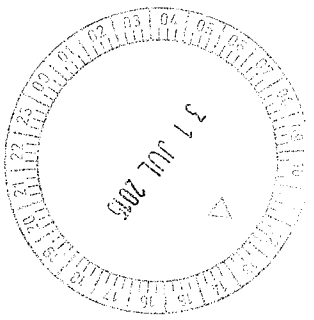

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Date: 24 June 2015

Department: Mental Health Commission

Supplementary Information No. D1: Hon Stephen Dawson MLC asked -

Question:

Stokes Review: The progress status dashboard on the Mental Health Commission's website provides an update of the details of the recommendations. The website states that 34 recommendations have been completed. I am keen to get a sense of what the cost has been to implement these 34 recommendations. I am also keen to find out about the 91 recommendations that are progressing or on track, if the department has costed those recommendations and if you can give a sense of what the figure is?

Answer:

The implementation of the recommendations of the Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia (Stokes Review), in the Department of Health, including the Health Services has largely been achieved through the use of existing staff resources as part of normal operations and ongoing service improvements. Therefore, the Department cannot provide specific total actual costs for implementing the Review.

Between 1 January 2013 and 30 June 2015, at least $897 790 (excluding Department of Health staff costs) was expended to deliver discrete Stokes Review projects. This amount includes costs for external consultants, sitting fees for mental health consumer carer participation, workshops and forums and providing resources for mental health clinicians, consumers and their families and carers.

Recommendations that relate to changes in clinical practice are, as far as possible, implemented within existing resources and/or the budgets of both the Mental Health Commission and the Department of Health.

The pilot Inter-Hospital Patient Transport Program commenced in March 2014 and the Mental Health Commission has allocated $894,455.71 (February 2014 – January 2016) to the North Metropolitan Health Service for its delivery. [Relates to Stokes Review recommendation 1.3]

Where the Stokes Review recommends new or additional services or supports, funding is dependent on the Government's fiscal capacity and subject to normal budgetary processes. The following initiatives are two examples from the Stokes Review that have received new or additional funds:

- The Court Diversion Pilot Program commenced in 2013 and comprises an adult program, the Specialised Treatment and Referral Team (START) Court, and a children's program, Links. The program integrates clinical and non-clinical supports and aims to reduce reoffending through diversion to appropriate mental health and other services. Since 2013, the total State Government contribution is $16 million to the end of 2015/16 for the delivery of the program. [Relates to Stokes Review recommendations 8.10.7 and 9.1.2]
- The State-wide Specialist Aboriginal Mental Health Service (SSAMHS), developed to assist Aboriginal people to access culturally secure mental health services, commenced in 2011. Between 2011 and June 2014 $22.9 million was allocated to delivering SSAMHS. In 2014/15 the Commission secured funding of $29.1 million until June 2017 for three years of service. The Commission is currently preparing a comprehensive evaluation of the SSAMHS program. [Relates to Stokes Review recommendations 7.6 and 7.8]

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Date: 24 June 2015

Department: Mental Health Commission

Supplementary Information No. D2: Hon Stephen Dawson MLC asked -

In terms of the 91 recommendations that are progressing still or are on track, is there matrix or a timeline in the months and years ahead for when these will be finished and finalised?

Answer:

In November 2011, Professor Bryant Stokes AM, was appointed to undertake a review of the admission and discharge practices within Western Australian public mental health services. The final Report from the Review, entitled Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia (Stokes Review), was officially released in November 2012.

An Implementation Partnership Group (IPG), chaired by Mr Barry MacKinnon AM, was established in March 2013 to oversee the implementation of the Stokes Review recommendations. The Commissioner for Mental Health and the Director General of the Department of Health are the joint sponsors of the IPG.

The Stokes Review set out 117 recommendations. Government supported all but two of the recommendations. Of the 115 supported recommendations, 65 have been completed with the remaining 50 on track and progressing well.

Many of the recommendations will be supported by the proposed actions in the Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan). Implementation of the Plan will be subject to Government endorsement and successful budgetary processes. The implementation of the Mental Health Act 2014 will also support the delivery of a number of the Stokes Review recommendations.

Estimated timeframes for the completion of processes to implement the recommendations can be found within the attached Table 1: Implementation of Stokes Review Recommendations Progress.

Table 1: Implementation of Stokes Review Recommendations - Progress

Please note: Completion refers to the finalising of a process being established for the on-going implementation of the nominated recommendation. On-going monitoring and evaluation will be required to ensure appropriate solutions to recommendations are delivered over time. The implementation of recommendations requiring additional funding will be subject to normal budgetary processes and will only be fully implemented when funding is available.

All estimated completion dates are as at 7 July 2015 and are subject to change.

Abbreviations:
MHA 2014 – Mental Health Act 2014
10-year Plan – 10-year Mental Health, Alcohol and Other Drug Services Plan

Recommendation Number	Recommendation Title	Scope	Anticipated Completion Date
1.1	That the Department of Health establish an Executive Director of Mental Health Services reporting to the Director General of Health and that the position be responsible for the following (1.1.1-1.1.9):	The position of the Executive Director of the Office of Mental Health has been established.	Complete
1.1.1	The development of the mental health Clinical Service Plan in collaboration with the MHC.	A Clinical Services Plan (CSP), that embraces the key elements of clinical care, rehabilitation, living accommodation, geographical location and infrastructure build and support, will be developed. Following on from the CSP, a 10-year Mental Health and Alcohol and Other Drug Services Plan (10-year Plan) will be developed.	September 2015 Draft printed for consultation December 2013

		Acceptance by Government of the 10-year Plan will be deemed achievement of this recommendation.	
1.1.2	Policy setting, including those of standards and those of best practice.	Oversight of the development of State-wide MH Policy via a MH System-wide Clinical Policy Group. As per the requirements of the Mental Health Act 2014, Chief Psychiatrist (CP) Standards for care and treatment are being developed. Compliance measures will be developed for the Standards.	Complete
1.1.3	Developing standard documentation for service provision, including model of care, patient risk assessment, and risk management.	A suite of state-wide Standardised Clinical Documents (SSCDs) has been endorsed and a Department of Health Operational Directive issued. Note: SSCD will be implemented on the mental health information system (PSOLIS) and Health Service compliance with SSCD requirements will be monitored and reported.	Complete
1.1.4	Oversight of the compliance of policies by the various service providers and reporting on those services that do not comply.	Monitoring and reporting on compliance of Health Services with implemented Stokes Review Recommendations, State-wide Policies, and CP Standards. Guidance and advice from the Compliance Reporting Working Group.	November 2015
1.1.5	Working closely with the Office of the Chief Psychiatrist to ensure compliance with regulations from that Office.	A collaborative approach to ensure the Standards, Guidelines and regulations from that Office can be measured for compliance. Compliance reports will be provided to the Health Services to promote continuous service improvement.	November 2015
1.1.6	Actively pursuing workforce development, service growth, and service provision.	Support the delivery of high quality MH Services through workforce development initiatives, including the MH Leadership Program, that foster a culture of continuous service	Complete

		improvement.	
1.1.7	Developing the mental health workforce and mandating systems of supervision, continuing professional development, and credentialing of a service as well as personnel, to provide the required mental health care of that service.	Establish systems for monitoring the credentialing of MH Professionals within the Health Services. Support the Health Services to meet this recommendation through a range of mental health workforce development initiatives, such as the MH Leadership Program.	Complete
1.1.8	Being involved in budget-setting with the Mental Health Commission in conjunction with the Performance Activity and Quality Division of the Department of Health, to ensure that this budget is appropriate to deliver safe and quality mental health care.	A collaborative process to ensure that the annual budget is appropriate to fund Mental Health Services for service growth and continuous quality improvement, in order to deliver safe and quality mental health care has been established. Appropriate Service Agreements are now developed on an on-going basis, as well as continued collaboration on bi-lateral budget discussions and Business Cases as required. The establishment of this process for collaboration is deemed as full achievement of this recommendation.	Completed (on-going)
1.1.9	Ensuring the development of a robust information system (including electronic) with flexibility for ease of use by all mental health practitioners including those who practice in areas of public mental health managed by a private provider.	Projects have been prioritised for the mental health information system (PSOLIS), to support greater ease of access to patient information for staff involved in the assessment and treatment of individuals with a mental illness. This work is being overseen by a PSOLIS Governance Committee. The development of Information Access Agreements to provide read/ write access to PSOLIS for MH Practitioners who practice in privately-managed public MH services.	Completed (ongoing)

1.2	Works closely with other service providers such as GPs, private hospitals, and NGOs to ensure the system has solid links between the inpatient and community health clinics so there is a seamless flow of patients between them and establishes and monitors those links.	A collaborative approach with the Health Services to encourage, develop, and promote initiatives that increase links between inpatient and community mental health clinics and other service providers. Compliance measures will be developed for Transfer of Care and Care Planning Standards (that are in development).	Complete
1.3	Develops a safe and quality mental health transport system in the metropolitan area with hospital staff trained in mental health and soft restraint, to transfer patients between hospitals.	Develop a mental health transport system model in the metropolitan area which will commence with the implementation of a pilot service. The successful implementation of the pilot project which has been in place since March 2014, is deemed as achievement of the recommendation with the ongoing model to be achieved following the passage of the Mental Health Act 2014.	Complete
1.4	Cultivates resources and builds knowledge that improve evidence-based care, strengthening practice and fostering innovations.	Collaboration with the MHC to support the sector to develop evidence-based, best practice Models of Service (MOS) and Service Delivery for MH Services, and to promote knowledge-sharing in this area. A Mental Health Network and MH System-wide Clinical Policy Group have been established.	Complete
1.5	The new Executive Director of Mental Health Services of the Department of Health needs to ensure there are bridge programs that associate mental health with disability and culturally and linguistically diverse services.	Ensure that there is an increased understanding of diversity needs throughout the mental health sector and that training is provided to ensure needs can be met across the sector. This is being achieved through the promotion of the MH in Multicultural Australia Framework towards Culturally Inclusive Service Delivery and other frameworks and guides. Where a specific service is required, this will be identified in the 10-year Plan.	September 2015
1.6	The new Executive Director of Mental Health Services develops policy with the	Develop and implement policies that support collaborative and effective care for individuals with complex and co-occurring	End of July 2015 for

	Drug and Alcohol Office to enable mutual cooperative working with complex cases.	mental health and substance use issues.	WACSUMH component September 2015 for 10-year Plan
1.7	The new Executive Director of Mental Health Services needs to urgently implement a review of the management structure of the services in each Area Health Service in conjunction with the area chief executives.	The Executive Director of the OMH, with the technical assistance of appointed consultants, has worked collaboratively with Mental Health Executive Directors to undertake a review of the current mental health management structures within Health Services. The review report is for internal use only. In addition to the review report, the WA Centre for Mental Health Policy Research has conducted an inter-jurisdictional review of MH service management structures, which has also been distributed to the Health Services for their consideration in reviewing their own MH service management structures.	Complete
2.1	The new Executive Director of Mental Health Services mandates the policy development of patient focussed service and insists that every patient is involved in care and discharge planning.	Promote the delivery of care aligned with the National Framework for Recovery-Orientated Mental Health Services 2013. A MH System-wide Clinical Policy Group has been established. Statewide policies will support the National MH Standards and CP Standards and Guidelines. A suite of State-wide Standardised Clinical Documents (SSCDs) has been endorsed, including a Treatment, Support, and Discharge Plan. This form includes fields for consumer and carer/support person signatures. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP	Complete

		Standards for care and treatment are being developed. Compliance measures will be developed for the Standards.	
2.2	Every patient must have a care plan and be given a copy of it. Prior to discharge, the care plan must be discussed in a way that the patient understands and be signed off by the patient. With the discharge plan the carer is also involved as appropriate.	Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. Promote CP's Clinical Guideline: Communicating with Carers and Families.	Complete
2.3	Every patient has access to individual advocacy services to assist with the navigation through the system and development of a care plan.	There are 3 key components to addressing this recommendation: Individual advocacy services will be provided through the provisions of the Mental Health Act 2014, with the proposed establishment of the new Mental Health Advocacy Service (MHAS) and appointment of mental health advocates. The Act will cover the needs of all involuntary patients. The 10-year Plan will identify the system wide need for advocacy services and any gaps will be considered as part of the implementation of the 10-year Plan. Ensure that care planning includes provision of advice as to how to access advocacy services.	November 2015 for MHA 2014 matters September 2015 for 10-year Plan related matters July 2015 for Chief Psychiatrist Standards

2.4	That adolescents and young people are assessed comprehensively, particularly for factors which encroach upon self-image and self -worth and that their concerns are validated and taken seriously.	Standardised assessment forms are utilised by all CAMHS services with use of audits to ensure compliance. An Experience of Service Questionnaire is administered.	Complete
2.5	A detailed explanation of the advantages and side effects of psychiatric drugs is given to the patient and the need to maintain medication regimes is comprehensively discussed.	A collaborative approach with the Health Services to encourage clinicians to comprehensively discuss the advantages, side effects, and requirements of psychiatric drug regimes with patients in order to effectively support patient communication and decision-making in the treatment and recovery process. CAMHS has a consumer medication information website. A similar website for adult mental health services is in development and will be made available.	Complete
2.6	When patients complain of medication side effects these are taken seriously and the issues explained fully. Medications should be reviewed regularly with the aim of identifying the side effects and the lowest effective dosage of drug should be used.	See Recommendation 2.5	Complete
2.7	All mental health clinicians must ensure that the physical wellbeing (including dental) of all patients under their care is regularly assessed and treated by appropriate specialist clinicians (e.g. podiatrist, diabetes educator). This is a key performance indicator that requires monitoring for compliance.	A suite of State-wide Standardised Clinical Documents (SSCD) has been endorsed, including Physical Appearance (including dental) and Physical Examination forms. A Physical Health Care Standard has been drafted by the CP. As per the requirements of the Mental Health Act 2014, a physical examination must be conducted within 12 hours of a person with a mental illness arriving at a hospital. A	Complete

		collaborative approach to support Health Services to meet this requirement and measure and monitor their compliance.	
	Oral Health: All mental health clinicians must ensure that the physical wellbeing (including dental) of all patients under their care are regularly assessed and treated by appropriate specialist clinicians (e.g. podiatrist, diabetes educator). This is a key performance indicator that requires monitoring for compliance.	A collaborative approach with the Oral Health Improvement Unit, Dental Health Services, the Clinical Research Centre, the Health Services and UWA to develop a state-wide approach to oral health screening and promotion and improved access to publicly funded services for MH consumers.	August 2016
2.8	Patients who have a mental illness and are admitted to general hospital wards for other conditions are assessed and monitored by mental health clinicians during their inpatient stay (partly supported, only where this is clinically indicated).	Health Services Psychiatric Consultation Liaisons (PCL) provide in-reach MH services to patients on general hospital wards. A collaborative approach to support Health Services to meet this recommendation and measure and monitor their compliance, including the capacity of PCL services. Work closely with the MHC to ensure that services are appropriately funded for service growth and quality.	December 2015
2.9	Where a patient has indicated the possibility of performing self-harm, that patient must always be comprehensively assessed by a mental health practitioner and their care plan be approved by a psychiatrist or psychiatric registrar and not discharged until that approval occurs.	A suite of State-wide Standardised Clinical Documentation (SSCD) forms has been endorsed, including a Risk Assessment and Management Plan and a Treatment, Support, and Discharge Plan. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed.	Complete

		Compliance measures will be developed for the Standards.	
2.10	No patient is to be discharged from an ED or another facility without an adequate care plan. Where there is a carer clearly involved, the carer should be included in the discussion of the care plan and discharge plan. Carer involvement is essential, especially in life-threatening situations, and is to be fostered at every opportunity. The sanctity of patients' confidentiality should not be used as a reason for not communicating with carers in these situations.	A suite of State-wide Standardised Clinical Documentation (SSCD) forms has been endorsed, including a Risk Assessment and Management Plan and a Treatment, Support, and Discharge Plan that includes fields for carer/support person details and signatures. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. Collaboration with the Chief Medical Officer about ED practices.	December 2015
2.11	Patients must be made clearly aware of their voluntary and involuntary status.	As per the requirements of the Mental Health Bill 2014, a person's legal status must be clearly communicated with them. PSOLIS captures a person's legal status. Health Service compliance with this recommendation will be monitored and reported, with guidance and advice from the Compliance Reporting Working Group.	Complete
2.12	The names and contacts of carers should be recorded for each patient where appropriate.	A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Treatment, Support, and Discharge Plan that includes fields for carer/support person details and signatures. Health Service compliance with SSCD requirements will be monitored and reported.	Complete

		As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards.	
3.1	Whilst the patient is the primary focus of care, the views of the carer must also be considered.	A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Treatment, Support, and Discharge Plan that includes fields for carer/support person details and signatures. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. MH Leadership Program service improvement initiatives.	Complete
3.2	Carers must be involved in care planning and most significantly in a patient's discharge plan, including the place, day, and time of discharge.	A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Treatment, Support, and Discharge Plan that includes fields for carer/support person details and signatures. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. MH Leadership Program service improvement initiatives.	Complete
3.3	The carers of patients need education, training, and information about the 'patient's conditions' as well as what are the signs of relapse and that may cause relapse triggers.	Materials to support the implementation of the new Mental Health Act 2014 will be developed including for consumers, carers and families and for clinicians to facilitate appropriate inclusion and provision of information to consumers, carers and their families. Where appropriate, information for voluntary patients will be included.	November 2014 for consultation on future education and training needs

		Any existing information/training resources that can be utilised with or without modification will be identified. Modifications will be actioned as necessary. A strong culture of actively supporting carers during the provision of care to people with mental illness and in the development of education and training initiatives that enhance the ability of carers and families to support individuals with a mental illness will be supported.	November 2015 to align with the MHA 2014 actions
3.4	The carers of patients need to be informed in a timely fashion when the patient is to be reviewed by the Mental Health Review Board and supported to attend.	The Mental Health Act 2014 (MHA 2014) received Royal Assent in November 2014 and will commence after an implementation period of approximately 12 months. The Mental Health Review Board (MHRB) will be replaced with a Mental Health Tribunal (MHT). Changes relevant to Recommendation 3.4 are, in summary: • Families and carers will automatically have the right to apply for a review by the MHT: section 390. • Families and carers must be notified of an application for a hearing: section 446. • Families and carers must be notified of the date, time and place of an upcoming hearing: section 447. • The person who applied for review automatically becomes a party to the hearing: section 393. • The MHT must have regard to the views of families and carers: sections 394 and 459.	Complete
3.5	The governance of the system should provide to carers, patients, and GPs an appropriate way to navigate the mental health system in seeking advice and support, particularly in crises.	Develop more streamlined pathways to access emergency mental health services and to communicate these pathways to consumers, carers, clinicians, and service providers. The 10-year Plan will identify the system-wide need for support services required to help consumers, carers and GPs to better navigate the mental health system.	September 2015

		Development of improved 'on the ground' responses to crisis e.g., co-response beginning with a review of the operation of current crisis response teams.	
3.6	A carer should have equal status with the patient in reporting triggers that might indicate deterioration in the patient's condition.	A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Treatment, Support, and Discharge Plan that includes fields for carer/support person details and signatures. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards.	Complete
3.7	Carer communication by mental health clinicians is mandatory for the system to be robust and provide patient best practice.	See Recommendations 3.3 and 3.6	Complete
3.8	Patients may demand confidentiality of care and treatment but mental health clinicians in this situation need to understand and take into account the requirements and vulnerability of carers. Mental Health practitioners must be aware of the rights and safety of carers.	See Recommendation 3.6	Complete
4.1	Clinicians need to work actively with the Executive Director of Mental Health Services of the Department of Health to assist in workforce planning and service development.	Work with the WA Health Network to progressively improve mental health services. Support best-practice by developing initiatives to foster a culture of collaboration and innovation-sharing. The 10-year Plan will define the high level workforce numbers required and whole of workforce system level planning and	September 2015

		these will subsequently be operationalised subject to endorsement and funding of the Plan.	
4.2	Clinicians must ensure the service in which they are working does not deviate from the standards and protocols set.	As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. Training will occur as part of the Mental Health Act 2014 rollout, which will refer to the CP Standards and Guidelines. Stokes Review compliance measures and reporting mechanisms are being developed, with guidance and advice from the Compliance Reporting Working Group.	November 2015
4.3	Clinicians must ensure within their area of work that the service is totally patient centred and that the patient's and carer's rights and responsibilities are understood and respected.	An endorsed suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Treatment, Support, and Discharge Plan that includes fields for consumer and carer/support person details and signatures. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards.	Complete
4.4	Mental health clinicians must comply with reporting requirements for the National Outcomes and Case mix Collection (NOCC) and Health of the Nation Outcome Scales (HoNOS).	Monitor and report on compliance of Health Services with NOCC requirements.	Complete
4.5	Compliance with the electronic information system is mandatory.	See Recommendations 1.1.3, 1.1.9, and 4.4	November 2015

4.6	Clinicians need to ensure that continued professional development occurs and is recorded yearly as required by the clinicians' respective colleges and professional organisations. This compliance must be audited.	See Recommendations 1.1.6 and 1.1.7	Complete
4.7	Links between community mental health services and inpatient facilities must be maintained and maximised to ensure continuity of care and continuation of treatment plans.	A collaborative approach with the Health Services to encourage, develop, and promote initiatives that increase links between community mental health services and inpatient facilities to enhance the continuity of care of consumers. Compliance measures will be developed for Transfer of Care and Care Planning Standards (that are in development).	Complete
4.8	Residents of psychiatric hostels and other mental health facilities should have equal access to mental health services as other members of the community.	A collaborative approach with the MHC to ensure that services are funded in a way that promotes equity of access to public mental health services for all community groups, including residents of psychiatric hostels. Work collaboratively with the MHC, Health Services and psychiatric hostels to explore MOUs between psychiatric hostels and MH services.	December 2015
4.9	Ensure adequate support is given to residents in psychiatric hostels and supported accommodation when advice is requested within the areas in which community mental health clinicians work.	See Recommendation 4.8. The planning aspect of this recommendation (need for services for hostel residents in the next 10 years) is being addressed by the 10-year Plan.	December 2015
4.10	Psychiatric hostels and supported accommodation should have appropriate levels of access to patients' care plans and receive clear communication of discharge plans.	See Recommendation 4.8.	December 2015

4.11	Since mental health and substance-use disorders, including drug and alcohol issues, co-occur with high frequency in mental illness, it is imperative that clinicians are trained in the recognition and treatment of comorbid disorders of this type.	Identify and address training needs for all staff working in the mental health sector and the AOD sector in regard to the management of co-occurring conditions of drug and alcohol misuse.	September 2015
4.12	Education and training should be provided to all staff to ensure ongoing quality of patient care and management. This should also be specifically available to workers of NGOs to ensure a high quality of care.	Monitor compliance with the National Mental Health Standards. Other initiatives supporting education and training of staff will also be considered by relevant agencies as part of their internal workforce development strategies. Specific training will be provided in relation to implementation of the Mental Health Act 2014.	September 2015
5.1	The current acute bed configuration can only be adjusted when there are appropriate step-down rehabilitation and supported accommodation beds established. Any attempt to close acute beds before these systems are in place will be further detrimental to the system.	Investment in some new services has begun including the establishment and operation of 22 subacute beds at Joondalup. The 10-year Plan will provide a framework that will enable the type and quantity of inpatient, subacute and community residential beds required in public and community-based mental health facilities to be identified. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
5.2	Adolescent beds need to be increased to take into account the increasing population of youths. Beds must also be provided for child forensic and eating	Investment in some new services has begun including a 14 bed youth mental health unit now at Fiona Stanley Hospital. The 10-year Plan will provide a framework that will enable the	September 2015

	disorder patients. These are urgent requirements.	type and quantity of inpatient, subacute and community residential beds required in public and community-based mental health facilities to be identified. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	
5.3	Rural, child, adolescent, and youth beds should be considered a priority in forward planning and attended to immediately.	The 10-year plan will provide a framework that will enable the provision of rural, child, adolescent and youth beds as a matter of priority. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
5.4	Close working between the Department of Health as the provider and the Mental Health Commission as the funder need to occur so that a robust Clinical Services Plan is developed that provides step-down facilities as an early and pressing need.	Work on subacute and other clinical services will be incorporated into the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
5.5	The full range of beds needs to be provided in each geographical area. This is crucial to ensure continuity of care across the spectrum of accommodation.	The 10-year Plan will provide a framework that will enable the type and quantity of inpatient, subacute and community residential beds required in public and community-based mental health facilities to be identified for each geographical area. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to	September 2015

		separate Government budget process.	
6	The functions of the Office of the Chief Psychiatrist align most closely with service provision. Therefore, in the opinion of the Reviewer, the Office is appropriately placed operationally in conjunction with the Department of Health so that ready communication to clinicians and the proposed Executive Director of Mental Health Services can occur. The Office should be entirely independent and report to both the Minister of Health and the Minister of Mental Health with access to the Office by both the Director General of Health and the Commissioner of Mental Health. The Reviewer is firmly of the view that the Office should not be placed in either the Mental Health Commission or the Department of Health where it can be seen that conflicts of interest would arise in either situation.	The Public Sector Commission are overseeing the Machinery of Government to transition OCP to an independent statutory authority.	End of November 2015 for Mental Health Act – reporting component March 2016 for location component
7.1	Patients presenting anywhere in the public health system with suicidal intent must undergo a best practice risk-screening process and, where required, a comprehensive assessment by a mental health professional. A care plan must be formulated and all decisions to discharge	A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Risk Assessment and Management Plan, and a Treatment, Support, and Discharge Plan. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP	Complete

	require medical oversight and approval.	Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. Compliance with WA Department of Health Clinical Risk Assessment and Management Policy and Clinical Handover Policy.	
7.1.1	It is important that no decisions are made in isolation or by isolated practitioners.	See Recommendation 7.1 Compliance with WA Department of Health Clinical Supervision Framework for Mental Health Services and Clinical Risk Assessment and Management Policy.	Complete
7.1.2	Any emergency response team will also require medical oversight for decisions made when attending to urgent referrals.	See Recommendation 3.5 Compliance with WA Department of Health Clinical Supervision Framework for Mental Health Services and Clinical Risk Assessment and Management Policy.	July 2015
7.2	If a patient is discharged they must receive an agreed and signed comprehensive discharge plan that includes a carer, if involved, stating: - appointment time and date with the community mental health services, - contact details of emergency services, - medication and consumer medicine information, - an understanding to return to the current service if needed, and - name of mental health clinician and caseworker.	A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Risk Assessment and Management Plan, and a Treatment, Support, and Discharge Plan that includes fields for consumer and carer/support person details and signatures. The SSCD Care Transfer Summary form includes a field for Case Manager. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. Compliance with WA Department of Health Clinical Risk Assessment and Management Policy and Clinical Handover	Complete

		Policy.	
7.3	The care plan must accompany the patient between community and other treatment settings and be communicated to new clinicians at the time of transition. This ensures the care passport maintains treatment continuity.	See Recommendation 1.2, 2.2, 4.7	Complete
7.4	Every patient must have an identified case manager.	See Recommendations 7.1 and 7.2	Complete
7.5	The assessment, care plan, and decision to refer a patient from one public mental health service to another should be seamless. The patient should not experience further assessments as barriers to entry. There should be no requirement to repeat triage.	See Recommendations 1.2, 4.7, 7.1 and 7.2	Complete
7.6	Continue to resource the currently COAG Closing the Gap funded Specialist Aboriginal Mental Health Service (SSAMHS) to assist Aboriginal people to access culturally secure mental	MHC has secured funds for SSAMHS to June 2017 and will evaluate the service during that time. Where appropriate any service gaps will be addressed through the 10-year Plan and through evaluation of the SSAMHS	Complete

	health services, particularly those in custody or on parole and those with comorbid conditions such as substance abuse disorders.	program.	
7.7	Encourage training and education of mental health workers in the management of comorbid conditions of drug and alcohol misuse.	Identify and address training needs for all staff working in the mental health sector and the AOD sector in regard to the management of co-occurring conditions of drug and alcohol misuse.	September 2015
7.8	Continue to resource the current COAG Closing the Gap funded SSAMHS suicide intervention teams, including the support of Aboriginal Elders Specialist Mental Health Services and government and non-government agencies.	MHC has secured funds for SSAMHS to June 2017 and will evaluate the service during that time. SSAMHS includes working with Elders, as well as working with individuals and communities regarding suicide. Alignment with suicide prevention will continue through the Suicide Prevention Strategy and associated projects.	Complete
7.9	Develop respite services and increase rehabilitation services.	The 10-year Plan will identify the overall need for services and make recommendations, including those for respite and rehabilitation. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
7.10.1	Risk assessments should always follow those guidelines published jointly in 2000 by the Australasian College for Emergency Medicine and the Royal Australian College of Psychiatry and as subsequently endorsed as policy by the WA Department of Health in 2001 as a minimum standard.	A suite of State-wide Standardised Clinical Documents (SSCDs) has been endorsed, including a Risk Assessment and Management Plan. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards.	Complete

		Compliance with the WA Department of Health Clinical Risk Assessment and Management Policy.	
7.10.2	Where a person has been referred to an authorised facility for admission by a medical practitioner, final risk assessment should be undertaken by a psychiatrist after triage and preliminary assessment by a RMHN (registered mental health nurse) if 'wait' time is a problem.	N/A	N/A
7.10.3	Where a person who has undergone prior admissions is taken to an ED by a carer experienced with that person, final risk assessment should be undertaken by a psychiatrist after triage and preliminary assessment by a RMHN if 'wait time' is a problem.	N/A	N/A
7.10.4	Where a person has undergone risk assessment in an ED and is not to be admitted to any facility but referred to a CMHS (community mental health service), the person and their carer are to be provided with written advice as to their relevant CMHS and contact numbers and their proposed management plan and relevant time frames.	A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Risk Assessment and Management Plan, and a Treatment, Support, and Discharge Plan . Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. Compliance with WA Department of Health Clinical Risk	July 2015

		Assessment and Management Policy and Clinical Handover Policy. Development of a state-wide emergency contacts and follow-up card.	
7.10.5	The contact numbers should include 24-hour emergency service numbers and people should be advised that these can be accessed by anybody at any time and trained workers, who have the ability to call out emergency teams if necessary, will respond. These should be a reality.	See Recommendation 3.5, in particular: Develop more streamlined pathways to access emergency mental health services and to communicate these pathways to consumers, carers, clinicians, and service providers. The OMH will work with the CP, the CMO, and other stakeholders to develop a state-wide emergency contacts and follow-up card. Development of a state-wide emergency contacts and follow-up card.	July 2015
7.10.6	Ultimately all community health services should be funded to respond holistically to crises. Families, as well as patients, need support, especially on discharge of patient back into their care. Carers need to know the people involved with the care of their patient.	Work with the MHC and the Department of Health's Resourcing and Performance Directorate to ensure Community Mental Health Services, including Crisis Response Services, are appropriately funded for service growth and continuous quality improvement. A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Treatment, Support, and Discharge Plan that includes fields for carer/support person details and signatures. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed.	September 2015 for the 10-year plan

		Compliance measures will be developed for the Standards.	
7.10.7	No person should leave an ED without being provided with written advice as to who to contact in case of a crisis.	See Recommendation 7.10.4 and 7.10.5	July 2015
7.10.8	CMHS should make every attempt to provide their clients with concrete continuity. By this, I mean written contact and appointment dates from appointment to appointment with emergency numbers to contact between dates and 24-hour numbers.	See Recommendation 7.2	July 2015
7.10.9	Every child or adolescent with mental health issues should know a person acting as a community liaison officer (case manager). PMH should be included in all authorised facility guidelines and directives and should be funded for community liaison officers to maintain contact with any child who has presented to PMH with mental health issues. This is regardless of whether or not carers choose private or public sector treatment for their child.	Every child or adolescent admitted to CAMHS is allocated a case manager who fulfils the functions of a community liaison officer/case manager. A Family Support Worker (0.4FTE) at Bentley Adolescent Unit provides an advocacy role for families to assist in navigating the system and their child's care.	Complete

7.10.10	The role of the liaison officer is to ensure a contact for the child in times of crisis. They should maintain contact with the Bentley Adolescent Unit if the child is admitted as a patient or the relevant CMHS where the child becomes a client of a CMHS. They should know by whom a child is being treated if the choice is for private treatment. I do not envisage the liaison officer as being involved with treatment per se, but as ensuring children and adolescents are being provided with or have access to ongoing treatment as a matter of community commitment to children and adolescents.	See Recommendation 7.10.9 Support provided by the Accute Community Intervention Team and Acute Response Team, as well as Peer Support Workers.	Complete
7.10.11	Bentley Adolescent Unit should also have community liaison officers with a similar role and function to ensure children not passing through PMH are also provided with ongoing input.	Every child, adolescent or young person admitted to the Bentley Adolescent Unit (BAU) is allocated a care coordinator who fulfils the functions of a community liaison officer/case manager. Support provided by the Accute Community Intervention Team and Acute Response Team, as well as Peer Support Workers.	Complete
7.10.12	There is a very real need for day hospital facilities/transition units/wellbeing centres—whatever one chooses to call them as outlined by Professor Silburn in more locations throughout the metropolitan region and the rest of the State, as outlined by Professor Silburn. Such centres will accommodate the	Investment has already commenced with the opening of 22 bed subacute service at Joondalup in 2013. Professor Silburn's model is not being used; the 10-year Plan is being used instead. The 10-year Plan will provide a framework that will enable the type and quantity of inpatient, subacute and community	September 2015

	difficult transition from admission to the community following discharge and as a community support for those dealing with mental health issues.	residential beds required in public and community-based mental health facilities to be identified. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	
7.10.13	There needs to be relevant facilities out of the metropolitan area for short term care of patients in crisis to avoid dislocation as an added stress. I don't know if the secure facility at Bunbury Regional Hospital is now adequate but there is nothing in the north of the State. I note the reference to a plan for a facility for Broome. This needs to become a reality.	The Broome inpatient unit opened in 2012. Subacute facilities including a 6 bed unit in Broome are being implemented. Subacute facilities are addressed in other recommendations (e.g. 7.10.12).	Complete
7.10.14	Practitioners prescribing medications should ensure they comprehensively discuss compliance issues and discontinuation issues as well as any other relevant information associated with the particular medication required. I would prefer both providers and dispensers of medication to ensure up to date CMIs (consumer medicine information) or other written information be provided to patients and/or carers as a written record, approved by the TGA (the Therapeutic Goods Administration), of the advice given.	As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. CAMHS has a consumer medication information website. A similar website for adult mental health services is in development and will be made available.	Complete

7.10.15	Those practitioners discussing discharge plans with patients and carers need to specifically consider the extent to which they discuss the potential for death as an outcome of self-harming behaviour.	A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Risk Assessment and Management Plan, and a Treatment, Support, and Discharge Plan. Health Service compliance with SSCD requirements will be monitored and reported, including with the Triage to Discharge Framework that requires assessment and mitigation strategies for risks, such as self-harming behaviour.	Complete
7.11.1a	All patients, regardless of how well known they are to the MHS (Mental Health Service) should receive as comprehensive a psychiatric assessment as is possible on entry to the MHS for each specific episode of care including patients transferred from other facilities.	A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Risk Assessment and Management Plan, and Mental Health Assessment forms. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. Compliance with the WA Department of Health Clinical Risk Assessment and Management Policy.	Complete
7.11.1b	The MHS should use a standardised psychiatric assessment form to ensure consistency of data collection within and between MH services.	See Recommendation 7.11.1a	Complete
7.11.1c	The MHS, with the patient's informed consent, includes carers, other service providers, and others nominated by the consumer in assessment.	See Recommendation 7.11.1a Promote CP's Clinical Guideline: Communicating with Carers and Families.	Complete
7.11.2a	The MHS adopt the current or revised Clinical Risk Assessment and Management Policy as mandatory practice.	See Recommendation 7.11.1a	Complete

7.11.2b	The MHS ensures that, where indicated, patients have a current risk management plan, separate from the Individual Management Plan (IMP)	See Recommendation 7.11.1a	Complete
7.11.2c	Risk management plans are updated or revised with any new information relevant to that individual patient.	See Recommendation 7.11.1a	Complete
7.11.3a	There is a current individual multi-disciplinary treatment, care, and recovery plan, which is developed in consultation with, and regularly reviewed with, the patient and, with the patient's informed consent, their carer(s). The treatment, care and recovery plan is available to both of them.	A suite of State-wide Standardised Clinical Documents (SSCDs) has been endorsed, including a Treatment, Support, and Discharge Plan. This form includes fields for consumer and carer/support person signatures. Health Service compliance with SSCD requirements will be monitored and reported. Promote CP's Clinical Guideline: Communicating with Carers and Families.	Complete
7.11.3b	The treatment and support provided by the MHS is developed and evaluated collaboratively with the patient and their carer(s). This is documented in the current individual treatment, care and recovery plan.	See Recommendation 7.11.3.a	Complete
7.11.3c	The MHS ensures that the IMP is kept on both the clinical record and on PSOLIS	A suite of State-wide Standardised Clinical Documents (SSCDs) has been endorsed, including a Treatment, Support, and Discharge Plan. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. Projects have been prioritised for the mental health information system (PSOLIS), to support greater ease of access to patient	Complete

		information for staff involved in the assessment and treatment of individuals with a mental illness. This work is being overseen by a PSOLIS Governance Committee. The development of Information Access Agreements to provide read/ write access to PSOLIS for MH Practitioners who practice in privately-managed public MH services.	
7.11.4a	The patient and their carer(s) and other service providers are involved in developing the exit (discharge) plan. Copies of the exit plan are made available to the patient and, with the patient's informed consent, their carer(s).	See Recommendation 2.2	Complete
7.11.4b	The MHS provides patients, their carers, and other service providers involved in follow-up with information on the process for facilitating re-entry to the MHS if required and other resources such as crisis supports are provided.	See Recommendation 7.2 See Recommendation 3.5, in particular: Develop more streamlined pathways to access emergency mental health services and to communicate these pathways to consumers, carers, clinicians, and service providers. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards.	December 2015
7.11.4c	The MHS ensures there is documented evidence in the file that the treating team is in agreement with the decision to discharge the patient. Alternatively, evidence was documented in the file as to why the decision was made that may have been different from the treatment plan for discharge.	A suite of State-wide Standardised Clinical Documents (SSCDs) has been endorsed, including a Risk Assessment and Management Plan and a Treatment, Support, and Discharge Plan. Health Service compliance with SSCD requirements will be monitored and reported. Compliance with the WA Department of Health Clinical Risk Assessment and Management Policy.	Complete

7.11.4d	The MH ensures, as far as possible, that the next agency or clinician to support or provide care for the patient is made aware of the discharge date, the urgency of review and a specific contact within the services to manage issues of urgency or failure of follow-up contact.	A suite of State-wide Standardised Clinical Documentation (SSCD) has been endorsed, including a Care Transfer Summary containing the discharge date, contact details for clinicians who provided care and who will provide follow up, and identified risk/safety issues. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. Compliance with the WA Department of Health Clinical Risk Assessment and Management Policy and Clinical Handover Policy.	Complete
7.11.4e	The MHS has a procedure for appropriate decision making in regards to those who decline to participate in any planned follow-up.	Compliance with the WA Department of Health Clinical Risk Assessment and Management Policy. A suite of State-wide Standardised Clinical Documents (SSCDs) has been endorsed, including a Risk Assessment and Management Plan and a Care Transfer Summary. Health Service compliance with SSCD requirements will be monitored and reported. As per the requirements of the Mental Health Act 2014, CP Standards for care and treatment are being developed. Compliance measures will be developed for the Standards. Collaborative approach with the Health Services and CP to develop a conistent approach, including via the MH System-wide Clinical Policy Group.	December 2015
8.1	A central referring position is established to receive referrals for children and youth	The Community CAMHS team in each locality is the central point to receive referrals within their catchment area. For	Complete

	services, which will then direct the referral to the correct services in the patient's locality.	emergency and acute presentations, the Acute Response Team receives and directs referrals.	
8.2	After-hours services are established for children and adolescent and youth services in rural and remote communities, where possible.	Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
8.3	Emergency response services, including the Acute Community Intervention Team and the King Edward Hospital Unit for Mother and Baby, are supported.	Investment commenced in 2013 through the CAMHS Acute Response Team (ART) and Acute Community Intervention Team (ACIT). Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
8.4	Clear entry processes are developed for the Bentley Adolescent Unit.	BAU entry criteria have been developed.	Complete
8.5	Recovery programs for children are established.	The 10-year Plan will provide a framework that will enable the type and quantity of inpatient, subacute and community residential beds required in public and community-based mental health facilities to be identified. Any gaps identified through the 10-year Plan will be considered for Government action through the implementation	September 2015

		mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	
8.6	Special provisions are made for the clinical governance of the mental health needs of youth (16–25 years of age). The State would benefit from the advent of a comprehensive youth stream with a range of services that do not have barriers to access.	The 10-year Plan identifies the commissioning of a dedicated youth stream. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
8.6.1	Children should be treated in separate areas from adults, and young children should be separated from youth. Establish a youth inpatient unit with the capacity to manage comorbidities and alcohol and drug withdrawal.	A 14 bed youth inpatient service is operational at Fiona Stanley Hospital. The 10-year Plan identifies the commissioning of a dedicated infant, child and adolescent stream as well as a youth stream which will address this recommendation. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015

8.6.2	Respite and rehabilitation services are developed for youth.	The 10-year Plan will provide a framework that will enable the type and quantity of inpatient, subacute and community residential beds required in public and community-based mental health facilities to be identified. These and any community based service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
8.6.3	A service is established for youths with gender and sexual identity problems. Such a service requires expertise in psychiatric morbidity, suicidal behaviour, endocrinology and hormone treatments and close links with surgical and legal services.	The 10-year Plan will provide a framework that will enable the type and quantity of inpatient, subacute and community residential beds required in public and community-based mental health facilities to be identified. These and any community based service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
8.6.4	Appropriate credentialing for children and youth health workers must be assured (refer Recommendation 1).	Credentialing process associated with qualifications and Working with Children Checks are in place.	Complete
8.6.5	Workforce planning must be made to	The 10-year Plan will identify the overall need for services and	September

	address the shortage of Child Psychiatrists.	make recommendations in relation to workforce requirements. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Appropriate strategies will be developed at an operational level to recruit adequate number of child psychiatrists to meet future demand.	2015
8.7	To reduce disconnection between inpatient and community, treatment teams involve all the child's services and communicate with one another in a timely and respectful manner.	CAMHS Clinical Handover Policy, Clinical Handover Document and Transfer of Care form endorsed and disseminated. Discharge and transfer policy in place. Use of endorsed suite of SSCD. Formalised referral pathways and MOU with external agencies.	Complete
8.8	A more equitable distribution of community resources is provided.	The 10-year Plan will identify the overall need for services and resources. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan.	September 2015
8.9	Early childhood assessment and intervention programs are established for those children who show signs of the development of possible mental illness.	One of the key objectives of the 10-year Plan is a focus on prevention and early intervention. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is s	September 2015

8.10	This Review supports the recommendations submitted by the Commissioner for Children and Young People.	Recommendations supported and implemented as per recommendations 8.10.1 – 8.10.12.	September 2015
8.10.1	A strategic and comprehensive plan for the mental health and wellbeing of children and young people across WA be developed by the MHC [Mental Health Commission]. This plan should provide for the implementation and funding of promotion, prevention, early intervention, treatment and programs.	An action in the 10-year Plan is to develop a comprehensive prevention plan for mental health, alcohol and other drugs which will include a range of evidence based strategies. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
8.10.2	Funding to the State's Infant, Child Adolescent and Youth Mental Health Service be increased so it is able to provide comprehensive early intervention and treatment services for children and young people across WA, including meeting the needs of those with mild, moderate and severe mental illness.	Investment has commenced through ART, ACIT and Youth Axis (commenced 2012 - 13) community services and the establishment of a 14 bed youth mental health unit at Fiona Stanley Hospital. The 10-year Plan identifies the need for increased investment in the infant, child, adolescent and youth streams. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015

8.10.3	Admission, referral discharge and transfer policies, practices, and procedures of mental health services need to ensure the cultural needs of Aboriginal children and young people are met.	CAHS Director of Aboriginal Health and CAMHS Aboriginal staff members involved with CAMHS policy development and available for consultation when requested. CAMHS policies, practices and procedures aim to meet the cultural needs of all children and adolescents, including the needs of Aboriginal children and adolescents. Aboriginal cultural competency training and employment of Aboriginal staff.	June 2016
8.10.4	The State-wide Specialist Aboriginal Mental Health Service (SSAMHS) and Infant, Child Adolescent and Youth Mental Health Service establish a close working relationship and seamless referral process to ensure the best possible outcomes for Aboriginal children and young people.	SSAMHS and CAMHS work closely to facilitate best possible outcomes for Aboriginal children and young people, including via MOUs. SSAMHS positions allocated to CAMHS.	June 2016
8.10.5	Priority is given by the mental health service to the assessment, referral, admission, and continuity of treatment of children and young people in out-of-home care or leaving care.	The 10-year Plan will provide a framework that will enable the type and quantity of inpatient, subacute and community residential beds required in public and community-based mental health facilities to be identified. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015

8.10.6	A dedicated forensic mental health unit for children and young people be established.	The 10-year Plan will provide a framework that will enable the type and quantity of inpatient, subacute and community residential beds required in public and community-based mental health facilities to be identified. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
8.10.7	Children and young people appearing before the Children's Court of Western Australia have access to appropriate, comprehensive mental health assessment, referral and treatment services.	The Court Diversion program funded by the MHC, in partnership with the Department of the Attorney General, has provided access to appropriate, comprehensive mental health assessment, referral and treatment services for children and young people appearing before the Children's Court of Western Australia. The Pilot Court Diversion Program is funded to 30 June 2015, with an evaluation and business case undertaken to address the future of the program. Securing funding for the Pilot Court Diversion program is deemed as achievement of the recommendation. Future funding of the program will be subject to ongoing budget processes and evaluation findings.	Complete

8.10.8	The new Acute Response Emergency Team and specialist mental health services establish a close working relationship and seamless referral processes to ensure rapid access to treatment.	The Acute Response Team commenced service delivery in November 2012 and has a close working relationship with specialist mental health services and a seamless referral processes to ensure rapid access to treatment.	Complete
8.10.9	Previous recommendations made by the WA Coroner, Deputy State Coroner, the Auditor General for WA and Telethon Institute for Child Health Research about assessment, referral, admission, discharge, follow-up care, communication and care coordination be taken into account.	Gap analysis conducted. For identified gaps, strategies linked with the implementation of other related Stokes Review recommendations will apply.	Complete
8.10.10	Transition strategies for young people moving from child and adolescent services to youth mental health services and from youth services into adult services be developed and implemented to ensure the individual is supported and continuity of care is maintained at both transition points.	Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process and consultation with Department of Health and Health Services.	September 2015
8.10.11	The Disability Services Commission work with the Mental Health Commission to identity the services required to address the unique needs and risk factors for children and young people with disabilities in a coordinated and seamless manner.	A Framework will be developed that will enable the seamless coordination of services provided to address the needs and risk factors of children and young people with disabilities. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of	September 2015

		services will be phased over 10 or more years and is subject to separate Government budget process.	
8.10.12	All children and young people admitted to the mental health system have a treatment, support and discharge plan and that policies, processes and procedure that ensure care and discharge planning occurs to the level that ensures continuity of services and includes planning for education, accommodation and other support services as needed.	CAMHS Discharge and Transfer Policy and use of standardised documentation, such as endorsed suite of State-wide Standardised Clinical Documents (SSCDs), including a Treatment, Support, and Discharge Plan. Compliance with WA Department of Health Clinical Handover Policy.	Complete
9.1	As a matter of urgency, the Department of Health, the Mental Health Commission and the Department of Corrective Services (and other relevant stakeholders) undertake a collaborative planning process to develop a 10-year plan for forensic mental health in WA. (This plan will form the forensic mental health component of the State Mental Health Clinical Services Plan). Important elements to that plan include: As early as possible in the planning process, a business case for expansion of the currently inadequate number and location of secure forensic mental health inpatient beds needs to be developed for urgent government consideration.	Within the 10-year Plan there is a forensic component to address forensic needs. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
9.1.1	To divert early and minor offenders from the formal justice system and further offending behaviour in appropriate model, business case and funding for a	Within the 10-year Plan there is a forensic component to address forensic needs. Service needs identified through the 10-year Plan will be	September 2015

	police diversion service in WA are established.	considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	
9.1.2	The rapid and timely establishment of the recently funded Court Diversion and Support Program for adult courts is supported. The approved program for the Children's Court is also supported and it is recognised it will need early expansion to a complete service as in the adult courts.	Future investment in the Court Diversion and Support Program for adult courts and the program for the Children's Court will be based on evaluation of the current pilot program and sought through the State Government Budget Cycle. Within the 10-year Plan there is a forensic component to address forensic needs.	September 2015
9.1.3	The planning, business cases and funding for provision of a full range of mental health services in WA prisons and detention centres. This will involve dedicated units and services in prison for mentally ill women, youth, Aboriginal and people with acquired brain injury/intellectual disability.	Within the 10-year Plan there is a forensic component to address forensic needs. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan. Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	September 2015
9.1.4	Community services are expanded to facilitate transition from prison, to assertively follow up people who are seriously mentally ill and present a serious risk of harm to themselves and others, and to closely follow up and	Within the 10-year Plan there is a forensic component to address forensic needs. Service needs identified through the 10-year Plan will be considered for Government action through the implementation mechanism for the 10-year Plan.	September 2015

	monitor mentally impaired accused patients on custody orders in the community. Also, there is a need to assess and care for particular groups of individuals with particular care needs such as sex offenders, stalkers and arsonists.	Practical completion will occur when the 10-year Plan is completed and accepted by Government. Actual rollout of services will be phased over 10 or more years and is subject to separate Government budget process.	

Note: The State Coroner was allocated recommendation 7.10.16 - The Office of the State Coroner review all suicides in 2009 to assess what, if any, contact the deceased persons had with State Mental Health Services in an attempt to determine progress in the provision of improved mental health services to the West Australian community. This has been completed.

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Date: 24 June 2015

Department: Mental Health Commission

Supplementary Information No. D4: Hon Stephen Dawson MLC asked -

Based on the latest population figures, where does WA currently sit in relation to other states in the number of child and adolescent beds and forensic beds and non-acute beds?

Answer:

The latest published data from the Australian Institute of Health and Welfare's Mental Health Services in Australia, relates to the years 2012-13 and shows that at that time:

- . Western Australia has the fifth highest rate of Child and Adolescent specialised mental health beds in Australia; and
- Western Australia has the equal fifth highest rate of forensic specialised mental health beds in Australia.

Totals for non-acute bed rates are not published at the State and national level, however, totals are published for non-acute bed rates by target population (see Table attached).

Public sector specialised mental health hospital beds per 100,000 population, by target population and program type, states and territories, 2012–13

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
General									
Acute	28.4	19.6	21.6	25.5	22.5	26.1	21.8	24.9	23.9
Non-acute	12.9	2.7	16.8	7.0	3.5	8.7	0.0	0.0	9.3
Total general	**41.3**	**22.3**	**38.4**	**32.5**	**26.0**	**34.8**	**21.8**	**24.9**	**33.2**
Child and adolescent									
Acute	5.1	5.6	5.5	3.3	3.4	0.0	0.0	0.0	4.7
Non-acute	2.6	0.0	1.4	0.0	0.0	0.0	0.0	0.0	1.1
Total child and adolescent	**7.7**	**5.6**	**6.8**	**3.3**	**3.4**	**0.0**	**0.0**	**0.0**	**5.8**
Older person									
Acute	15.8	26.3	8.2	39.9	24.7	0.0	35.5	0.0	19.8
Non-acute	16.5	0.0	24.0	6.5	23.3	0.0	0.0	0.0	12.7
Total older person	**32.3**	**26.3**	**32.2**	**46.4**	**48.0**	**0.0**	**35.5**	**0.0**	**32.5**
Forensic									
Acute	2.1	2.2	0.0	1.6	0.6	5.8	0.0	0.0	1.6
Non-acute	2.7	1.3	2.0	0.4	2.4	0.0	0.0	0.0	1.8
Total forensic	**4.8**	**3.4**	**2.0**	**2.0**	**3.1**	**5.8**	**0.0**	**0.0**	**3.4**

Source: Mental Health Services in Australia (http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=38654706325) Table 14.

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Date: 24 June 2015

Department: Mental Health Commission

Supplementary Information No. D5: Hon Stephen Dawson MLC asked -

Question

Again, on the Stokes review, the latest quarterly chairman's report that I have seen, which is from February- obviously the Minister will have more up-to-date information- states that all IPG member agencies were asked to provide an update on the actions taken by the agency to address the reforms proposed by the Stokes Review. It goes "All agencies other than the Department of Corrective Services, Department of Premier and Cabinet, Aboriginal Health Council, Carers WA, CoMHWA, Arafmi, WAAMH and the Office of Multicultural Interests provided appropriate responses".

Are you in a position now to tell me if all those agencies have now provided responses; and if not, which agencies have not yet provided responses, and what is Mental Health Commission doing to ensure that responses are provided?

Answer:

The Stokes Review Annual Report March 2014 – March 2015 supersedes the February quarterly report. All members of the IPG were invited to comment on the Annual Report and if necessary, to provide any further updates. IPG members contribute to the Report through their continuing attendance at IPG meetings.

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Date: 24 June 2015

Department: Mental Health Commission

Supplementary Information No. D6: Hon Rick Mazza MLC asked -

Question

From an estimates point of view, I just want to know the average cost per day was for patients on the MITH program and how many days there is the program in the last 12 months.

If you could give me how many 'in the home' days there is for the MITH program in the last 12 months, that would be good.

Answer:

- I refer to page 399 of the Mental Health Commission's Government Budget Papers 2015-16, the estimated average cost per bedday Hospital in the Home services are as follows:

	2014-15 Estimated Actual
Average cost per purchased bedday in Hospital in the Home mental health units (price paid by Mental Health Commission)	$1,156

- Note: Hospital in the Home services for acute mental health care are an expanding service and it is anticipated that the cost of a Hospital in the Home bed will decrease as the number and scope of the service increases.
- The above estimated value is based on the price that the Mental Health Commission pays the Department of Health for the delivery of the program.
- In the 2014/15, there was 8,673 occupied beddays in Hospital in the Home units.

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Date: 24 June 2015

Department: Mental Health Commission

Supplementary Information No. D8: Hon Adele Farina MLC asked -

Question

How much block funding has been allocated for tier 2 services in the lower South West in the budget?

Answer:

Total funding allocated for Tier 2 Services in the lower South West for 2015/16 is $3,332,900.

2015/16 block funding amounts to non-government organisations in the lower South West region for provision of tier 2 services are outlined in Attachment 1.

ATTACHMENT

Service Provider	Service Type	Location	Catchment/Service Area	2014/15 Funding (ex GST)	Indicative 2015/16 Funding (ex GST)
Collie Family Centre	Counselling – face to face	Collie	South West	$77,417	$79,816
Total Funding				**$77,417**	**$79,816**

Service Provider	Service Type	Location	Catchment/Service Area	2014/15 Funding (ex GST)	Indicative 2015/16 Funding (ex GST)
Tender Care	Personalised support - other		South West	$176,165	$181,626
	Family and carer support		South West	$33,113	$34,139
Total Funding				**$209,278**	**$215,765**

Service Provider	Service Type	Location	Catchment/Service Area	2014/15 Funding (ex GST)	Indicative 2015/16 Funding (ex GST)
LAMP	Personalised support - other	Busselton	South West	$196,298	$202,303
	Family and carer support	Busselton	South West	$129,028	$133,028
	Personalised support – linked to housing	Bunbury	South West	$73,684	2015/16 funding is subject to grant extension
Total Funding				**$399,010**	**$335,331**

Service Provider	Service Type	Location	Catchment/Service Area	2014/15 Funding (ex GST)	Indicative 2015/16 Funding (ex GST)
Pathways South West Inc.	Personalised support – other	Bunbury	South West	$494,293	$509,616
	Personalised support – linked to housing	Bunbury	South West	$97,348	$100,366
	Family and carer support	Bunbury	South West	$135,569	$139,771
Total Funding				**$727,210**	**$749,753**

Service Provider	Service Type	Location	Catchment/Service Area	2014/15 Funding (ex GST)	Indicative 2015/16 Funding (ex GST)
Richmond Wellbeing Inc.	Staffed residential services – community supported residential units	Bunbury	South West	$1,136,121	$1,171,341
		Busselton	South West	$757,414	$780,894
Total Funding				**$1,893,535**	**$1,952,235**

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

24 June 2015

Mental Health Commission

Supplementary Information No. D9 (Pages 19/ 20)

Question: Hon Adele Farina MLC asked -

In relation to the vacant clinical psychologist position at South West CAMHS, what alternative methods are you exploring to have that position filled?

Answer: The Clinical Psychologist position at South West Child and Adolescent Mental Health Service (CAMHS) is currently being advertised for recruitment. A number of strategies continue to be explored to fill this position including short term contract, part time and secondment options of visiting health professionals. It is important to note that wait times for assessments have reduced from 4 months to 1 week since November 2014, and urgent cases are assessed within 24 hours. If WA Country Health Service cannot fill the position during this current recruitment process, the following alternative options will be to:

- advertise more broadly;
- review Clinical profile of multi-disciplinary team to determine alternative professional roles to support the CAMHS program;
- strengthen professional links with private Clinical Psychologist providers (including those based at Headspace); and
- strengthen professional links with all stakeholder agencies to ensure provision of Clinical Psychology support can be sourced.

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Date: 24 June 2015

Department: Mental Health Commission

Supplementary Information No. D10: Hon Stephen Dawson MLC asked -

Question

The duration of all persons who are currently or who have been in ICLS since it commenced.

Answer:

The duration of all persons who are currently or who have been in ICLS since it commenced is outlined in Attachment 1.

ATTACHMENT

Individuals who have exited ICLS			
ID	**Duration in program (months)**	**ID**	**Duration in program (months)**
MHC-02025	6	MHC-00752	24
MHC-00726	6	MHC-00742	25
MHC-00730	7	MHC-00734	26
MHC-00739	13	MHC-00740	26
MHC-01070	16	MHC-01437	27
MHC-01332	17	MHC-00801	27
MHC-01510	17	MHC-01234	28
MHC-00774	19	MHC-00731	30
MHC-00759	22	MHC-00938	31
MHC-01439	24	MHC-00884	31
MHC-00723	24	MHC-00757	36
MHC-00896	24	MHC-00886	37
MHC-00763	24	MHC-00903	40
MHC-00738	24		

Individuals currently accessing ICLS			
ID	**Duration in program (months)**	**ID**	**Duration in program (months)**
MHC-03414	1	MHC-01290	32
MHC-02846	2	MHC-01228	32
MHC-03423	2	MHC-01223	32
MHC-03424	2	MHC-01291	32
MHC-02850	3	MHC-01226	34
MHC-02889	3	MHC-00724	35
MHC-02794	4	MHC-00894	35
MHC-02518	6	MHC-01131	37
MHC-02521	6	MHC-00746	38
MHC-02484	6	MHC-00937	38
MHC-02519	6	MHC-00777	38

MHC-02486	6	MHC-00780	38
MHC-02520	6	MHC-00765	38
MHC-02344	7	MHC-01135	38
MHC-02485	7	MHC-00720	39
MHC-02336	7	MHC-00899	39
MHC-02112	8	MHC-00749	39
MHC-02103	9	MHC-00883	39
MHC-02104	9	MHC-00776	39
MHC-02089	9	MHC-00906	39
MHC-02026	10	MHC-00893	39
MHC-02027	10	MHC-01224	39
MHC-02046	10	MHC-00915	39
MHC-01438	10	MHC-00939	39
MHC-02028	10	MHC-00770	39
MHC-02049	10	MHC-00904	40
MHC-02048	10	MHC-00728	40
MHC-02024	10	MHC-00735	40
MHC-02050	10	MHC-00729	40
MHC-00907	14	MHC-00909	40
MHC-01846	15	MHC-00741	40
MHC-01844	15	MHC-00897	40
MHC-02023	15	MHC-00751	40
MHC-01881	15	MHC-00936	40
MHC-01795	16	MHC-01069	40
MHC-01847	17	MHC-00891	40
MHC-01786	17	MHC-00755	40
MHC-01609	20	MHC-00721	40
MHC-01669	21	MHC-00778	40
MHC-01322	21	MHC-00764	40
MHC-01628	23	MHC-00766	40
MHC-01627	23	MHC-00898	40

MHC- 01640	23	MHC-00792	40
MHC-01629	23	MHC-00760	40
MHC-01626	23	MHC-00895	40
MHC-01497	25	MHC-00722	41
MHC-00916	25	MHC-00892	41
MHC-00725	26	MHC-00890	41
MHC-01452	26	MHC-00727	41
MHC-01498	26	MHC-00733	41
MHC-01499	26	MHC-01133	41
MHC-01451	27	MHC-00879	41
MHC-01441	27	MHC-00880	41
MHC-01440	28	MHC-00888	41
MHC-00935	28	MHC-00882	41
MHC-01327	29	MHC-00900	41
MHC-01292	30	MHC-00748	41
MHC-01250	30	MHC-00750	41
MHC-01242	32	MHC-00908	41
MHC-01252	32	MHC-00773	41
MHC-01251	32	MHC-00775	41
MHC-01231	32	MHC-00887	41
MHC-01235	32	MHC-00784	41
MHC-01321	32	MHC-01132	41
MHC-01233	32	MHC-00798	41
MHC-01230	32	MHC-00771	41
MHC-01227	32	MHC-00800	41
MHC-01225	32	MHC-00901	41
MHC-01232	32	MHC00761	41
MHC-01236	32	MHC-00933	41