3.6 Mental health beds

A number of managers and clinicians informed the Review that there are more acute mental health beds per head of population in WA than in other states. It was suggested to the Review that the mental health system in WA is skewed towards an inpatient focus.

The total number of private and public specialist mental health beds is 936.

This comprises 726 public beds as tabled; with the addition of the beds proposed for Broome (14) and Albany (7) will bring the total public beds to 747.

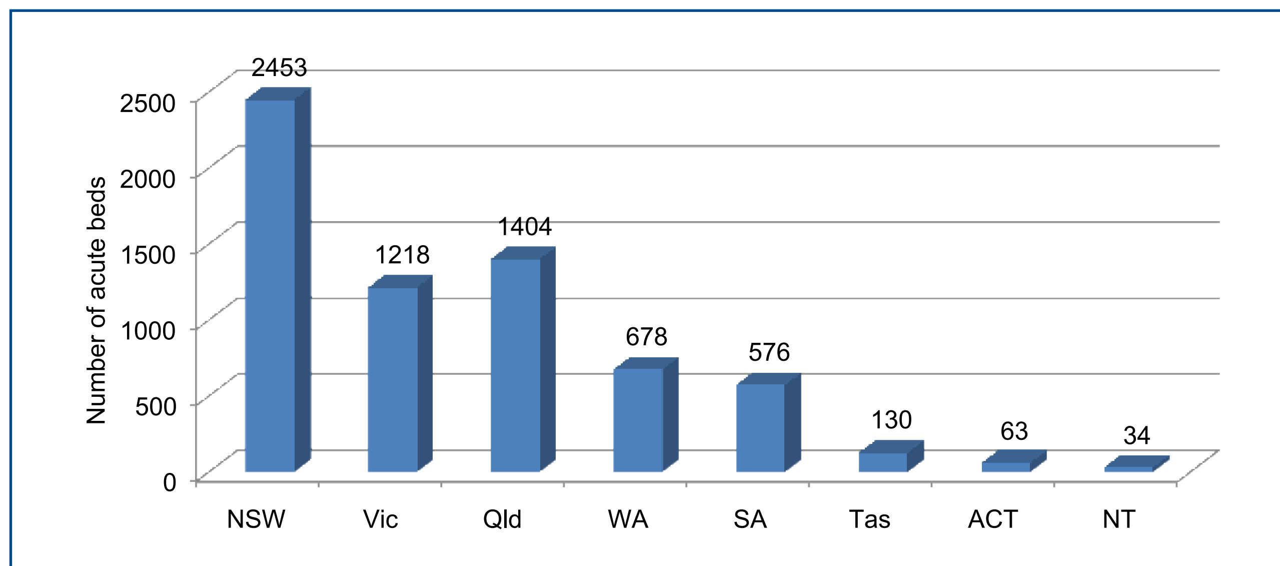
	Hospital/Facility	Adult	Child/ Youth	Older adult	Rehabilitation	Total
NMAHS	Graylands Hospital	62			114	
	Frankland Centre	30			8	
	Selby			39		
	Joondalup	42				
	Swan Valley Centre	27		16		
	The Ursula Frayne Unit			12		
	Sir Charles Gairdner	36				
	Osborne Lodge			24		
	Mother and Baby Unit	8				
	Sub-total	205		91	122	418
SMAHS	The Alma Street Centre	48		16		
	Armadale	25		8	8	
	Bentley	74		26		
	Rockingham	20				
	Royal Perth Hospital	20				
	Sub-total	187		50	8	245
WACHS	Albany	9				
	Kalgoorlie	7				
	Bunbury	27				
	Sub-total	43				43
CAHS	Bentley Adolescent Unit		12			
	Princess Margaret		8			
	Sub-total		20			20
	Total					**726**

There are 189 private beds.

Hospital/Facility	Adult Beds
Abbotsford Private Hospital	18
Hollywood Private Hospital	40
Perth Clinic	100
The Marian Centre	31
Total Private Mental Health Beds	189

Referencing AIHW analysis, the Review concludes that WA has fewer acute mental health beds and less acute mental health patient separations than many other states (3.1 per 100,000 populations) and territories in Australia (AIHW 2011a; see figures 11 and 12).

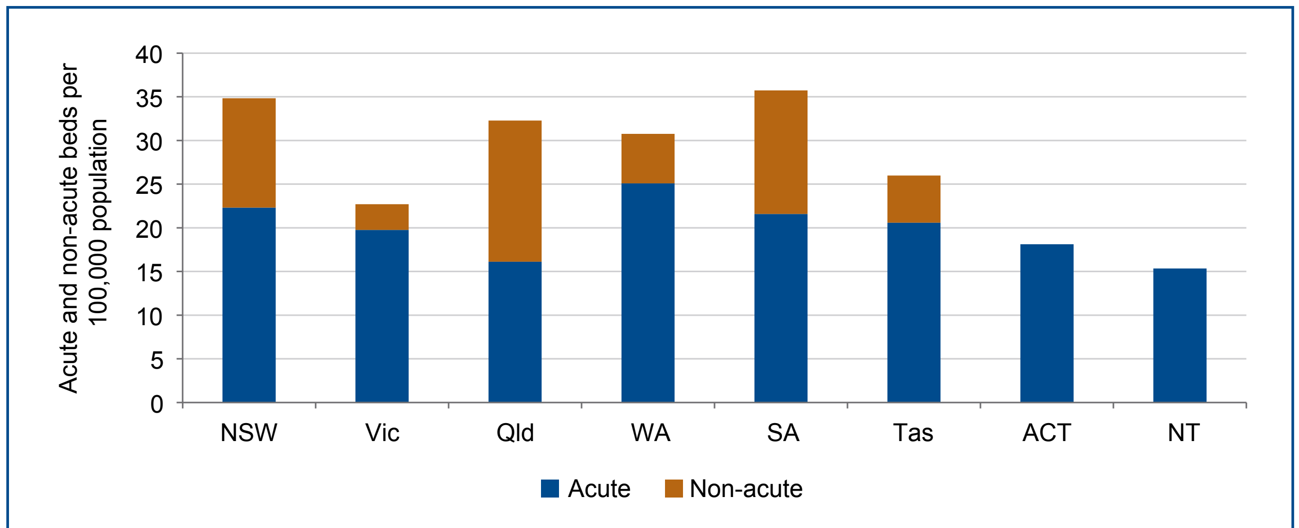
Figure 11 **Total acute MH beds per state and territories, 2008–09**



Note: Since these data were collected there have been some changes in bed numbers in WA. At the Alma Street Centre, two beds closed; eight beds were removed from Royal Perth Hospital, 16 rehabilitation beds were decommissioned in Hawthorne House and 20 beds were opened at Rockingham. The 14 beds in Broome will open soon, totalling eight additional beds.

Source: Table 12.13: Public Sector specialised mental health hospital beds per 100,000 population by target population and program type, states and territories, 2008-09. National Mental Health Establishments Database. Population as at 31 December 2008. http://mhsa.aihw.gov.au/resources/facilities/beds/ AIHW (2011).

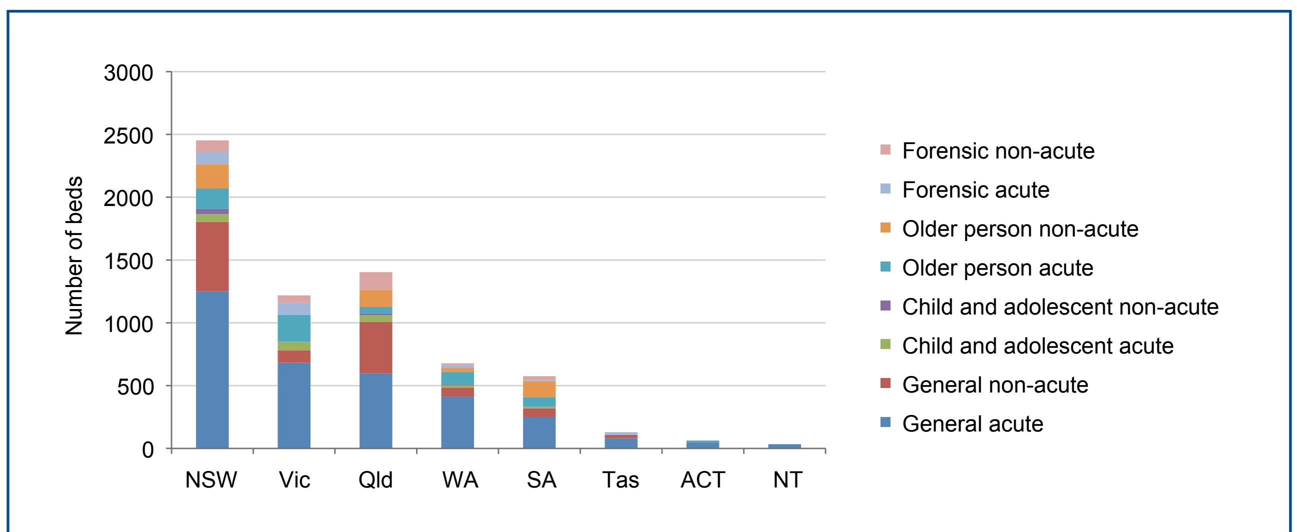
Figure 12 **Acute beds per 100,000 population, states and territories, 2008–09**



Source: AIHW (2011).

WA has proportionally fewer child and adolescent beds, forensic beds and non-acute beds than other Australian states (see the mix of mental health beds per 100,000 population and program type in Figure 13).

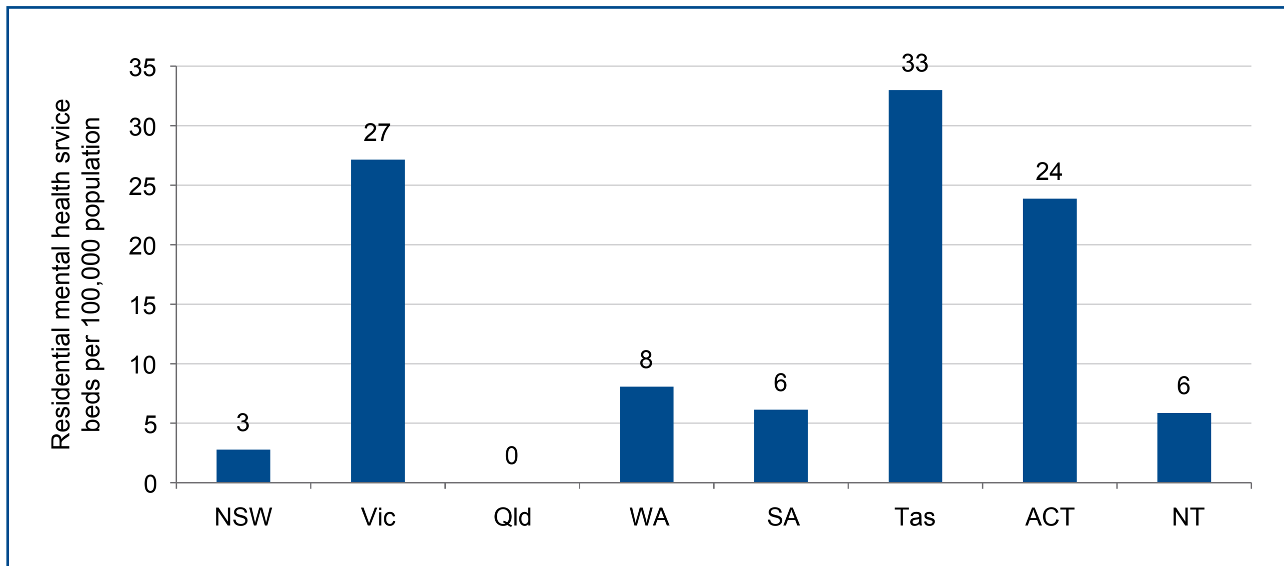
Figure 13 **Public specialised mental health beds by target population and program type, states and territories 2008–09**



Source: National Mental Health Establishments Database, based on population at 2008. Table 12.13: Public sector specialised mental health hospital beds and beds per 100,000 population, by target population and program type, states and territories, 2008–09, AIHW (2011).

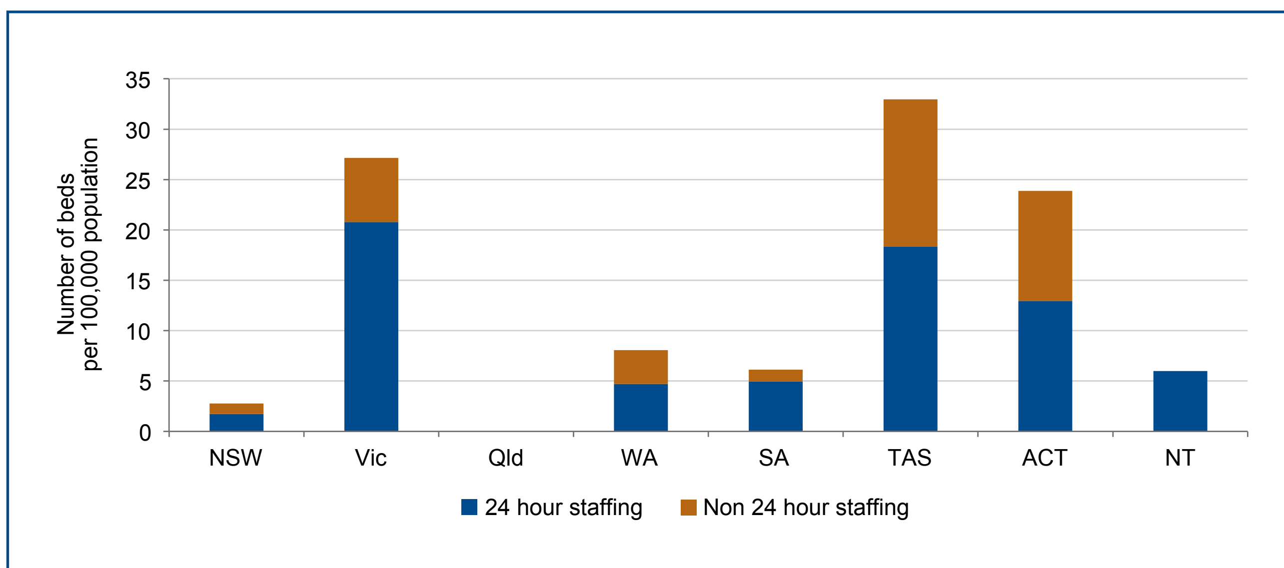
There is insufficient step-down and supported residential accommodation. The effect is that patients remain in acute mental health beds rather than receiving rehabilitation and care in the community (see Figures 14 and 15).

Figure 14 **Residential mental health service beds per 100,000 population, states and territories 2008-09**



Source: AIHW (2010).

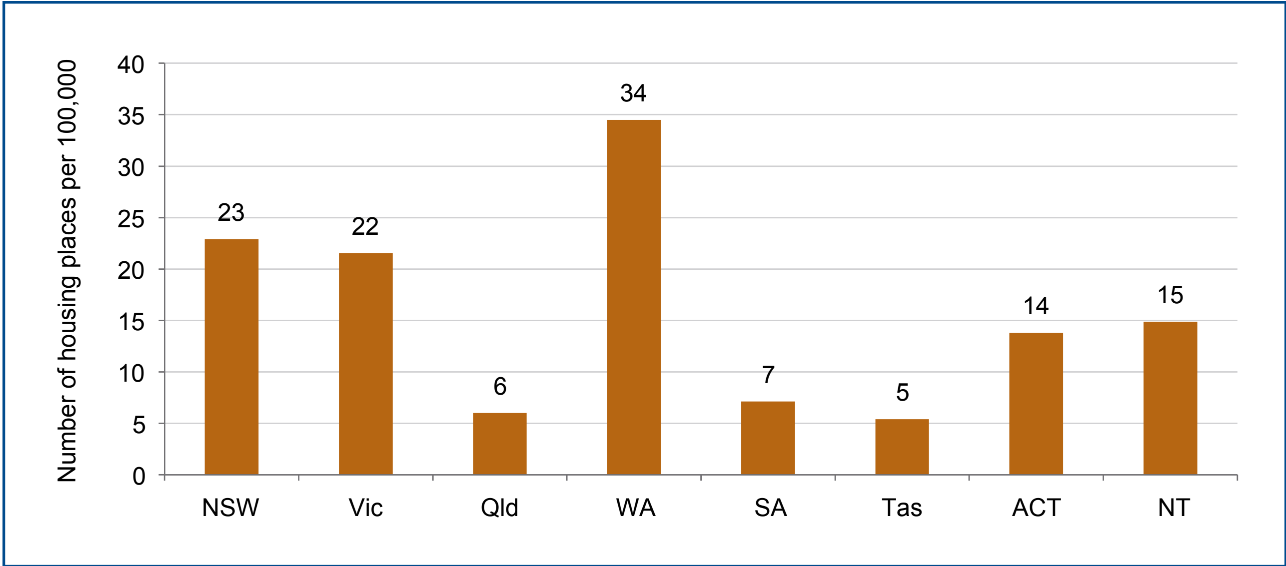
Figure 15 **Staffing 24 hours and non 24 hours residential mental health service beds per 100,000 population, states and territories, 2008–09**



Source: National Mental Health Establishments Database: Table 12.15 Residential mental health service beds and beds per 100,000 population, by target population, states and territories, 2008-09 and Table 12.14: Number of residential mental health service beds and beds per 100,000 population by service operator and staffing provided, states and territories, 2008–09, AIHW (2010).

There appears to be more supported housing places in WA than other states (see Figure 16). This figure includes the psychiatric hostels discussed in Section 3.13.4. These numbers do not appear to fit with a contemporary model of mental health care.

Figure 16 **Number of supported housing places per 100,000, states and territories 2008/09**



Note: The number of supported housing places in WA is 760.

Source: Table 12.16 Number of supported housing places per 100,000 population, states and territories, 2008-09 National Mental Health Establishment Database, AIHW (2010).

A contemporary Australian model

In order to provide meaningful comparative bed numbers, reference is made to Andrews and Tolkien II Team's (2011) contemporary Australian modelling.

Applying this modelling, and based on the WA population of 2,366,900 (ABS 2011), an ideal bed stock of 3197 places is required in a stepped configuration as follows:

Figure 17 **Ideal mental health bed stock for WA, 2012**

	Existing places	Recommended places/100,000	Optimal places	Change required
Inpatient services				
Acute	469	15	355	–114
Non-acute	130	10	237	+107
Community rehabilitation				
Clinical staffed 24/7	111[1]	15	355	+244
Staffed <12 hours	79[2]	15	355	+276
Supported permanent housing				
Supported public housing	174[3]	20	474	+300
Supervised hostels	748[4]	20	474	–274
Permanent housing	n/a	40	947	n/a
Total places		**95/100,000**	**3197**	

Notes: Private hospitals are omitted from this equation because they ‘do not admit people as involuntary patients and the level of acuity is less than in the public sector. There are no data as to the offset that private beds make to dealing with the burden of mental disorders.’ (Andrews and the Tolkien II Team 2011, p. 11).

This table excludes specific services for older persons and persons with dementia. (Andrews and the Tolkien II Team 2011).

1. Based on figures 14 and 15.
2. Based on figures 14 and 15.
3. Based on 34.5 per 100,000 AIHW 2008–09 and population 2.17 million in 2008 accessed at: http://mhsa.aihw.gov.au/resources/facilities/beds.
4. Based on AIHW 2009–10 Data Cube.

Using this model, it would appear that WA requires more non-acute, community rehabilitation places and supported housing. Two important qualifications are:

- that supported accommodation beds need to be operational before it would be feasible to reduce acute beds
- places must be configured to account for population growth.

A range of accommodation is needed within each region of the State and there is a need to properly negotiate a formulated 10-year clinical services plan that:

- articulates the Mental Health Commission purchasing intention and reform agenda
- defines the required capital investments and infrastructure build over 10 years
- provides facilities and services that allow best practice clinical mental health care
- defines how services configuration and investment best meets contemporary best practice care models and future demand.

The Review has not resolved a conclusion as to a best mix and distribution of bed stock. It is, however, essential that a consistent methodology and defining of ideal bed stock is a feature of a mental health clinical services framework.

See Recommendation 1: Governance (1.1.1); and Recommendation 5: Beds and Clinical Services Plan.