ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE
2015-16 ANNUAL REPORT HEARINGS
QUESTIONS PRIOR TO HEARING

Mental Health Commission

Hon Stephen Dawson MLC asked:

1) In regard to the West Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 I ask:

a) Can the Minister provide updated details to the Plan Matrix on page 105 showing the change in funded beds as at 30 June 2016?
b) Page 33 of the Annual Report states that the Final Report by the Chair of the IPG is available on the Mental Health Commission's website, as this report is not found under progress reporting, can the Minister please advise the status of release?
c) Which actions within the Plan 'can also be funded by the Commonwealth and private sector'?

ANSWER:

a) Hospital bed based:

Type of Funded Beds	Funded Mental Health and Alcohol and Other Drug Beds in Western Australia					
	Actual at 30 June 2014 (beds)*	Actual at 30 June 2016 (beds)**	Bed Changes	2017 (beds)*	2020 (beds)*	2025 (beds)*
MH Infant, Child and Adolescent	26	20	-6	20	20	27
MH Youth Acute		8	8	18	42	83
MH Youth Subacute/Non-acute				14	14	18
MH Adult Acute	384	404	20	386	388	409
MH Adult Subacute/Non-acute	102	87	-15	102	102	87
MH Older Adult Acute	144	144	0	93	95	78
MH Older Adult Subacute/Non-acute				55	63	114
MH HITH	12	42	30	73	121	195
Mental Health Observation Area (MHOA)	6	6	0	28	40	40
AOD (High/Complex Medical Withdrawal)	22	22	0	33	70	98
Specialised State-wide Services (inpatient)	**8**	**16**	**8**	**40**	**54**	**75**
Eating Disorders				24	34	47
Perinatal beds	8	16	8	16	20	28
Forensic Services	**38**	**37**	**-1**	**38**	**38**	**92**
MH Acute Hospital	30	30	0	30	30	62
MH Subacute Hospital	8	7	-1	8	8	30
Forensic Services (in-prison)				**70**	**70**	**70**
In-prison MH/AOD beds				70	70	70
Total Funded Hospital Based Mental Health Beds	**720**	**764**	**44**	**937**	**1048**	**1289**
Total Funded Hospital Based AOD beds	**22**	**22**	**0**	**33**	**70**	**98**

Sources:
* Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025
** BedState system, Department of Health; extracted on 11/10/2016

b) The Final Report by the Chair of the Stokes Review Implementation Partnership Group (IPG) can be found on the Mental Health Commission's (MHC) website, under "Progress Reporting" in the Stokes Review section of the website.
c) The Commonwealth Government and/or the private sector can fund any actions outlined in the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives (the Plan) to be implemented by the end of 2017, 2020 and 2025

2) In regards to the Stokes Review I ask:

a) Which are the 32 recommendations not yet implemented?
b) What are the 17 recommendations that have been delivered since the 2014/15 annual report?
c) For each of the recommendations not yet implemented what additional funding is required to deliver each outcome?

ANSWER:

a) There are 127 recommendations and sub-recommendations of the Stokes Review. Of these, two recommendations were not supported. 39 recommendations are in progress, but are not yet complete. These are:
   i) 1.1.4 - Oversight of the compliance of policies by the various service providers and reporting on those services that do not comply.
   ii) 1.1.5 - Working closely with the Office of the Chief Psychiatrist to ensure compliance with regulations from that Office.
   iii) 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.
   iv) 2.3 - Every patient has access to individual advocacy services to assist with the navigation through the system and development of a care plan.
   v) 3.5 - The governance of the system should provide to carers, patients, and General Practitioners an appropriate way to navigate the mental health system in seeking advice and support, particularly in crises.
   vi) 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.
   vii) 4.2 - Clinicians must ensure the service in which they are working does not deviate from the standards and protocols set.
   viii) 4.5 - Compliance with the electronic information system is mandatory.
   ix) 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 Non-Government Organisations to ensure a high quality of care.
   x) 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.
   xi) 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 disorder patients. These are urgent requirements.

xii) 5.3 - Rural, child, adolescent, and youth beds should be considered a priority in forward planning and attended to immediately.

xiii) 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.

xiv) 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.

xv) 7.9 - Develop respite services and increase rehabilitation services.

xvi) 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.

xvii) 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 difficult transition from admission to the community following discharge and as a community support for those dealing with mental health issues.

xviii) 8.2 - After-hours services are established for children and adolescent and youth services in rural and remote communities, where possible.

xix) 8.3- Emergency response services, including the Acute Community Intervention Team and the King Edward Hospital Unit for Mother and Baby, are supported.

xx) 8.5 - Recovery programs for children are established.

xxi) 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.

xxii) 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.

xxiii) 8.6.2 - Respite and rehabilitation services are developed for youth.

xxiv) 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.

xxv) 8.6.5 - Workforce planning must be made to address the shortage of Child Psychiatrists.

xxvi) 8.8 - A more equitable distribution of community resources is provided.

xxvii) 8.9 - Early childhood assessment and intervention programs are established for those children who show signs of the development of possible mental illness.

xxviii) 8.10 - This Review supports the recommendations submitted by the Commissioner for Children and Young People.

xxix) 8.10.1 - A strategic and comprehensive plan for the mental health and wellbeing of children and young people across Western Australia be developed by the Mental Health Commission. This plan should provide for the implementation and funding of promotion, prevention, early intervention, treatment and programs.

xxx) 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

Western Australia, including meeting the needs of those with mild, moderate and severe mental illness.

xxxi) 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.

xxxii) 8.10.6 - A dedicated forensic mental health unit for children and young people be established.

xxxiii) 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.

xxxiv) 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.

xxxv) 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 Western Australia. (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.

xxxvi) 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 police diversion service in Western Australia are established.

xxxvii) 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 1service as in the adult courts.

xxxviii) 9.1.3 - The planning, business cases and funding for provision of a full range of mental health services in Western Australian 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.

xxxix) 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 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.

b) There have been 18 Stokes Review recommendations completed since the 2014/15 Mental Health Commission annual report, and they are:

i) 1.1.1 - The development of the mental health Clinical Service Plan in collaboration with the Mental Health Commission.

ii) 1.6 - The new Executive Director of Mental Health Services develops policy with the Drug and Alcohol Office to enable mutual cooperative working with complex cases.

iii) 2.7 - 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.

iv) 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).

v) 2.10 - No patient is to be discharged from an Emergency Department 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.

vi) 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.

vii) 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

viii) 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.

ix) 4.10 - Psychiatric hostels and supported accommodation should have appropriate levels of access to patients' care plans and receive clear communication of discharge plans.

x) 4.11 - Since mental health and substance-use disorders, including drug and alcohol issues, co-occur with high frequency mental illness, it is imperative that clinicians are trained in the recognition and treatment of comorbid disorders of this type.

xi) 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.

xii) 7.1.2 - Any emergency response team will also require medical oversight for decisions made when attending to urgent referrals.

xiii) 7.7 - Encourage training and education of mental health workers in the management of comorbid conditions of drug and alcohol misuse.

xiv) 7.10.8 – Child Mental Health Service 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.

xv) 7.11.4b - The Mental Health Service provides patients, their carers, and other service providers involved in follow-up with information on the process for facilitating re-entry to the Mental Health Service if required and other resources such as crisis supports are provided.

xvi) 7.11.4e - The Mental Health Service has a procedure for appropriate decision making in regards to those who decline to participate in any planned follow-up.

xvii) 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.

xviii) 8.10.4 - The State-wide Specialist Aboriginal Mental Health Service 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.

c) Stokes Review recommendations which are not complete, are currently in progress and on track. Many of the 39 outstanding Stokes Review recommendations are dependent on the implementation of the Plan. The Mental Health Commission calculates costing for implementation of the Plan (and therefore Stokes Review recommendations) as required though business case development, for Government consideration. Due to the interdependencies of the recommendations, and the monitoring and compliance nature of many of the recommendations, costing for each Stokes Review recommendation is not available.

3) In regard to the West Australian Meth Strategy 2016 I ask:

a) Where will the beds be located and if not know yet, when can the announcement be expected?
b) What is the budgeted cost per bedday for a low medical withdrawal bed and how many days are expected to be deliver?
c) What is the budgeted cost per for a residential rehabilitation bed and how many days are expected to be delivered?

ANSWER:

a.) Residential rehabilitation and low medical withdrawal beds will be allocated in both the metropolitan and regional areas. The tender process for the expansion of withdrawal and residential rehabilitation services is close to completion. It is anticipated that the Minister for Mental Health will announce the providers and locations of the beds by the end of October 2016.

b.) Cost per bed day for a low medical withdrawal bed is budgeted at approximately $430.64 based on 80% occupancy. For eight beds over the period of 1.5 years this would equate to 3,506 bed days.

c.) Cost per bed day for a residential rehabilitation bed is budgeted at approximately $204.02. For 52 beds over the period of 1.5 years this would equate to 22,792 bed days.

4) In regard to funding from the Federal Government in 2015/16 I ask:

a) What was the total value of lost funding from the Commonwealth for mental health services?
b) Which programs were affected by (a) and what is the value of lost funding to each?

ANSWER:

a) Commonwealth funding for mental health services decreased by $8.072 million between 2014-15 and 2015-16 as follows:
    i) Commonwealth funding for Mental Health Services (excluding hospital based services under the National Health Reform Agreement) decreased by $0.38 million between 2014-15 and 2015-16; and

    ii) Commonwealth funding for Mental Health hospital based services under the National Health Reform Agreement decreased by $7.692 million between 2014-15 and 2015-16.

b) Excluding Commonwealth funding for Mental Health hospital based services under the National Health Reform Agreement, funding for the National Perinatal Depression Initiative decreased by $1.008 million due to cessation of the program at 30 June 2015. This was partially offset by increases in funding for the National Partnership Agreement – Supporting National Mental Health Reform, Individualised Community Living Strategy of $0.473 million and Assertive Community Intervention Initiative of $0.155 million.

5) In regard to sexual assaults in mental health facilities I ask:

a) What was the number and location of reported sexual assaults reported in 2015/16?
b) Why is there no female only ward in Western Australia?

ANSWER:

a) **North Metropolitan Health Service Mental Health** (including State Forensic Mental Health Service)
- Actual assault total = 4
- Graylands Hospital (Ellis Ward x2 15/07/2016 & 27/08/2015) and (Montgomery Ward x1 06/05/2016). Frankland Centre (Acacia Ward x1 20/09/2015)

Child and Adolescent Health Service
At Ward 4H Princess Margaret Hospital for Children (PMH) there were 4 clinical incidents of a sexual nature in the financial year 2015/16:
- 3 of these incidents involved allegations of unwanted physical contact between patients; and
- 1 of these incidents involved a patient allegedly using a mobile phone to send inappropriate photos.

At the Bentley Adolescent Unit there was 1 clinical incident of a sexual nature in the financial year 2015/16:
- This incident involved an allegation of a patient making sexual contact with members of staff.

Depending on the definition used, these incidents may or may not be classified as incidents of reported 'sexual assault'. All of the above incidents were investigated and where appropriate reported to the Child Protection Unit at PMH for further investigation.

South Metropolitan Health Service
Fiona Stanley Fremantle Hospital Group
- In the 2015/2016 financial year Fremantle Hospital: Alma Street Centre had 2 reported incidents
- One incident occurred in the secure ward area between consenting adults, which was reported to both the Office of the Chief Psychiatrist and the Police
- The second incident occurred in an open ward between two consenting adults. This was reported to the Office Of The Chief Psychiatrist
- No recommendations or charges were made for either incident.

Rockingham Peel Group (RkPG)
In the 2015/2016 financial year, there were no sexual assaults reported.

WA Country Health Service

The number and location of reported sexual assaults report in 2015/16 in WACHS In-patient Acute Psychiatric Units (APU) is nil.

East Metropolitan Health Service
Armadale Kalamunda Group
Nil

Royal Perth Bentley Group
There is one recorded instance of alleged sexual assault on Ward 7 at Bentley Health Service, Mental Health Inpatient Service which occurred on 24 August 2015. The matter was reported to police and is currently progressing going through formal legal proceedings.

b) **North Metropolitan Health Service Mental Health**
- The care provided in Mental Health inpatient wards takes into consideration the clinical recovery needs of all patients, without gender discrimination. Specific gender needs are addressed within the personalised care plan for each patient
- From a clinical care point of view, there is no apparent evidence that females or males receive better clinical care in a gender only or mixed gender ward.
- As far as can be ascertained, there are no gender specific mental health beds or units anywhere else in Australia.

6) In regard to West Australian's with eating disorders I ask:

a) During 2015/16 where were inpatient treatments offered?
b) For each treating facility how many patients with the condition were admitted?
c) What was the average length of stay for a patient with an eating disorder?
d) Were any deaths attributed to the disorder?

ANSWER:
a) In 2015-16, inpatients with eating disorders were treated in the following hospitals:
i) Albany Hospital
ii) Armadale/Kelmscott District Memorial Hospital
iii) Bentley Hospital
iv) Broome Hospital
v) Bunbury Hospital
vi) Busselton Hospital
vii) Esperance Hospital
viii) Fiona Stanley Hospital
ix) Fremantle Hospital
x) Geraldton Hospital
xi) Graylands Hospital
xii) Joondalup Health Campus
xiii) Kalgoorlie Hospital
xiv) Katanning Hospital
xv) King Edward Memorial Hospital For Women
xvi) Kununurra Hospital
xvii) Margaret River Hospital
xviii) Nickol Bay Hospital
xix) Osborne Park Hospital
xx) Princess Margaret Hospital For Children
xxi) Rockingham General Hospital

xxii) Royal Perth Hospital
xxiii) SCGH Mental Health Service
xxiv) Sir Charles Gairdner Hospital
xxv) St John of God Midland Hospital
xxvi) St John of God Mt Lawley Hospital
xxvii) Swan District Hospital
xxviii) Wyndham Hospital

b) The counts of separations and patients for each hospital in 2015-16 are as below:

Hospital	Separations	Patients
Albany Hospital	12	< 5
Armadale/Kelmscott District Memorial Hospital	6	< 5
Bentley Hospital	29	23
Broome Hospital	< 5	< 5
Bunbury Hospital	10	6
Busselton Hospital	< 5	< 5
Esperance Hospital	< 5	< 5
Fiona Stanley Hospital	75	51
Fremantle Hospital	23	16
Geraldton Hospital	6	6
Graylands Hospital	8	6
Joondalup Health Campus	32	26
Kalgoorlie Hospital	< 5	< 5
Katanning Hospital	< 5	< 5
King Edward Memorial Hospital For Women	5	5
Kununurra Hospital	< 5	< 5
Margaret River Hospital	< 5	< 5
Nickol Bay Hospital	5	< 5
Osborne Park Hospital	< 5	< 5
Princess Margaret Hospital For Children	143	67
Rockingham General Hospital	17	12
Royal Perth Hospital	35	18
SCGH Mental Health Service	21	14
Sir Charles Gairdner Hospital	50	35
St John of God Midland Hospital	18	11
St John of God Mt Lawley Hospital	< 5	< 5
Swan District Hospital	10	9
Wyndham Hospital	< 5	< 5

c) In 2015-16, the average length of stay for eating disorder related separations from all WA public system was 15.1 days.
d) There were less than five patients who died in hospital and had an eating disorder diagnosis recorded in their hospital medical record. However, please note that the eating disorder may not necessarily be the cause of death.

7) In regard to Hospital in the Home services I ask:

a) Why was the cost of a hospital in the home bed more than 115% the cost per purchased inpatient bedday?
b) Why was the average length of stay in a hospital in the home setting 24 days when the target was 15 days?
c) Where is the value in providing Hospital in the Home treatment when the cost is substantially more than a hospital based setting?

ANSWER:

a) Hospital in the Home was recently introduced within WA Health as a new model of care and therefore this is the first time this key performance indicator has been included in the Mental Health Commission Annual Report. Currently the Mental Health Commission is investigating methodologies to more accurately allocate and report funding related to Hospital in the Home, including better differentiation of the acute and Hospital in the Home components of the episode of care. The improved methodology will be available for reporting in the 2016/17 Mental Health Commission Annual Report.
b) The target length of stay for Hospital in the Home was established in the very early stages of the model of care being introduced. Based on the latest available international research, the average length of stay of Hospital in the Home was found to be 7 days longer than an acute length of stay, which will be considered in future target setting.
c) As outlined within the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, Hospital in the Home is consistent with the approach of providing care in the community, closer to where an individual lives. Patient outcomes will continue to be monitored via existing effectiveness indicators. As the methodology for reporting funding associated with Hospital in the Home is refined, the efficiency of Hospital in the Home can be more accurately quantified.

8) In regard to key effectiveness and efficiency indicators I ask:

a) What population data for Western Australia is used to determine the percentages presented?
b) Who are the main consumers of each service area?
c) What proportion of patients admitted are homeless on entering?

ANSWER:

a) The population data used for the effectiveness and efficiency indicators is based on the latest Australian Bureau of Statistics workbook 3101.0 (June 2015).
b) The main consumers of hospital bed based, community bed based, community treatment and community support services are people within Western Australia who

require mental health and alcohol and other drug services and supports. However, prevention is applicable to everyone within Western Australia.

c) This information was not analysed or presented in the development of the 2015-16 Mental Health Commission Annual Report.

9) In regard to mental health beds I ask:

a) What is the status of the Rockingham Psychogeriatric service?
b) On how many occasions and at which facilities was there a need to lock the doors of open wards because of the overflow of involuntary mental health patients from secure wards?

ANSWER:

a) The Mimidi Park Mental Health service continues to deliver purchased activity targets with 26 beds rather than 30 beds. The older adult unit continues to operate with six beds; currently the annexed four secure beds are closed.

b) The Open Unit at Rockingham General Hospital was locked on six occasions in the 2015-16 financial year.

The open ward at Armadale Health Service- Mental Health was locked on 101 occasions from January to August 2016.

No other sites had to lock the doors in open wards due to overflow.

10) In regard to ambulatory mental health care service I ask:

a) Where were ambulatory mental health care services delivered?
b) What was the total number of patients cared for?
c) How many of the patients were 15-24 year olds?
d) How many of the patients were Aboriginal?

ANSWER:

a) Ambulatory mental health care services were delivered by the following specialised mental health service organisations:
   i) Acute Child And Adolescent Mental Health Service
   ii) Armadale Mental Health Service
   iii) Bentley Mental Health Service
   iv) Central West Mental Health Service
   v) City Catchment Mental Health Service
   vi) Community Child And Adolescent Mental Health Service
   vii) Fiona Stanley Mental Health Service
   viii) Fremantle Mental Health Service
   ix) Goldfields And South East Mental Health Service
   x) Great Southern Mental Health Service
   xi) Joondalup Catchment Mental Health Service

xii) Kimberley Mental Health Service
xiii) Park Mental Health Service
xiv) Pilbara Mental Health Service
xv) Royal Perth Hospital (Psychiatry)
xvi) South West Mental Health Service
xvii) Specialised Child And Adolescent Mental Health Service
xviii) Statewide Specialised Mental Health Service
xix) Stirling Catchment Mental Health Service
xx) Swan Catchment Mental Health Service
xxi) Wheatbelt Mental Health Service
xxii) Women's And Newborn Health Service
xxiii) Youth Mental Health Service

b) During 2015-16, there were 56,422 patients who had at least one service contact with specialised ambulatory mental health services.
c) During 2015-16, there were 11,838 patients between the ages of 15 to 24 years of age who had at least one service contact with specialised ambulatory mental health services.
d) During 2015-16, there were 5,758 Aboriginal patients who had at least one service contact with specialised ambulatory mental health services

11) Did construction of the sub acute mental health facilities in Karratha and Bunbury commence on schedule in 2015/16 and if not why not?

ANSWER:
Planning has continued while formal approval, through normal government processes, for the release of capital funds is received. Funds allocated for 2015/16 have been carried forward.

12) In regard to Suicide Prevention in 2015/16 I ask:

a) What was the value of investment for suicide prevention?
b) Was all funding allocated expended?
c) Which programs and or services were delivered?
d) Which programs and or services were planned to be delivered but were not delivered?

ANSWER:
a) $4,132,196
b) No. $26,851 was not expended.
c) The programs and services delivered included:
- Strategic partnerships program
- Grants program
- Suicide Prevention Community Coordinators program
- MATES in Construction Standby Response service
- Response to Suicide and Self-Harm in Schools service
- Long term support for children and young people bereaved by suicide program
- Western Australia Workplace Mental Health Standards: Preventing Suicide program
- Gatekeeper training service
- Coronial database – Western Australian Coronial Suicide Information System (WACSIS) program
- First Responders program

d) N/A

13) What was the final weighted inpatient activity units purchased for specialised mental health wards in 2015/2016?

ANSWER:
The total number of inpatient weighted activity units purchased for specialised mental health wards in 2015/16 was 57,662.

14) What was the total difference in funding for Prevention from 2014/15 to 2015/16?

ANSWER:
$282,000.

2014/15 - $21.194 million
2015/16 - $20.912 million

15) What was the total difference in funding for Training from 2014/15 to 2015/16?

ANSWER:
There is no overall amount specified for training in the Annual Report.

16) What was the total number of children admitted to an adult facility in 2015/20 16?

ANSWER:
For 2015–16, there were 182 children (under 18) who separated from an adult inpatient mental health facility or ward.

17) In regard to the mental health unit at Sir Charles Gairdner Hospital I ask:

a) What was the total operating expense for the unit?
b) How many patients were admitted?
c) What was the average length of stay?
d) What was the average cost per bedday?
e) On how many occasions was the unit at capacity?

ANSWER:
a) $26,379,738.
b) 1,303 patients which resulted in 2,315 admissions due to multiple presentations.
c) 7.3 days.
d) $1,560.
e) In 2015/2016 there were 97 occasions the unit was at or above 100% occupancy.

18) In regards to forensic beds I ask:

a) How many patients were admitted during 20 15/16?
b) How many children were admitted?
c) Were any patients sent from Banksia Hill and if yes, how many?
d) What was the occupancy rate?
e) What was the total number of patients reported missing from a forensic facility and have all patients been located?
f) Did the 2014 Mental Health Commission internal modelling on juveniles in the justice system determine any data relating to Children in the Care of the CEO and if yes, what was the information?

ANSWER:

a) In 2015-16, there were 198 patients who separated from the State Forensic Mental Health Service.
b) There were less than five children (under 18) separated from the State Forensic Mental Health Service during 2015-16.
c) There were less than five patients admitted from the Banksia Hill Detention Centre into the State Forensic Mental Health during 2015-16.
d) In 2015-16, the State Forensic Mental Health Service had an occupancy rate of 88%.
e) There were no patients reporting missing from State Forensic Mental Health Service during 2015-16.
f) No. The 2014 modelling undertaken did not generate any data relating to Children in the Care of the CEO.

19) In regard to Community Support I ask:

a) What services were affected by the decrease of $6.02 million of funding in 2015/16?
b) Given one of the aims of Community Support is to 'decrease the burden of care for carers' how was the Impact of the funding cut managed to ensure carers were not adversely affected?

ANSWER:

a) The $6.02 million decrease quoted in your question is taken from the 2016-17 State Budget papers for the Mental Health Commission. This figure relates to the variance between the 2015-16 Estimated Actual for total cost of service ($57.426 million) and the 2016-17 Budget Target for total cost of service ($51.406 million).
The decrease between the 2015-16 Estimated Actual and the 2016-17 Budget Target is due to the reduction in Commonwealth funding for the Individualised Community Living Strategy (ICLS) and the Assertive Community Intervention (ACI) Program.

b) The decrease in Commonwealth funding has had no impact on the burden of care for carers as the programs are continuing in 2016-17.

A K Mitchell.

MINISTER FOR MENTAL HEALTH