JOINT STANDING COMMITTEE ON THE COMMISSIONER FOR CHILDREN AND YOUNG PEOPLE

INQUIRY INTO THE MONITORING AND ENFORCING OF CHILD SAFE STANDARDS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 17 APRIL 2019

SESSION ONE

Members

Hon Dr Sally Talbot, MLC (Chair)
Mr K.M. O'Donnell, MLA (Deputy Chair)
Hon Donna Faragher, MLC
Mrs J.M.C. Stojkovski, MLA

Hearing commenced at 10.09 am

Dr ARESH ANWAR
Chief Executive, Child and Adolescent Health Service, examined:

Dr KAVITHA VIJAYALAKSHMI LAKSHMINARAYANAN
Consultant Psychiatrist and Executive Director for Medical Services, examined:

Ms DEBRA CLEMENTS
Manager, Statewide Protection of Children Coordination Unit, examined:

Ms PATRICIA SULLIVAN
Service Co-Director, Child and Adolescent Health Service, examined:

The CHAIR: On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the Joint Standing Committee on the Commissioner for Children and Young People's inquiry into the monitoring and enforcing of child safety standards. My name is Sally Talbot; I am a member for South West and the chair of this committee, and I will ask my colleagues to introduce themselves.

Hon DONNA FARAGHER: I am Donna Faragher, member for East Metro Region.

Mr K.M. O'DONNELL: Kyran O'Donnell, member for Kalgoorlie.

Mrs J.M.C. STOJKOVSKI: Jessica Stojkovski, member for Kingsley.

The Acting Principal Research Officer: Michele Chiasson, acting principal research officer.

Dr Anwar: Hello. Nice to meet you.

The CHAIR: It is important to understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything you might say outside of today's proceedings. Thanks for all coming in this morning. Before we start with our questions, do you have any queries about your appearance and your attendance here today?

Dr Anwar: No. We have come as a team because we felt that breadth of knowledge would make us most likely to be able to answer your questions today, as opposed to taking questions on notice, so I hope that the team approach will be more productive.

The CHAIR: Yes, it is generally the case, certainly. Thank you for that. Yes, we do indeed have a facility for questions on notice, so if we get into any areas where you want to check things or there is additional information, we do not expect you to have it all in your heads today. Did you want to start by making any sort of opening statement?

Dr Anwar: No—well, would you mind, actually, if I just outlined CAHS because often our service is simply taken to be PCH. I know that will not be by the committee. I am very privileged to be the chief executive of child and adolescent health service. For us, there are probably, very broadly and simplistically speaking, three arms to the work that we do. The work that occurs in the Perth Children's Hospital, and then work which happens in community health, under the banner of community health, and the work that occurs under the banner of the child and adolescent mental health service. It is an integrated service where obviously each arm of the health service has areas within which it provides expertise, and it has a very clearly defined remit. We are currently working at trying to break down some of those barriers, which have been traditionally as a consequence of the structure that has been set up, so I was just keen to ensure that the committee is aware that CAHS has a remit right across metropolitan Perth and has three very distinct remit service delivery.

The CHAIR: Have you found, certainly as a common experience in the public sector, that the three arms are in a sense siloed from each other? Is that what you are trying to break down? Is that what you are explaining?

Dr Anwar: We are trying to break that down. I mean, that has been a journey. Some of that is occurring organically and some of that is occurring in a very concerted way. One, as a health service, we have stated very, very clearly to all staff and our patients and families that we are one CAHS. The second is that we have a clinical workstream that is driving integration, which is based around three principles; that is, let us all understand what an integrated service means. Let us have a common understanding, because it, obviously, is nuanced and different to each member. The second is can we just please ensure that we have some processes to support those principles. Lastly, can we just start implementing that and making sure that the principles of process actually translate into a better experience and service delivery for our patients. And, thirdly, we have a review of our corporate services to support that clinical integration, which we hope will translate into better outcomes for our children and families.

Yes, there is organic. There is an absolute will in the system, but obviously just the way services have developed has resulted in three silos. The other bit that I think is important is that people join services for some of the unique aspects that those services bring. What we do not want to lose is the creation of some homogeneous mass where people do not feel a sense of belonging and a sense that their expertise is genuinely valued. So it is getting that balance right, but absolutely focused on families, children, and making sure that integration is smooth. That has been very clearly articulated from the board level right across the organisation. There is a genuine will; there is no resistance. It is just a process that, sadly, we have to go through to make sure that we are set up to actually deliver on that desire.

The CHAIR: When you do that restructure, do you do it from the viewpoint of what you might call the consumer or what we might call the child or the young person?

Dr Anwar: Yes.

The CHAIR: Presumably, one of the things you are talking about is a child's transition between services; it may well be for the child a process of moving between those three arms.

Dr Anwar: No, undoubtedly. We are in the midst of that, and there are a couple of ways in which we are trying to ensure that that happens. The first is our health service executive committee. We have representation from our community advisory councils and youth advisory councils, who sit on our health service executive. I am not being kind—this is exactly as it should be, to have access to all the information that is discussed, and they participate and there is agenda. There is a slot in the agenda for them specifically to be able to feedback some of the challenges they want to communicate to the health service. That is the first element of engagement at a very, very senior level. Then in this process around integration, and the discussions that have been occurring, some of it is around how do we make sure that what we do not do is reconfigure the health service in our own eye of what we think the consumer wants. So the challenge around ensuring that we capture consumer experience feedback and their ideas around how we should be best configured is a really important element.

The CHAIR: Has that approach been put into practice yet? You said you were in the process of breaking down the barriers.

Dr Anwar: There are parts of the service where that is probably more advanced than others. There are a couple of services we have tried to test it in. For example, in the diabetes service, trying to reduce inpatient stay at the start of the journey and get people out in into the community is part of that work. I do not know whether Kavitha and Trish, as team members who are leading this service, want to comment around some of the other areas where the barriers have been broken.

The CHAIR: it would be good if you want to throw it to others. I will explain a little bit about the context of this question. As well as understanding how organisations set themselves up to involve children and young people, and particularly the aspects of complaints and advocacy, what we are interested in seeing what mechanisms you might have in place to measure how effective those changes might be. How are you going to measure them? How do you know that they are working? How do you know that when you are involving children and young people, that it is not just a tokenistic thing that does not actually change any outcomes? That is the context of the question.

Dr Vijayalakshmi: I think I will let Trish answer this. This about consumer engagement. We would like to give you an idea of consumer engagement in child and adolescent mental health services.

[10.20 am]

Ms Sullivan: The motto for mental health for many, many years has been "Nothing to me without me". As mental health professionals, we take that very seriously. In every aspect of our work the consumer is put front and centre. We do that through a variety of ways in CAMHS. We do consumer forums where, because it is child and adolescents, you are inviting children and their families. We are very transparent. We basically have it open and ask them to talk about what it is that they want to talk about. We provide all our stats, access to services and waitlists, all those sorts of things, so they can then see that this is us, and what we can provide—yes, there are gaps—and their input.

Our most recent one was in December last year, which we then wrote up. We provided a copy of that to all the people who attended. The Office of the Chief Psychiatrist also requested a copy of that. The recent review into the clinical governance of mental health levels requested a copy, and that has been progressed to them.

In mental health, we also employ peer support workers. They are people with a lived experience. Especially in the eating disorders space, we have peer support workers who are employed. They guide both the clinicians in how to provide the work, but also they provide added support to young people accessing those services because they are actually talking to someone who has been through that same experience. Kavitha probably would be the better one to talk about this, because I have only been in the position eight months: they introduced what they call the choice and partnership approach in the 10 community CAMHS. Our CAMHS is the whole of the metro area. You have got child and adolescents in the country run by WACHS, but in the metro area it is run by us.

It was not uncommon for someone to wait anywhere up to nine months to actually access a community service. They trialled what is known as a choice and partnership approach, where the consumers set a benchmark of 28 days from referral to a choice appointment. A choice appointment is like a triage, but every opportunity that you meet with a mental health clinician is also therapeutic. Even a telephone call can be a therapeutic engagement. The young person and the family come to this choice appointment. Depending on what their condition is in their referral letter, there is a choice coordinator and it might be the child psychiatrist that is also sitting in on the appointment. They work out: does this person need to be in a child and adolescent mental health service or could they be supported better by another agency such as headspace or their GP? Or can they just be given some simple things to go on, or do they need urgent assessment to go into what we call partnership, where they are actually received into our service and given treatment? Some people might have six sessions; some might have 14 sessions or more. Once their acuteness and their illness is managed, they are then discharged, enabling us to take on someone else.

As part of this implementation, they also implemented the "Experience of Service Questionnaire". This is a questionnaire that both the consumer—the child or the young person—and the family fill out separately about their experience of the service. Based on their comments, any negative feedback is fed back to the service, as in "You said, we listen." Those things are being implemented. Out of the evaluation, it works so well in one service that they have implemented it across our 10 community CAMHS. At a recent visit, one of the services said to us that they were really resistant to providing services this way, but what they did find was previously referrals would go into a drawer and no-one knew about them. No-one could picture the family and all their concerns. But now with the referral, the people come and they are seen. The service is acutely aware of everyone who is waiting to access their service, so they prioritise. They are working at a more acute level because they are always generating and seeing people in the acute stages. That is what they have done in the community CAMHS. The "Experience of Service Questionnaire" was implemented across all our CAMHS services, whether you are an inpatient or in one of the specialised teams. The inpatient ward at our new children's hospital also do the "Experience of Service Questionnaire", but they also have—it is absolutely lovely—a message board for young people where they write messages to other young people coming to the ward. The consumer voice is great. Recently, it was captured in our values. CAHS have implemented values. They had a drawing competition—an artwork competition. A child from the inpatient mental health unit got his picture selected for the excellent value: "When you're really unwell, you go to CAMHS and they make you better." Everything needs to be improved. You never sit there and say, "We're doing it great." We are always looking at ways to improve. We recently had to cancel a consumer forum because we had set it at the wrong time. We thought we would try it during school holidays, but it was not a good time. We learn and move on, but very much so consumers are at the heart of everything that we do.

The CHAIR: Is your service questionnaire given to all children who are patients or receive services?

Ms Sullivan: Yes.

The CHAIR: What proportion of the children and young people actually complete the questionnaire?

Ms Sullivan: I would not know the exact stat, but the majority of them do.

The CHAIR: Do you have a way of finding that out for us? Would you like to take that on notice, or is it data that is not collected?

Ms Sullivan: Yes, we can take that on notice.

The CHAIR: If you could make that the first question on notice: what proportion of children actually return the questionnaires to you? Then, if you could give us an idea about whether children are using that as a complaints service. Presumably you categorise the comments that you get in some way; whatever categorisation you give them.

Dr Vijayalakshmi: We do get compliments and complaints through that, but we have a separate complaints process as well which is used by consumers—for children and young people and parents.

The CHAIR: It might be useful if you outline that as well. Perhaps we will do that in the context of the dot points up on the screen.

Hon DONNA FARAGHER: With respect to the consumer forums that you mentioned, how often would you have those in a year?

Ms Sullivan: We are aiming to do four a year.

Hon DONNA FARAGHER: You are aiming to. Just so that I am clear, say last year, were you actually undertaking them then?

Ms Sullivan: I started in July last year. One of the things I asked for was consumer forums.

Hon DONNA FARAGHER: So this is a fairly new initiative?

Ms Sullivan: Yes. In Eating Disorders Awareness Week, there was a very public forum held at PCH. That was in August —

Dr Vijayalakshmi: September last year.

The CHAIR: Was that the forum that you said other people asked for a report on—the Chief Psychiatrist?

Ms Sullivan: No. We did our own CAMHS-specific one in December. The September one was an open forum about eating disorders. It was not just CAMHS; it was also WAEDOCS and private providers of eating disorder services. It was very much a forum focusing on eating disorders.

Hon DONNA FARAGHER: Thank you for that, and for clarifying that part. With regard to the notion of a consumer forum, and you mentioned children and their families, is there a particular purpose to the forum? It sounds a strange question, but I ask that in the context: is it for you to impart information or for them to raise complaints/compliments or whatever it may be that they seek to raise? Is it a combination of both? I am trying to get an understanding of how these forums work.

Ms Sullivan: The forum is a concept that is evolving. It is very much about, "We want to hear from you what you want from us." We prepared all these presentations about our stats and about our services, none of which were presented on the day because the consumers and the families wanted to have their say. It was actually facilitated by a person with lived experience as well. We felt that was very important that it was a consumer that led the forum. Aresh attended. People just wanted to share their stories and their frustrations. They also wanted to know where they could go to lobby for more services and where they felt that we could improve as well. In the end, the report was pretty much a type-up of the discussions of the day, and all our presentations that we had prepared were attached.

[10.30 am]

The CHAIR: Thank you. I was going to draw your attention to these dot points, perhaps in relation to talking about your complaints advocacy oversight mechanisms. These dot points are a bit old now, but they were drawn from an Australian Law Reform Commission report. These were identified as being the principles up against which the organisations could measure themselves. They are not all relevant to your organisation, clearly. Is there anything there that jumps out at you as being worthy of discussion in this context, as far as Child and Adolescent Health Service is concerned?

Dr Anwar: I think there are two or three. Well, they are all relevant, and we could discuss each of the elements. We are a statutory independent body, as you know, but for me the issue around a good relationship with decision-making bodies is important. We have excellent relationships with decision-making bodies. My challenge would be that decision-making bodies are very adult orientated. The vast majority of work that occurs in health services affects adults. They represent 75 per cent of the population; as a consequence, there is a huge focus on adults. The metrics that are measured are adult-centric measures, and you focus on what you measure. I think, for me, that is an important aspect: for children to have a profile that is more prominent than measures of health service success or failure or shortcomings has to reflect the nature of their business.

The CHAIR: Is there such a thing as child-focused metrics in that area?

Dr Anwar: There are a couple, which we can apply to children, such as immunisation rates. But I think there are two elements where we need to move forward. We were having this discussion in the car on the way here. One is that we are a health service, and we focus on sickness. I think that is a really important aspect. If we can look after kids really holistically and well in those early years in life, then we know we set them up for a much more successful and fruitful life in the long term.

The CHAIR: Do you have a formal or informal relationship with the children's commissioner?

Dr Anwar: We have an informal relationship with the children's commissioner. We have a good relationship with the children's commissioner. We are also trying to build and make far more robust our relationships with the Department of Communities and the Department of Education. As you will be aware, I think one of the amazing statistics that bubbled out of the sustainable health review was this challenge that only 16 per cent of health is related to acute clinical care. I think our role in working with others in addressing those social determinants of health is really important going forward, and that is an aspect we are really keen to focus on. We have good relationships with the decision-making bodies. We have put a challenge in, asking for the metrics to better reflect the nature of our business. We are happy to be performance managed against them, but we want health, wellbeing and prevention to be far more prominent in the metrics that we are measured against; also a focus away—I am regularly challenged by my colleagues both in mental health and in community health around the hospital-centricity of health service providers. I think we are very unique in the strength we have and our ability to potentially influence provision of care in the community. I would like to advocate for that to be much more strongly promoted and focused on than it is at present. It really does separate the adults' from the children's sector very, very overtly.

The CHAIR: Is there some work on that development of the child-focused metrics that you could share with the committee? Are you aware of any reports, or are you working on any substantive matters to do with that?

Dr Anwar: We have been working on some metrics. Yes, we need some surrogate markers that work on that. We have a briefing that we have put together, and we are happy to share that with you.

The CHAIR: That would be great. Perhaps you could indicate if it is a private document. We are happy to keep it private.

Dr Anwar: Sure. It is early, it is in evolution, but that has been a recurrent discussion.

The CHAIR: We would be very interested to see that, even if it is in draft form. What occurs to me while I listen to you talking is that the commissioner did an education and learning survey at the end of last year. One of the results was the significant number of children who reported that they had undiagnosed disabilities—disabilities that were not recognised by the education system. One would assume that that would cover a range of physical and mental disabilities or illnesses. Obviously, you would have a deep interest in that. The commissioner and we are terribly conscious of a lot of this work going on in silos. The commissioner has commented in his oversight report and in his submission to this inquiry, which is now a public document, that we are very good at producing reports and recommendations, and far less good at making them anything other than doorstops.

Dr Anwar: We have. It is interesting that from the point of birth through the first couple of months there is very, very close scrutiny in working with families and making sure that the screening is in place, but by the age of one or two, that communication between health and parent and child drops off very rapidly. We have an interaction rate of close to or above 90 per cent with parents and their children at the point of birth, 14 days, and the first couple of months. That drops off to pretty close to 25 per cent, I think, by two years. I will make sure that I back that up with some data for you. As part of our priorities to make sure that point of entry children have the maximum chance of success, for example, there has to be some intervention in those first four years, and that probably requires us to somehow change the way in which we interact with parents and children. That is not for lack of want by us, but there are obviously some challenges in delivering on that, so we are really looking hard to see how we can improve that.

The CHAIR: Any information you can share with us would be greatly appreciated.

Dr Anwar: Sure.

Hon DONNA FARAGHER: Just out of interest, taking note of what you have been talking about, I would presume that the child and parent centres that are operating—they are obviously not everywhere—where there is quite a strong connection between health, education, communities and other not-for-profit organisations is an area that you would think was very beneficial from that point of view, from the perspective of the very early years?

Dr Anwar: What you get from me is my personal opinion—I apologise—but the feedback I have had is, yes, they have been beneficial. I have only been in the post since August. We have done some site visits: the feedback is excellent, the atmosphere is excellent, and the level of engagement seems to be really good as well. Yes, from a personal point of view, the feedback that I have had from talking to staff and parents that we have met in the centres has been very positive.

Mrs J.M.C. STOJKOVSKI: I also have an interest in this area, as I have small children. Is there any work being done on how to interact with parents on a technological level? The child health nurse is out here a lot of times, but there are times in between that it can be very difficult, when something comes up and you cannot get in to see the child health nurse; you call Ngala, and you get a call back two days later. Is there any work being done on how to address that, using technology?

Dr Anwar: There has. I do not want to speak out of turn. I have met with Professor Cross from TKI. It is not my place to speak on her behalf.

The CHAIR: We are very familiar with Professor Cross' work. She is a regular testifier to this committee.

Dr Anwar: Okay, great. We have had some preliminary discussions with CAHS and her around how there are potentially some apps and other tools that would allow us to better interact. I think our website—our other form of communication—requires access to the technology and a lot of proactive work, so we are really keen to try to get mobile technology up and running as a means of interaction.

[11.40 am]

Mrs J.M.C. STOJKOVSKI: When you have a newborn, accessing a website is not the most productive way to do things.

Dr Anwar: No, absolutely.

The CHAIR: Perhaps I can take you now to the commissioner's oversight report, the 2017 report, and ask Michelle to put recommendation 2 up on the screen. This was the recommendation that related particularly to mental health services.

Dr Anwar: Yes.

The CHAIR: You will be aware that the six recommendations relating to the six service areas are pretty troubling. He did not actually look at CAHS or the mental health service, but you will be aware of which organisations he did look at, and that is his recommendation. He is talking about further strengthening independent oversight, and then goes through a number of specific areas. Are you aware of any actions that have been taken to address recommendation 2? He points to deficiencies and areas needing improvement.

Dr Anwar: I will ask Kavitha and Trish to comment.

Dr Vijayalakshmi: After the implementation of the Mental Health Act 2014, the identified persons in that act for advocacy are patients who are under the Mental Health Act, so they are involuntary patients. However, since then there has been a change and an amendment has been made to the act that allows for any voluntary patient to be an identified person under the act, which I think is a great step forward. However, due to resource issues in the mental health advocacy council, what we have currently is that if a voluntary patient actually requests for advocacy to be involved, then we notify advocacy. If, as a clinical team, we become concerned about certain issues with regard to the care of the young person and we would like advocacy services to be involved to enhance that care, then we would make that referral after talking to the young person and the family. So not every voluntary patient is now being referred to advocacy services, which is what I think this recommendation would like.

The CHAIR: Yes, we did have a hearing with Debora Colvin a couple of weeks ago. I am sure you read the transcript because it was a public hearing. She talked about that at some length.

Dr Vijayalakshmi: Yes. So there are some significant benefits of having an advocacy service for voluntary patients, especially when there are issues around accommodation, post-discharge plans, and care and support for the parents. From our perspective, we would like this to be strengthened further, but we note the resource implications both for the advocacy service and for us, because notifications take some paperwork from our side.

The CHAIR: Did anyone else want to comment?

Ms Sullivan: I suppose on the first dot point under recommendation 2, we have had a review by the Office of the Chief Psychiatrist—so the clinical standards review—and that was done in May 2018. I think the Chief Psychiatrist has actually provided you a copy of the review.

The CHAIR: No, we do not.

Dr Anwar: Can I apologise. We are very comfortable to provide that. I was away last week when the request came through and I apologise.

The CHAIR: Okay, that would be excellent, if you could take that on notice.

Dr Anwar: Would you be comfortable if we provided you, also, with the formal responses in terms of actions taken since May 2018?

The CHAIR: Yes, that would be very useful.

Ms Sullivan: We can update you on where we are at with his recommendations in regard to that. Restraint and seclusion—we are all working towards zero restraint and zero seclusion. As part of the Mental Health Act, we report through all our seclusions and restraints to the Chief Psychiatrist. We also review all our decisions with regard to seclusion and restraint, and we report them to our CE, and our board also actually sees those metrics as well, with regard to seclusion and restraint. We are actually in conversations with other benchmark hospitals in Australia to look at what things they may have implemented to reduce their use of restraint and seclusion. The new children's hospital, having ward 5A, the way it has been set up—having a better facility has enabled a reduction in seclusion and restraint. There are also a number of practices that the ward has implemented: safe wards but therapeutic crisis intervention, which is a technique that focuses on de-escalation, and restraint is the last measure. It is very much turning the approach away. We have done a lot of work in TCI, as we call it, and other areas have approached us to have training, such as the Department of Justice, Autism WA and other areas where children may be at risk of being restrained.

The CHAIR: So children using your services, if they have a complaint where do they go, in practice?

Dr Vijayalakshmi: They raise the complaint with the service that they are using. There is a lot of information on the website and in services as to how they can talk to the consumer liaison service at CAHS, and they can put in a complaint. We see informal complaints come through the "Experience of Service" questionnaire. Sometimes the families and their young children can go direct to HADSCO or the OCP—Office of the Chief Psychiatrist. We have had certain complaints raised to the commissioner and it has come to us. It also happens that they go to the minister directly, so there are various avenues that they use.

The CHAIR: With your internal processes, do you have a specific complaints service for children or is it just a general complaints service that deals with everything across the board?

Dr Anwar: Do you mean in terms of issues that affect people as opposed to parking, et cetera?

The CHAIR: Yes.

Dr Anwar: Okay, no. All complaints go under a complaints umbrella—a concerns and challenges umbrella—so we do not split them up. Obviously, a responsible officer, in terms of provision of a response, will come from different areas around the organisation —

The CHAIR: If I can just interrupt you, it is often found in organisations that complaints mechanisms are not child-friendly. A child might struggle to navigate a complaints system; for instance, where they have to look things up on the internet or make the complaint to the actual service provider, a child may struggle to do that. Do you have any advocacy services built in to the complaints mechanism—somebody who can help a child, walk with the child through the complaints process?

Ms Sullivan: If they are an involuntary child they will often go to the mental health advocacy service. There is a youth advocate who will assist the young person to actually make the complaint. In much of our space it is the family that is making the complaint on the child's behalf. But children themselves will sometimes present to the emergency department and will put in their own words their concerns about the services that they have received in the community or in the hospital. There is also the public website, Patient Opinion, of which CAHS is a part, and people can actually write their complaint there. But, yes, I would agree with you that children themselves often are not always making the complaint—it is often their family on their behalf—so that is why we tried the implementation of the "Experience of Service" questionnaire, to try to get it in their words.

The CHAIR: Okay. Can I take you now to the issue of data. You will remember in the oversight report the commissioner said, and I will just read you his words, "Reliable data that provides information about the mental health and wellbeing of Western Australian children and young people, and the extent to which they suffer from mental health problems and disorders is not readily available." Does CAMHS capture data relating to the provision of your services and who is accessing them?

[10.50 am]

Ms Sullivan: We capture a lot of data. Mental health is one of those areas that at a commonwealth level there is reporting under the successive national mental health plans. We are probably the only component of Health that report on health outcomes. There is HoNOSCA, the Health of the Nation Outcome Scales — Children and Adolescents. That looks in coming into treatment—has the treatment they received been effective?—and reducing their symptoms. There are the strength and difficulties questionnaires and the child global assessment scale, so there are some outcomes scales presented via the Mental Health Commission to the commonwealth as the mental health minimum data set. It looks at length of stay. We are also captured in 28-day readmission and the seven-day follow-up in the community, following an admission. We have reporting to the Stokes report in regards to the Stokes review into admission and discharge within mental health services. There are recommendations around there. A lot of them are about the standardised documentation and clinical handover. We also have the Chief Psychiatrist reporting in regards to seclusion and restraint, and off-label prescribing around psychosis et cetera. There is a lot of reporting that mental health does, but often the quality metrics are not out there in a public space that allow consumers and their families to see. Internally, we report our wait times and referral to choice. We are trying to improve our data system so we can also report from their choice appointment to their partnership appointment, because we know that our resources are stretched, and especially in some of the outer suburban areas the wait times are longer than what the consumer targets have been set for. We have had quite a number of discussions internally about how we improve this data and make it more transparent to the public.

The CHAIR: Do you know the answer to that question?

Dr Anwar: Do I know how we do it?

The CHAIR: No, it is: how can we make our data more transparent and comprehensive?

Ms Sullivan: I think we need to agree on what needs to be out there, plus we also need to have it in a web format on the internet that people can easily access.

Dr Anwar: Maybe just a couple of comments around that, and it is not just because we are in front of the committee. We are genuinely committed to being open and transparent. That is a commitment that sits all the way down from the board. We have been trying to consider what a phased approach to that would be, I think there are two or three elements to it. One is just making sure that the data is meaningful, that the way that the information is communicated is not technical, but actually translates into something that means something to our consumers and actually also our staff. Most of our metrics are operational, and I am not sure there is a huge level of interest in our operational metrics. People want to know, “Can I get to see the healthcare professional in a timely way? Will that experience be compassionate and respectful? Will I come out with a meaningful outcome?” I think we do collect a lot of data, so it just got to make sure whatever surrogate markers we choose are firstly, an accurate reflection and secondly, meaningful and translated. We are just trying to work that through at the moment for all elements of our business.

The CHAIR: What is the challenge with data sharing? Is that something you grapple with—data sharing with, for instance, child protection, education or other services you are engaging? You have got the same child on this path through service provision.

Dr Anwar: There is certainly a very strong perception that data sharing is prohibited. I think we are working that through as part of—I am very privileged, I sit on the Bright Futures program, and I think there is a very commitment to overcome that. Even outside the setting of that program I think there is a drive between health, communities and education to use the data in a meaningful way to translate it. I suppose we would be pedantic and make a very careful articulation of the difference between and information. We are actually pretty data rich; we are information poor. Some of that is capability; that is a very specialised skill set we have all invested in heavily. I think that is needed, and then there is a bit of work to be done.

Mrs J.M.C. STOJKOVSKI: I find that interesting, because from the perception in the community it would appear that if a child has come in contact with protective services, health and education, they would share that data.

Dr Anwar: Yes, absolutely.

Mrs J.M.C. STOJKOVSKI: To find out then that is not is a bit concerning. That is not a question; it is an observation.

Dr Anwar: Yes!

The CHAIR: I take you quickly to the recommendations the royal commission. The royal commission and the state government's response to the royal commission obviously talks about the whole-of-government approach. Is your organisation involved in the process is being led by DPC to enact a response to all those 400-plus recommendations?

Dr Anwar: Sure, do you want me to talk to or do you want to make any comments? I am happy to.

Ms Clements: I will comment, if you like. The Department of Health is represented on the Department of the Premier and Cabinet's coordinating group, and I work closely with the Department of Health representative in matters relating to the royal commission. I think you would have heard of the Department of Health implementation working group in relation to the royal commission. Both the Department of Health and myself from CAHS are represented on the Department of Communities interagency group. The Office of the Commissioner for Children and Young People is obviously also involved in that group.

The CHAIR: Is that the group that is looking specifically at oversight?

Ms Clements: No, it is looking at all the recommendations that the Department of Communities leads on, so that includes the Child Safe Standards, it includes recommendations around harmful sexual behaviours, therapeutic responses, advocates, treatment and support, working with children's checks and you have probably got a list.

The CHAIR: We have got a map!

Ms Clements: Right, okay!

The CHAIR: We had to ask for a map!

Ms Clements: Yes, indeed!

The CHAIR: I think some people have found these here quite enlightening, because they work out which group they are on!

Ms Clements: It was determined that the best way was to have a fairly large interagency group and that everyone could be part of those discussions. The Office of the Commissioner for Children and Young People, as I said, is obviously represented on that group, so is alongside all the discussions that are being had. CAHS also works quite regularly with the Office of the Commissioner for Children and Young People, so we are across all their resource material in relation to the Child Safe Standards and that sort of capacity-building aspect that they have undertaken, which we found very useful.

Mrs J.M.C. STOJKOVSKI: Can I just clarify that the representative from health on the DPC working group that is doing the work on the royal commission on child sexual abuse recommendations does not come from CAHS?

Ms Clements: No, they come from the Department of Health. Aresh can probably describe the structure of health better than I can, but there is the Department of Health, which is the system administrator, and then there are a number of health service providers of which Child and Adolescent Health Service is one. Because of the nature of that work and the seniority, I suppose, the representative on the Department of the Premier and Cabinet coordinating group comes from the Department of Health. Because of CAHS' specific knowledge, expertise and service delivery in relation to child protection, we work closely with them and are kind of on the committee on the next layer down, I suppose, in a sense with the Department of Communities. Having said that, I have deputised for the Department of Health at that DPC committee.

Hon DONNA FARAGHER: I think you would be very relevant.

The CHAIR: You would think, would you not?

Dr Anwar: I think there is a second practical thing. One is, I suppose, just an acknowledgement that we feel responsible for it, but in a formal structure. We look after about 75 per cent of children in Western Australia, so the organisation is very committed, making sure that no-one is left out as such, but we have a very specific remit articulated. WA Country Health Service looks after children in the country. We obviously interact. We have very strong relationships, and in no way would I want the committee to feel in any way this comment is suggesting an abrogation of responsibility.

The second is that, within CAHS, we have started some work to address the concerns that were raised as part of the royal commission, with the start of a gap analysis—an identification of workstreams that are currently compliant and where we have got to go in order to address all the issues that were raised as part of the commission. Not only is there system-wide work that needs to be done, but we are ensuring that we do some focus work internally as well.

[11.00 am]

Hon DONNA FARAGHER: You mentioned that you effectively have responsibility for 75 per cent, and the other 25 per cent is from country health. Is that right?

Dr Anwar: Yes.

Hon DONNA FARAGHER: With regard to the Department of Communities implementation working group, which I think Ms Clements sits on, does country health have some representation or are their views taken up by CAHS?

Ms Clements: The representatives on the Department of Communities group is a representative from the Department of Health and myself from CAHS, but because there is an internal Department of Health group, the WA Country Health Service is represented on that group. We also have other mechanisms where we are meeting with representatives across the health service providers to keep them informed of emerging issues.

Dr Anwar: Again, I apologise for just reiterating it. My roots lie in a different health service in a different country, but I would want to reiterate that the spirit of constructive collaboration in health is huge. I do not believe that I have witnessed any competition that comes at the cost of someone else's failure. I think that is a really important value set that everyone brings to the table around making sure that success is universal and that we collaborate. Just this challenge between say, for example, the WA Country Health Service and CAHS, there is no competition. It is a really strong value set, I think, that is witnessed at every level, and definitely strongly advocated for from the very, very top.

The CHAIR: Just finally, this refers to a report following an inspection by the Chief Psychiatrist. I do not think we referred to it earlier. Is it the same report that we are talking about? I just want to clarify that we have covered this. I have a question about some evidence we heard from a previous hearing a couple of weeks ago with Audrey Koay from the Department of Health. We were advised that the Chief Psychiatrist had recently conducted an inspection of CAMHS and we have not yet received a copy of that report. Is that the report that you are talking about?

Dr Anwar: Yes, I apologise. It is a report from an inspection in May 2018. Is that the report?

Ms Sullivan: No. What she would have been alluding to is that the Chief Psychiatrist visits. He recently visited PCH ward 5A and then he provided us a letter following that. If Audrey needed that letter, she needed to speak to the Chief Psychiatrist or request it from us.

The CHAIR: It was a public hearing, so what we might do is follow this up with you by letter. We will give you the extract from the hearing. If it is a document other than the one you have talked about already in relation to the Chief Psychiatrist, if you could provide that to us, it would be very useful. I stress again that anything that you want to be kept private, just indicate that on the document or on the notes that accompany it.

Dr Anwar: I take on board, Trish, that there may be some confusion. We are happy to provide both the recent letter from the Chief Psychiatrist and also the 2018 report by the Chief Psychiatrist and actions that were instituted as a consequence of that and our current standing against that.

The CHAIR: That would be very useful; thank you.

Dr Anwar: I believe it is the May 2018 report that Audrey talked about.

The CHAIR: Yes; I think that is now clear. There may be some other follow-up questions after we have reflected on what we have heard from you, in which case we will include those in the letter that we send to you. I will formally close the hearing. Thank you for 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 added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary document for the committee’s consideration when you return your corrected transcript of evidence. Thank you very much for coming in today.

Dr Anwar: Thanks for giving us the time.

The CHAIR: It has been very interesting. Thank you.

Hearing concluded at 11.05 am

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