

- NSW, WA and Victoria have all revised their target benchmarks of community mental health staff needed to adequately address current demand
- Even if Queensland was to use the lowest of these, that is 70 FTE per 100 000 population we currently need a further 1520 staff to provide clinical services for people living in the community in Queensland.

3. Inpatient Services

- Queensland is one of the few states that has not seen a loss of beds in the past 13 years
- However there has been a failure to build all the beds identified in the TYMHSQ.
- Many facilities are outdated and are in need of replacement or major overhaul
- Queensland needs approx 382 beds constructed in the next 10 years if the full range of support and alternatives to admission are developed, if not we will need more than that figure.

4. Non Government Sector



4. Non Government Sector

- No Strategic plan for services
- Many NG Services are barely financially viable
- Large parts of Queensland lack NG providers
- There needs to be a coordinated approach to ensure support for local providers, within a framework that ensure quality services
- The NG Sector needs to be valued by the specialist sector and work in collaboration not competition

4. Non Government Sector

- A target to benchmark the NG Sector should be defined.
- This should be in the order of 15% of total government mental health expenditure by 2011.
- The role of the Commonwealth following CoAG needs to be considered as there is likely to be considerable duplication and the potential to undermine the Queensland NGS

5 Promotion, Prevention and Early Intervention

- The longer term vision for how to reduce future demand on mental health services.
- Key areas
 - Mental Health Literacy
 - Stigma
 - Discrimination
 - Mental Health First Aid
 - Resilience (esp cultural)
 - Social and emotional well-being

6. Primary Care & Private Psychiatric Sector

- Better Outcomes in Mental Health Care Initiative
- Partners in Mind Framework
- “Teams of Two”/ “Who is your GP?”
- Liaison and Support for Primary Care
- How to best support GPs who are not interested in mental health
- Consider who to make best usage of the Commonwealth announcements

WE KNOW GP'S PRESCRIBE MORE ANTIPSYCHOTICS THAN SPECIALISTS DO, AND THERE ARE 2x VARIATIONS BETWEEN JURISDICTIONS

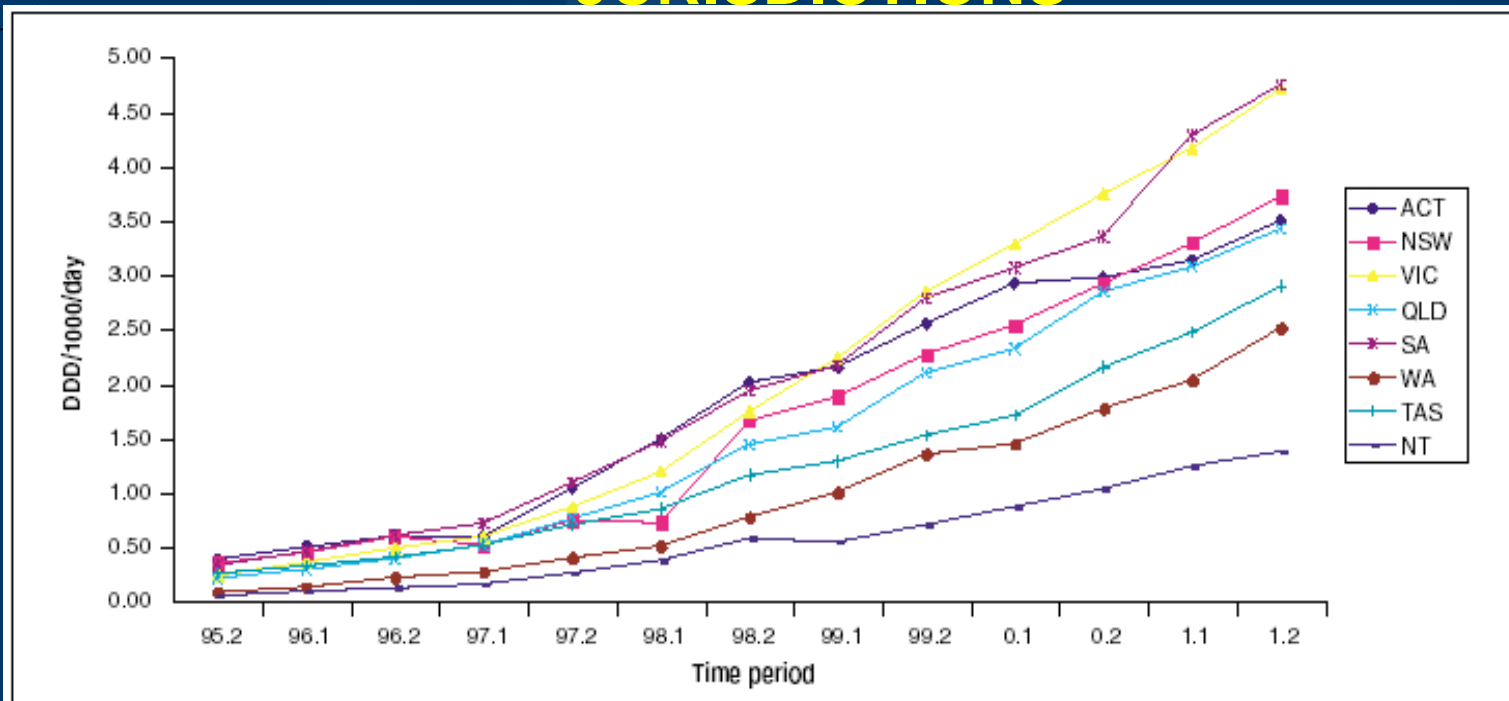


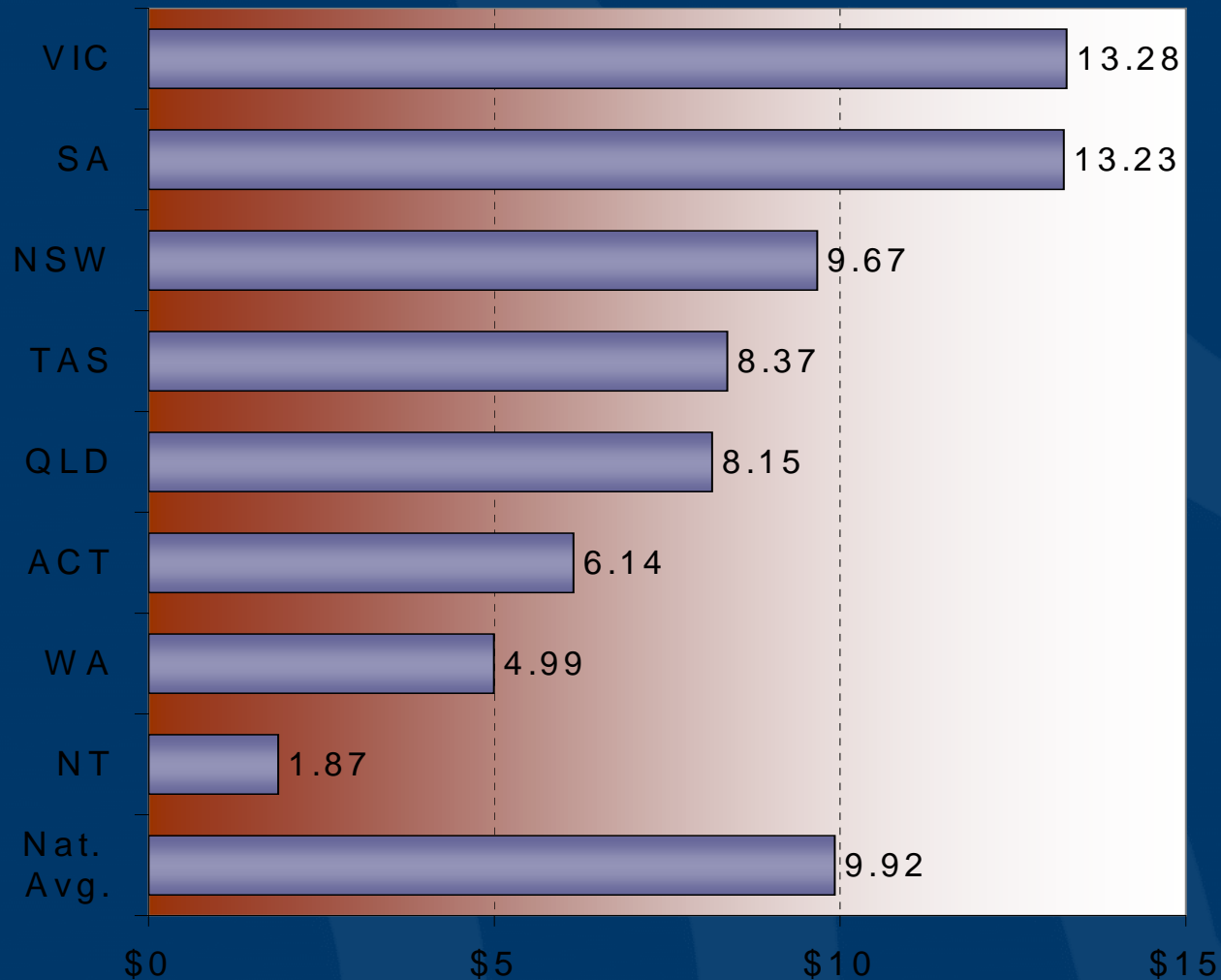
Figure 1: Utilization of atypical antipsychotic medications (defined daily doses per thousand population per day; DDDs/1000/day) in Australian States and Territories between July 1995 (95.2) and December 2001 (1.2). 95.2, July 1995–December 1995 etc.

"... the overwhelming majority of [PBS] prescriptions for [antipsychotic] medications are now written by GP's"

Source: Mond J, Morice R, Owen C. Use of antipsychotic medications in Australian States and Territories between July 1995 and December 2001. *Australasian Psychiatry* 2003;11(3):267-272.

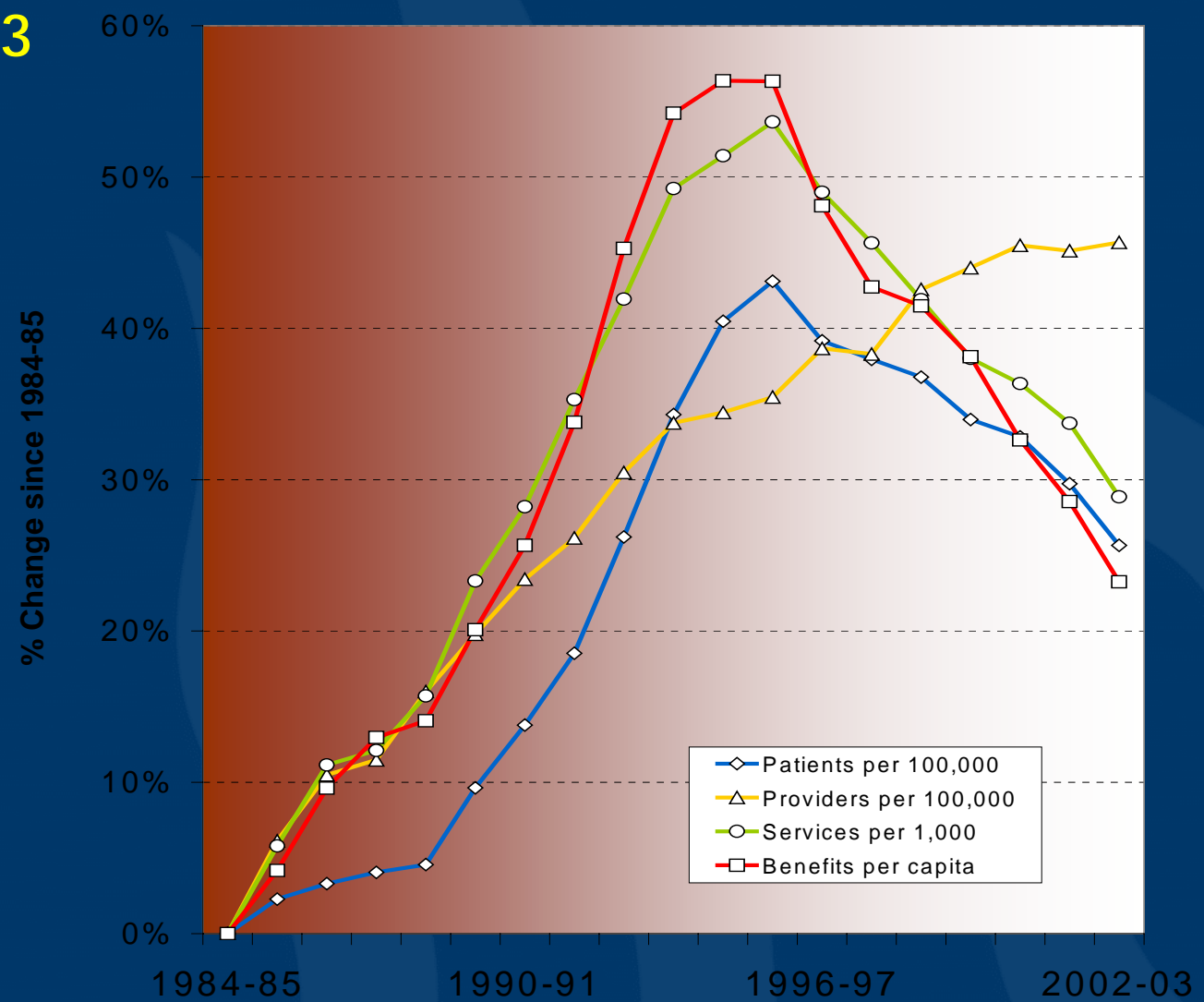
6. Primary Care & Private Psychiatric Sector

MBS per capita benefits paid for Consultant Psychiatrists by state and territory, 2002-03



6. Primary Care & Private Psychiatric Sector

MBS consultant psychiatrists - percentage change in patients seen, number of providers, services and benefits per capita 1992-2003

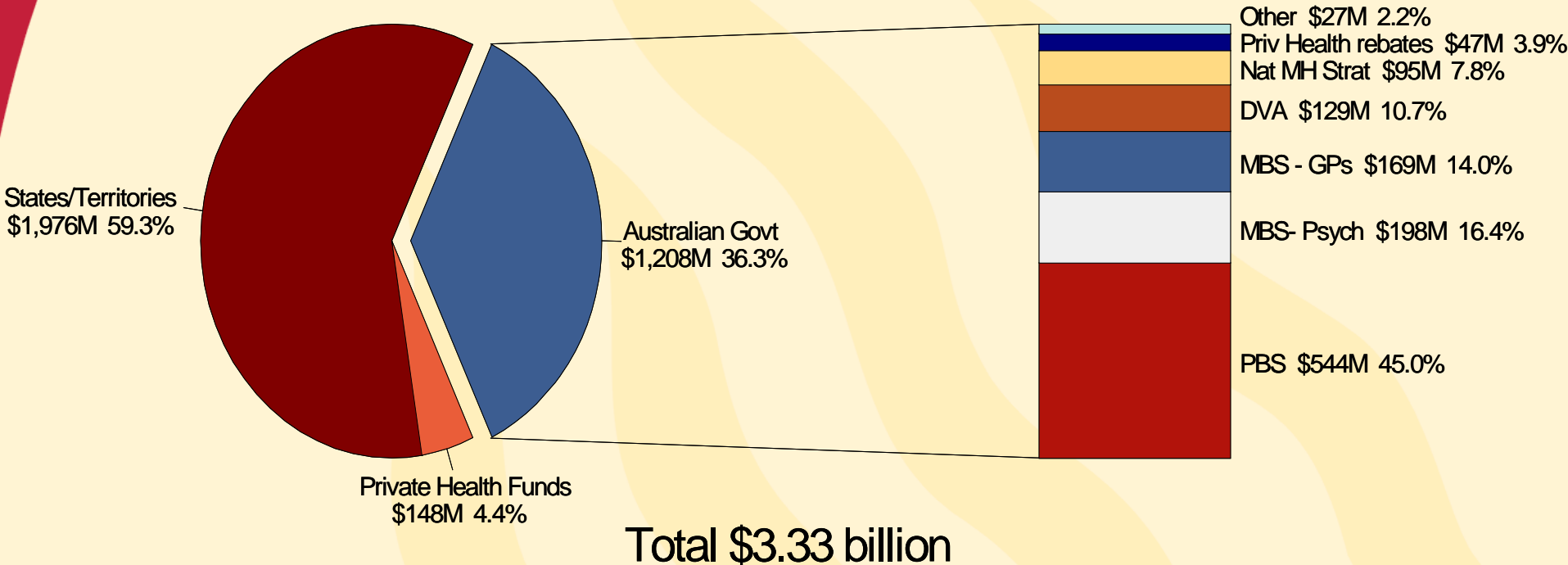


7. Overall Expenditure

- Queensland's Mental Health expenditure needs to be considered in the context of overall health and National Mental Health expenditure
- Queensland Health's Expenditure will have less benefit unless there is considerable across government effort within Queensland to support people who are living in the community

7. Overall expenditure

WE ALSO KNOW THAT 40% OF THIS ...



Sources: National Mental health Report 2005

IS FOR TWO LOW PREVALENCE DISORDERS

ACCESS ECONOMICS/ SANE AUSTRALIA ESTIMATE [Schizophrenia]

Direct health system costs were \$661 million in 2001,

including 60% hospital costs, 22% community mental health services, 6% medical costs (GPs and specialists), 4% nursing homes and 2% pharmaceuticals.

ACCESS ECONOMICS/ SANE AUSTRALIA ESTIMATE [Bipolar Disorder]

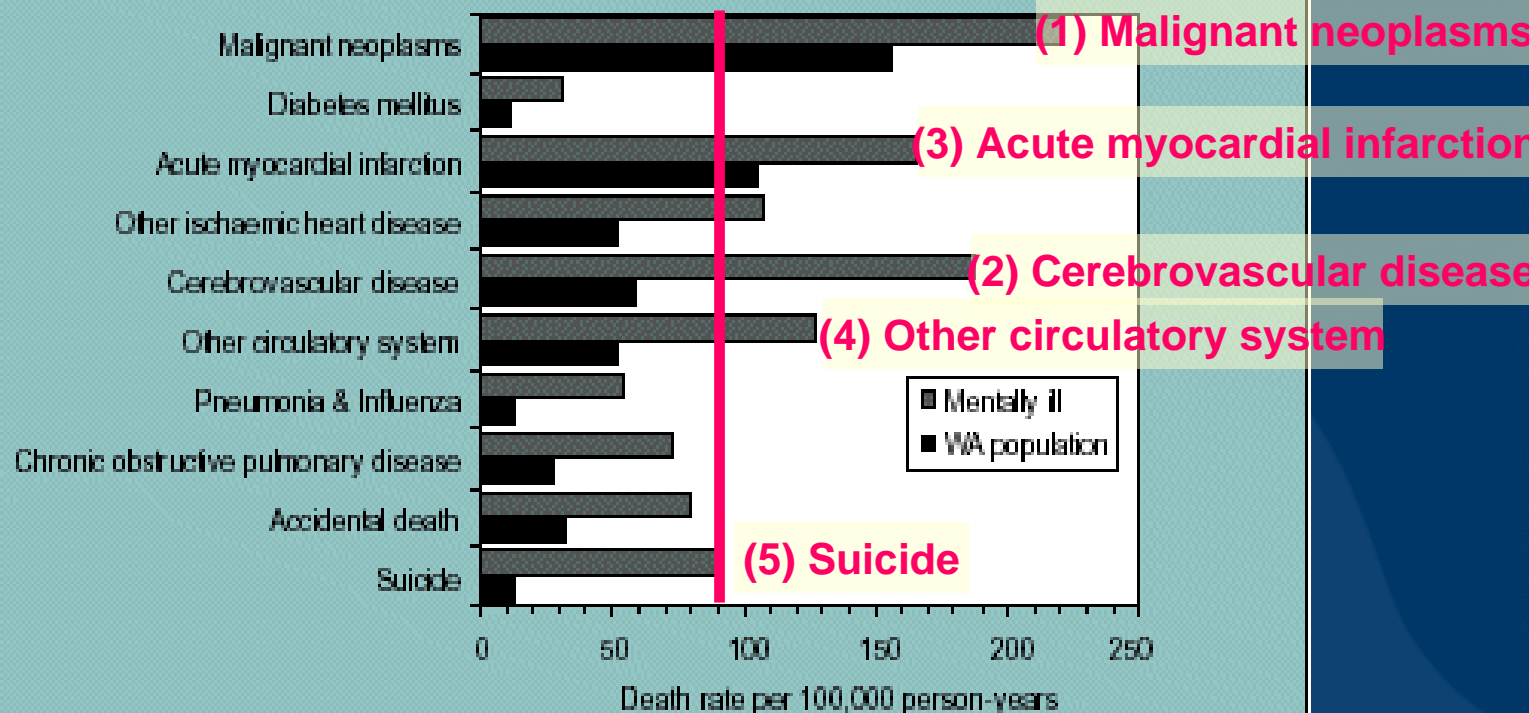
Direct health system costs are estimated at \$298 million in 2003,

with two-thirds being hospital expenditure, 13% medical expenditure (GPs and specialists), 11% residential care, 2% pharmaceuticals and the remainder on allied health, pathology, research and administration.

WE KNOW THAT SUICIDE IS NOT THE MAIN CAUSE OF CLIENT MORTALITY, BUT THE FIFTH-HIGHEST CAUSE.

FIGURE 1

DEATH RATES IN PEOPLE WITH MENTAL ILLNESS COMPARED TO THE REST OF THE POPULATION, WESTERN AUSTRALIA, 1980-1998



Sources: Lawrence D, Coghlan R. Health inequalities and the health needs of people with mental illness. *NSW Public Health Bulletin* 2002; 13(7): 155-158.

**AND CARDIOVASCULAR DISEASE (NOT SUICIDE)
IS THE LEADING CAUSE OF EXCESS MORTALITY IN
MH SERVICE CLIENTS**

“The findings of this study are an indication that our health system has failed to meet the full health needs of people with mental illness.

... We cannot leave people with mental illness on the margin while so many others in our society enjoy a high standard of comprehensive health care.”

WHILE HIGH PREVALENCE DISORDERS ARE OFTEN UNTREATED

Figure 7-1:

Prevalence (%) of Single and Comorbid Affective, Anxiety and Substance Use Disorders Amongst Australian Males in the Past Year

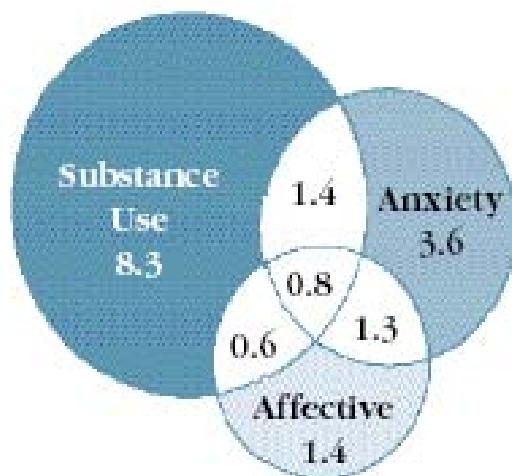
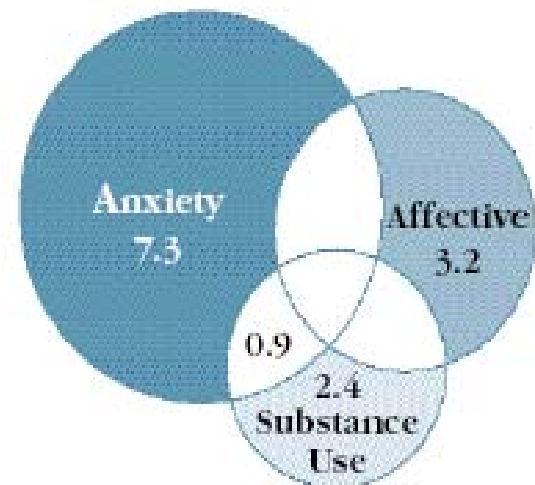


Figure 7-2:

Prevalence (%) of Single and Comorbid Anxiety, Affective and Substance Use Amongst Australian Females in the Past Year



AND GENERATE LARGE LOSSES IN PRODUCTIVITY

The Epidemiology of Major Depressive Disorder

Results From the National Comorbidity Survey Replication (NCS-R) [2001]

Ronald C. Kessler, PhD; Patricia Berglund, MBA; Olga Demler, MS; Robert Jin, MA; Doreen Koretz, PhD; Kathleen R. Merikangas, PhD; A. John Rush, MD; Ellen E. Walters, MS; Philip S. Wang, MD, DrPH

JAMA. 2003;289:3095-3105.

The prevalence of MDD for ... 12-month was 6.6% ... (13.1-14.2 million US adults).

Cost of Lost Productive Work Time Among US Workers With Depression

Walter F. Stewart, PhD, MPH; Judith A. Ricci, ScD, MS; Elsbeth Chee, ScD; Steven R. Hahn, MD; David Morganstein, MS

JAMA. 2003;289:3135-3144.

US workers with depression employed in the previous week cost employers ... **an excess of \$31 billion per year** compared with peers without depression.

AND WE KNOW THAT GOOD CLINICAL MANAGEMENT IS DIFFICULT TO ACHIEVE

Suicide: the leading cause of maternal death.

Oates M. *British Journal of Psychiatry* 2003;183:279-281.

“A CASE FOR IMPROVED DETECTION OR IMPROVED MANAGEMENT?”

“Of all the women who died, 85% had their psychiatric problems identified and were receiving treatment, 46% of the suicides were in contact with psychiatric services and the majority of those with substance misuse were in contact with substance misuse services. In only three cases were women not receiving care.”

RECOMMENDATIONS

- Protocols for the management of women at risk of serious mental illness following delivery should be in place in every maternity service
- Enquiries about previous psychiatric history should be made routinely at the antenatal booking clinic

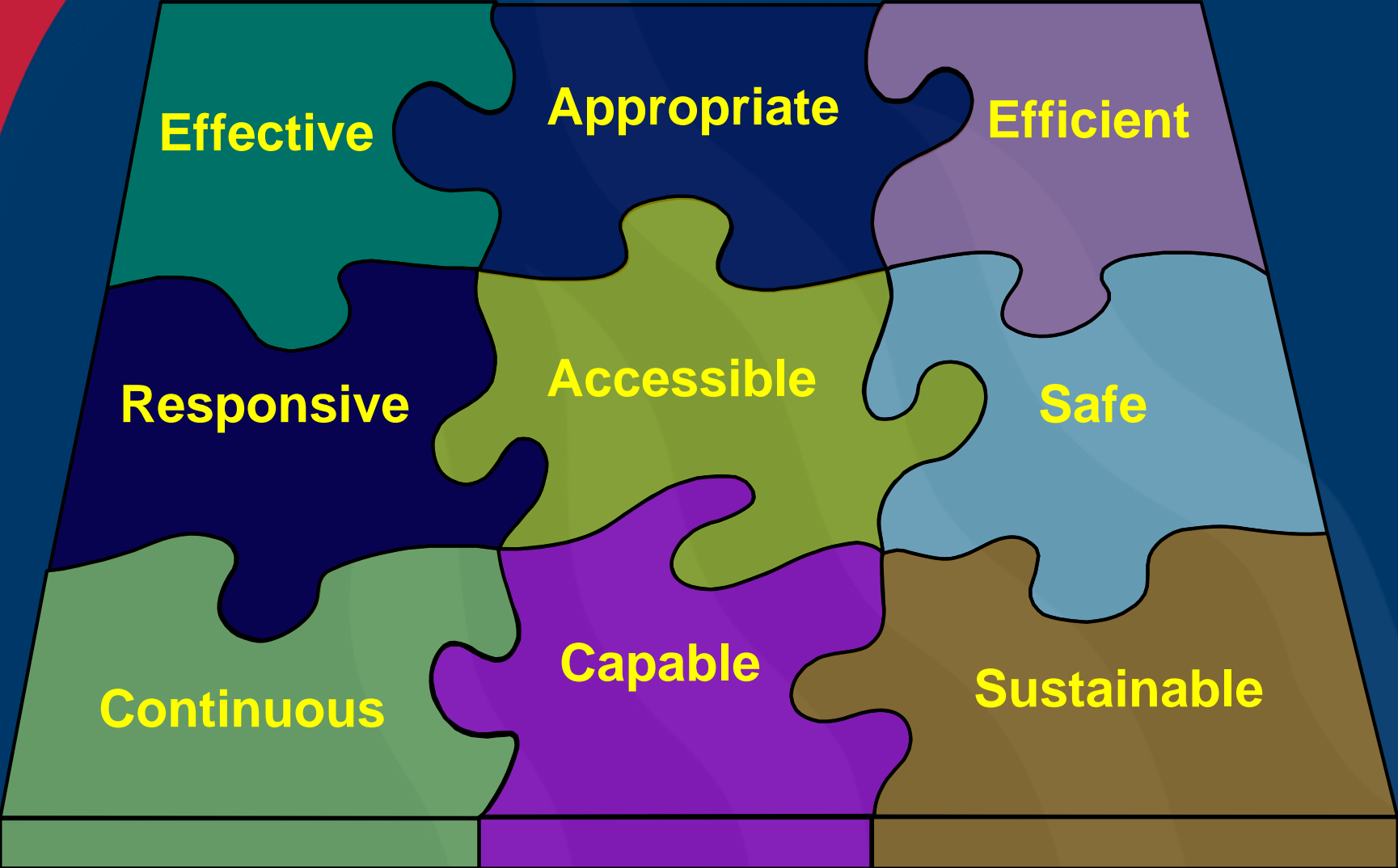
The term ‘postnatal depression’ should not be used as a term for all types of psychiatric disorder

See also: Clinical Negligence Scheme for Trusts. Clinical risk management standards for maternity services London: NHS Litigation Authority, August 2003.

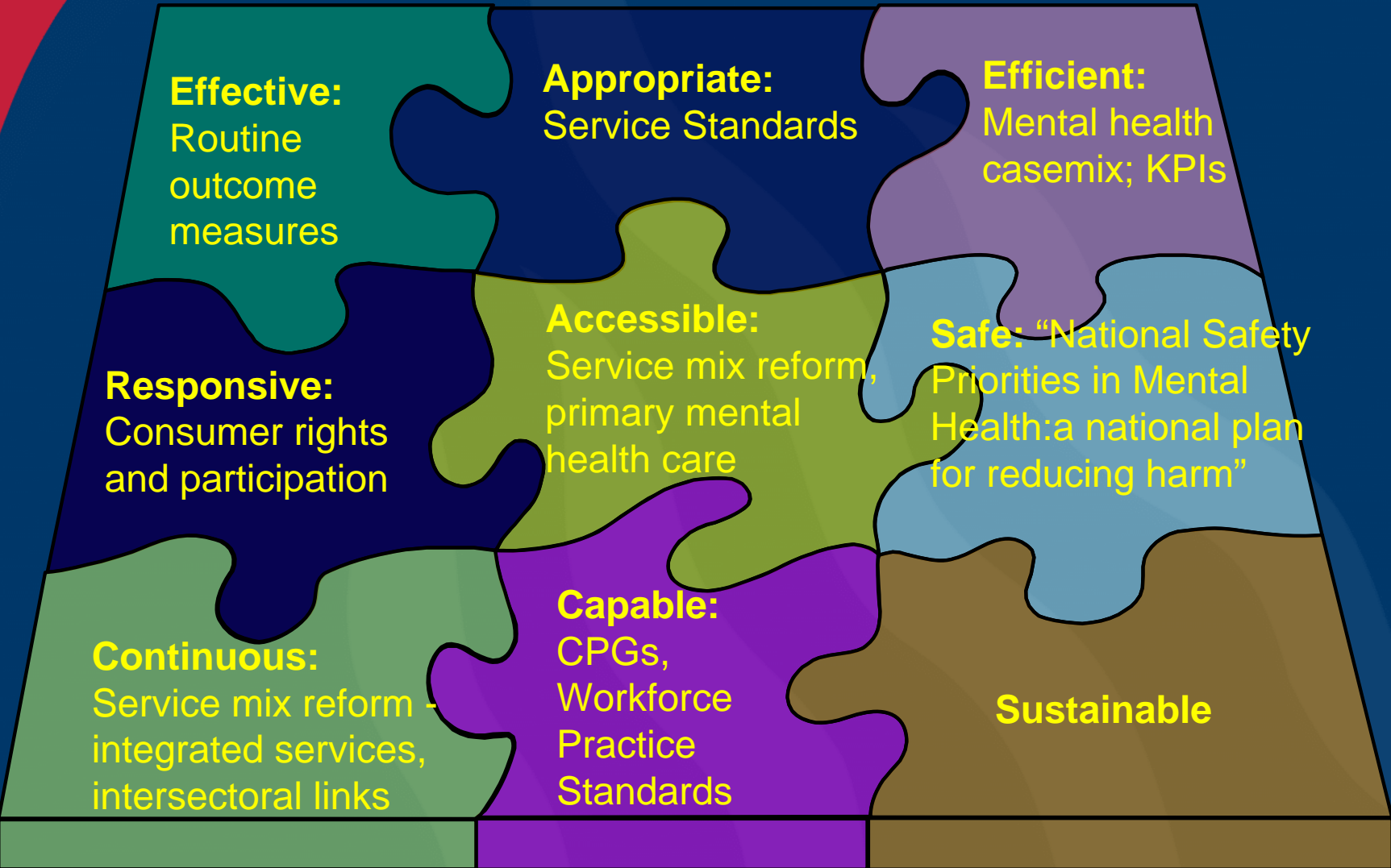
How should we improve the Quality of Mental Health Services?

- Ensure further services development and reform is in line with the National Mental Health Quality framework
 - ✓ Performance Framework
 - ✓ Benchmarking
 - ✓ Safety Priorities
 - ✓ Clinical Governance
 - ✓ Information

Quality Domains
Based on National Health Performance Framework



Key national developments in mental health

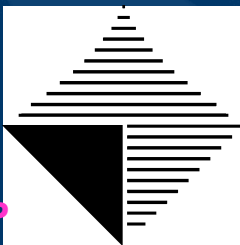


Reducing suicide and deliberate self harm;

Reducing the use of and where possible eliminating, restraint and seclusion;

Reducing adverse drug events in mental health services; and

Safe transport of people experiencing mental disorders.



Benchmarking to improve performance

- Need greater engagement of mental health services across the state in processes of benchmarking through participation in the National Mental Health Benchmarking exercise.
- The mental health collaborative is a good start.

Clinical Governance

- Adopt an agreed State-wide Clinical Governance Framework for Mental Health that includes:
 - Clinical Risk Management Framework
 - ✓ Incident/Adverse event reporting and trend analysis,
 - ✓ Sentinel event reporting, monitoring and clinical investigation
 - ✓ Risk profile analysis
 - Clinical Performance/Evaluation
 - ✓ Clinical Standards and Mental Health Act Compliance
 - ✓ Indicators
 - ✓ Clinical audits

Clinical Governance (cont)

- Consumer Value
- ✓ Consumer Liaison
- ✓ Consumer participation
- Professional Development and Management
- ✓ Competency Standards
- ✓ Continuing Professional Development
- ✓ Maintenance of Professional Standards

Mental Health Information Priorities for Queensland

- Development of the mental health enterprise integrated information system as an interim solution
- Embed routine clinical outcomes measurement
- Implement consumer perceptions of care project
- Develop a clinical information system that is meaningful to clinicians

The directions of Queensland Mental Health Reform

- Service Delivery
- Service Mix
- Safety and Quality
- Information to support clinicians and managers
- In the end what we need is... *“the right people, with the right skills, in the right place at the right time”*

Queensland Mental Health Plan 2006-11

Key Dates

- **March 30** **First meeting of Mental Health Service Plan Working Group (MHSPWG)**
- **April 5** **First official meeting of State-Wide Mental Health Network (SWMHN)**
- **June 26** **Circulation of Subgroup Reports to SWMHN**
- **June 28** **Mental Health Mini Summit**
- **June 29** **State Health Services Planning Mental Health Options Paper Presentation to State Health Services Plan Steering Committee**
- **July 5** **Discussion of subgroup reports at SWMHN**
- **July 10** **Final meeting of (MHSPWG)**
- **July** **Circulation of consultation draft of Mental Health Service Plan**
- **July** **Completion of final draft of Mental Health Service Plan**
- **August 11** **Final Draft of State Health Services Plan Completed**

Issues arising from the State Planning Process

- Planning and allocation across a continuum of care & local need – Resource Allocation
- Planning Networks – Hub & Spokes
- Planning Clusters - @ 250 000 people
- Communities <7,000
- Clinical Services Capability Framework

Queensland Mental Health Plan – emerging priorities

- Service Capacity to meet population growth
- Promotion Prevention and Early Identification
- Targeted Early Intervention
- Community Mental Health Services
- Acute Inpatient Services and Sub-Acute Care
- Non Government Services
- Sub Speciality Areas – Statewide coverage
- Consumer Driven & Carer inclusive

Mental Health Service Principles

- **Consumer driven services:** putting individuals first, family and carer inclusive;
- **Recovery focused:** optimism and strength;
- **Whole of person approach;**
- **Promotion of mental health and prevention of mental illness:** a community responsibility;
- **An integrated journey** to mental health and well-being;
- **Responsive and accessible** services and support ;
- **Quality, evidence-based, safe services;** and
- **Care and support in the community:** at home, locally, in the community.

Service Delivery

A draft State Mental Health Plan is expected to be completed in July

- Priority areas
- Community Mental Health
- Rural and Regional
- Indigenous
- Forensic
- Older Persons
- Child and Youth
- Crisis services
- After hours services
- Mobile Intensive Treatment
- Re-assess
- Inpatient beds and their distribution
- ET& R
- Medium and High Secure
- Viability and sustainability

Service Mix

But we can't just keep doing more of the same

- Need to develop services based on the Recovery concept
- Need to more actively engage consumers/carers
- Need to work in partnership especially with Primary Care and the Non-Government Sector

Also need to establish better relationships with other providers

- Primary Care
- Private Sector
- Non Government Sector
- Housing Sector
- Corrections
- Education
- Disability Sector
- Police
- Ambulance
- Communities
- Child Safety
- The Commonwealth
- ✓ FACSIA
- ✓ DOHA
- ✓ DEWR
- ✓ DEET
- ✓ DIMA

The Commonwealth COAG package

MEASURE	Portfolio	5 year total \$m
Services to the community - Health		855.2
Supporting psychiatrists, psychologists and GPs	DoHA	538.0
New specialist mental health nurses	DoHA	191.6
Mental health services in rural and remote areas	DoHA	51.7
Improved services for people with drug and alcohol problems and mental illness	DoHA	73.9
Services to the community - Other		847.3
Telephone counselling, self help and support programmes	DoHA	56.9
Expanding suicide prevention programmes	DoHA	62.4
New personal support workers	FaCSIA	284.8
Helping people with a mental illness enter and remain in employment	DEWR	39.7
Support for day-to-day living in the community	DoHA	46.0
Helping young people stay in education	DEST	59.5
More respite care places to help families and carers	FaCSIA	224.7
Community based programmes to help families coping with mental illness	FaCSIA	45.2
New early intervention services for parents, children and young people	DoHA	28.1
Workforce		109.1
More education places, scholarships and clinical training in mental healths	DoHA	103.5
Mental health in tertiary curricula	DoHA	5.6
Community awareness		43.4
Alerting the community to links between illicit drugs and mental illness	DoHA	21.6
Improving the capacity of workers in Indigenous communities	DoHA	20.8
Increased funding to the Mental Health Council of Australia	DoHA	1.0
PACKAGE TOTAL		1,855.0

Opportunities

- Whole of Government
- Significant Investment by the Commonwealth
- Uses general practice infrastructure
- MBS items for GPs, psychologists.
- New coordination model for clinical care and community support
- What does this mean for mental health service delivery in Queensland?

Implementation

- COAG Mental Health Working Group in each State/Territory
- Chaired by Department of Premier and Cabinet
- Implement initiatives to suit Queensland
- State planning needs to take account of new initiatives
- Report back to COAG Senior Officials after six months.



Thank you