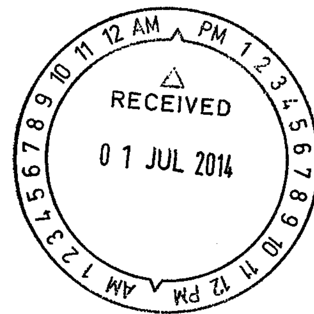

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

11 June 2014

Mental Health Commission

Question No. 1: Hon Robin Chapple MLC asked -

1. I refer to page 395, "Significant Issues Impacting the Agency", and ask regarding the sub-headings "Mental Illness and Aboriginal People" and also "Suicide Prevention", while I congratulate the Government at one level for providing $29m over three years for extending the State-wide Specialist Aboriginal Mental Health Service, and for providing $3m in 2014-15 to continue the State-wide Suicide Prevention Strategy, and ask –

a) Is there anywhere else in the budget estimates or forward estimates where such culturally-based programs may be funded as well or instead, as the case may be?

b) If so, please provide details of those programs and the extent to which they are funded in each of the budget estimates and forward estimates periods?

NOTE: I consider culturally-based programs to be best explained by the following quote from Emeritus Professor Michael Chandler: "If suicide prevention is our serious goal, then the evidence in hand recommends investing new monies, not in the hiring of still more counsellors, but in organised efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives".

Answer:

a) Yes.
b) In addition to the Western Australian Suicide Prevention Strategy and State-wide Specialist Aboriginal Mental Health Service, to date, around $420,000 over 2013/14 to 2014/15 has been allocated to culturally appropriate mental illness prevention and suicide prevention programs targeting Aboriginal communities. This includes:
    - Looking Forward Aboriginal Mental Health Project to improve the effectiveness of public mental health services for Aboriginal families affected by serious mental health issues in the south east metropolitan corridor of Western Australia;
    - David Wirrpanda Deadly Sister Girlz program for school girls;
    - Connect Groups small grants and capacity building for Aboriginal self-help groups;

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- Black Dog Institute for Kimberley Suicide Prevention App with Alive and Kicking Goals
- Country Arts WA to deliver Sandtracks workshops in language for young people in the Ngaanyatjarra lands; and
- Circle of Security early intervention program for Aboriginal families.

The Mental Health Commission also funds state and national mental health and suicide prevention initiatives which partner with Aboriginal communities and support participation of Aboriginal individuals and families; for example *beyondblue*, Act Belong Commit, and the Suicide Prevention Australia Conference and The Mental Health Services Conference to be held in Perth in 2014.

Approved

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Mental Health Commission

Question No 2 Hon A Farina MLC asked –

I refer to Budget Paper No2, page 393, "Appropriations, Expenses and Cash Assets", line item Service appropriation - Community Service Subsidy component, and ask –

(a) *The 2013/13 budget estimate for the Community Service Subsidy Component was $12,218,000 but the estimated actual is $18,637,000, what is the reason for the cost blow out in this line item?*

Answer: The Community Service Subsidy (CSS) recognises the higher cost of hospital service delivery in Western Australia compared to the national average, and is based on the difference between the State Price and the national Projected Average Cost (PAC).

The Department of Health's (DoH) projected 2013/14 estimated outturn (EOT) indicates significant unbudgeted expenditure for hospital activity. To address this, the 2014/15 Budget rebased the State Price to the average unit cost of delivering in-scope hospital services, based on the DoH's 2013/14 EOT. This increase in State Price has provided a higher CSS.

(b) *In the forward estimates, funding for this line item decreases in 15/16 and by 16/17 is less than half the appropriation for this year, what is the reason for the decline in appropriations in the forward years?*

Answer: The 2014/15 Budget settings maintain the Government's policy to reduce inefficiencies in the Western Australian health system by transitioning the State Price to the PAC over the forward estimates.

(c) *Of the total appropriation for this year, how much is anticipated being spent in the South West electoral district?*

Answer: Of the total CSS component, $237,181 has been allocated to Bunbury Regional Hospital for inpatient mental health services.

Approved

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

ADDITIONAL QUESTIONS FOR THE 2014-15 BUDGET ESTIMATES HEARING

Wednesday, 11 June 2014

Mental Health Commission

Question 3: Hon Member Adele Farina MLC asked -

I refer to Budget Paper No2, page 393, "Spending Changes", line item *Sub-acute Services,* and ask -

a) There is additional funding for sub-acute funding allocated in 2016-17 and 2017-18, what will this funding be used for?

Answer:

a) The $778,000 in 2016-17 is the incremental amount required to fund services at the Joondalup, Rockingham and Broome subacute centres. Total operating cost of these centres in 2016-17 is estimated at $7.367 million. The remainder of the funding is from redirection of an amount no longer planned to be directed towards the Early Psychosis Youth Centre ($5.589 million) and other savings ($1 million).

   In 2017-18, the estimated total operating cost of the Joondalup, Rockingham and Broome subacute centres is $7.661 million. Of this, $1 million is to be found from redirection of savings. The remainder is the new allocation noted in the Spending Changes table.

Approved

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Mental Health Commission

Question No. 4: Hon Adele Farina MLC asked - refer to Budget Paper No2, page 393, "Spending Changes", line item National Perinatal Depression Initiative Funding Transfer, and ask –

a) I understand perinatal depression services funded directly by the state are concentrated at King Edward Memorial Hospital while national funding provided services more broadly, given the national funding has been discontinued, how will the Government ensure regional women continue to have access to specific perinatal depression services?

Answer:

The 2008/09-2012/13 NPDI Agreement fully funded 4 Department of Health rural and remote perinatal nurse positions in Goldfields (0.5FTE), Midwest (0.6FTE), Wheatbelt (1.0 FTE) and South West (1.0FTE) and partially funded 1.0FTE Aboriginal Perinatal Mental Health Worker and 0.6FTE Perinatal Project Officer within the Department of Health in Carnarvon. In addition, a therapeutic support group, Babe Ease, was funded in Goldfields and 0.8FTE Perinatal Clinical Nurse Specialist was funded at KEMH. The KEMH nurse's role included coordinating specialist clinical support and training to rural and remote clinicians managing women with perinatal depression.

Since the expiration of the 2008/09-2012/13 NPDI Agreement, WA used a combination of State funds and remaining NPDI funds to continue two rural and remote positions, a 0.5 FTE perinatal mental health nurse inclusive of the Babe Ease Support Group in the Goldfields and a 1.0 FTE perinatal project officer in Carnarvon until 30 June 2014.

A 2014/15 NPDI Project Agreement was offered to the State on 14 June 2014 and will provide $1.02 million. Consideration will now be given to whether the Agreement will be accepted. In the meantime the State Government has agreed to continue funding in 2014/15 for all services that operated to June 2014 pending negotiation of a replacement Agreement for 2014/15. In country WA the Goldfields perinatal mental health nurse position and Babe Ease therapeutic support group operated through to June 2014 and will be funded in 2014/15. The remaining rural and remote areas will continue to receive support where applicable from KEMH.

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In consultation with key stakeholders, the Mental Health Commission will identify where further investment in perinatal mental health services and programs is viable and needed, while being mindful that long term commitment to NPDI by the Commonwealth will not be known until the Commonwealth has considered the review of mental health services which is due to be undertaken by the National Mental Health Commission by November 2014. Consideration will then be given to the feasibility of funding additional clinical positions in country areas if future Commonwealth funds are assured, noting that it takes a number of months for such services to become operational.

The State Government has committed $29.055 million over 3 years to continue (and evaluate) the Statewide Specialist Aboriginal Mental Health Service (SSAMHS). Over 2014/15 – 2017/18, $16.7 million will be provided to Western Australian Country Health Service and $2.3 million to the Kimberley Aboriginal Medical Services Council for the delivery of the SSAMHS to Aboriginal people in regional areas. Women experiencing perinatal depression can receive support through SSAHMS adult mental health where they meet eligibility criteria. Conversely, SSAHMS child mental health services are expected to identify mothers with depression while providing family support to improve child mental health outcomes.

In the meantime mothers will continue to be screened for perinatal depression and those who may need perinatal depression support will be assisted and prioritised according to their immediate needs as occurs with all people who present with mental health problems.

Approved

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

ADDITIONAL QUESTIONS FOR THE 2014-15 BUDGET ESTIMATES HEARING

Wednesday, 11 June 2014

Mental Health Commission

Question 5: Hon Member Adele Farina MLC asked -

I refer to Budget Paper No2 Vol.1 at page 394 "Service Summary", line item *Promotion and Prevention,* and ask -

a) There is a steady decline in appropriations for this line item each year from the 12-13 actual to the 17-18 forward estimate when funding will be only 60.6% of what it was in 12-13, what is the reason for this decline?

Answer:

a) The 60.6% difference between the 2012-13 Actual and 2017-18 forward estimate equates to $15.5 million and is largely attributable to:
   - $7.6 million was included in Service 1 for the Individualised Community Living Support in 2012-13. This has transferred to Service 4 for subsequent years.
   - Funding for the Suicide Prevention Program peaked in 2012-13 at $8.8 million due to the slower than anticipated take-up of grants by non-government agencies and community groups in prior years. Funding in future years is dependent on the results of extensive evaluation being conducted in 2014-15. The Government has allocated an additional $3 million in 2014-15 to continue important initiatives under the program while the evaluation proceeds.

Approved
[signature]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Department of Health

Question No. 6: Hon Adele Farina MLC asked -

I refer to Budget Paper No2 Vol.1 at page 395 "Significant issues impacting the agency", line item Mental Health Infrastructure, and ask -

a) I note new mental health beds will be provided at the Perth Children's Hospital, how many patients aged 18 years or younger were admitted to the Bunbury Mental Health unit in each of 2011, 2012 and 2013?

Answer:

The total number of patients aged 18 years or younger admitted to the Bunbury Acute Psychiatric Unit for the period 2011 – 2013 is:
2011 – six (6)
2012 – 14
2013 – 16
All of the above patients were 17 or 18 years of age.

b) How many patients aged between 19 and 25 years were admitted to the Bunbury Mental Health unit in each of 2011, 2012 and 2013?

Answer:

The total number of patients aged 19 to 25 years admitted to the Bunbury Acute Psychiatric Unit for the period 2011 – 2013 is:
2011 – 88
2012 – 118
2013 – 146

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

11 June 2014

Mental Health Commission

Question No. 7: Hon Member Adele Farina MLC asked -

I refer to Budget Paper No 2, page 395 "Significant issues impacting the agency", line item Mental Health Infrastructure, and ask –

a) *How advanced is planning for the Bunbury step-up, step-down sub-acute service?*

b) *Given the Goldfields will be the next focus for the Government once the Broome and Rockingham Services are fully implemented, when can we realistically expect the Bunbury facility to be complete and operational?*

Answer:

a) Planning for the Bunbury step-up, step-down subacute service is in the preliminary stages.

b) The Mental Health Commission will be developing a business case for the Bunbury subacute service as part of the 2015/16 budget process to secure capital and operational funding. Learnings from subacute service projects undertaken at Joondalup, Rockingham, Broome and Goldfields will inform the delivery of this important service. Timelines for implementation and completion of the Bunbury subacute service will be dependent on the approval of funding; negotiations with the Department of Housing on undertaking capital works; design and building approval processes; and consultations with key stakeholders including community members.

Approved

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Mental Health Commission

Question No. 8: Hon Adele Farina MLC asked -

I refer to Budget Paper No2, Vol. 1 at page 395, "Significant issues impacting the agency.", line item Mental Illness and the Criminal Justice System and ask –

a) *What KPIs have been developed to evaluate the success of the Mental Health Court Diversion and Support Project?*

Answer:

The objectives of the Mental Health Diversion and Support Program (START Court – Adult Program) are as follows:

Objective 1: Provide a diversion option in the Perth Magistrates Court for people with a mental illness.

Objective 2: Reduce further offending behaviour by providing access to early assessment and interventions that address both defendants' offending behaviour and their psychosocial needs.

Objective 3: Provide assistance to the Court in the identification and management of people with a mental illness who come before the Court.

Objective 4: Improve coordination and communication between criminal justice agencies and mental health service providers.

The objectives of the Mental Health Diversion and Support Program (Links – Children's Program) are as follows:-

Objective 1: Reduce further offending behaviour by providing access to early assessment and interventions that address both defendants' offending behaviour and their psychosocial needs.

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Objective 2: Provide assistance to the Court in the identification and management of young people with a mental illness who come before the Court.

Objective 3: Record data which indicates the extent of mental health need within the Children's Court.

Objective 4: Improve coordination and communication between criminal justice agencies and mental health service providers regarding young people.

A measurement framework to evaluate performance in meeting these objectives has been developed for the Adult and Children's initiatives respectively. These incorporate "indicators" and "output measures". The comprehensive evaluation of the overall Program scheduled to be undertaken by December 2014 will evaluate the initiatives against these frameworks. The proposed measurement framework documents are attached and marked "Attachment 1" and "Attachment 2". These will be subject to final agreement as part of the evaluation process.

b) *Do regional people have access to the project*

Answer:

The Adult pilot is based in the Perth Magistrates Court and the Children's pilot in the Perth Children's Court. A decision was made in scoping the pilot that at least in the initial phase the Program would not be made available regionally.

c) *If the project is continued, will it be extended to regional locations?*

Answer:

The State Government has made funding available for a 12 month extension of the pilot in 2014/15. During this time the focus will be on consolidating the existing models of care in the Perth-based courts and conducting a comprehensive evaluation of the Program against the measurement framework. A potential expansion of both the Adult and Children's programs was envisaged subject to evaluation outcomes and securing ongoing funding beyond June 2015.

These matters will be considered following the completion of the evaluation.

Approved
[illegible]

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ATTACHMENT 1 – ADULT PROGRAM MEASUREMENT FRAMEWORK

Objective 1: Provide diversion options in Magistrates Court for people with a mental illness		
Outcomes	**Indicators**	**Output measures**
Better access to court diversion programs/Mental Health Services	Rate of referral into START Court	Number of people listed in the START Court (Clients counted once only) [DotAG]
	Proportion of clients eligible for START Court	Number of clients found to be suitable [DotAG]
		Number of clients with matters dealt with on the day or referred to another court (e.g. Drug Court) [DotAG]
	Average amount of time in the court process (i.e. time between first appearance and finalisation)	Amount of time between initial assessment and reappearance in court [DoH, DotAG]
		Number of days/weeks/months from first appearance to finalisation (Recorded as dates) [DotAG]
	Average number of court appearances	Number of court appearances per client [DotAG]
	Proportion of people who are terminated or suspended from the program (self-choice or court-decision)	Number of clients no longer wanting to participate in PATHS [DotAG]
		Number of clients not complying with Program conditions and sentenced [DotAG]
Improved understanding of the demographic, clinical and offending profile of people attending MH court	Participation rates by various clinical, demographic and offending characteristics	Demographic information (age , gender, Aboriginality, country of birth, employment status, current housing situation[i])[ii] [DoH, DotAG, Legal Aid, Police, NGO]
		Mental Health Diagnosis (or Diagnoses) [DoH]
		Number of clients with current alcohol and other drug issues [DoH]
		Charges: number of charges, charges by offence type (ASOC Division), most serious offence [iii] [DotAG]
		Client representation (Legal Aid, etc) [DotAG]
	Proportion of clients with a pre-existing mental illness	Number of clients with a PSOLIS record (i.e. previous contact with public mental health

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	already identified (e.g. has a PSOLIS record)	services) [DoH]
A clinical team located in the START Court to perform Culturally appropriate assessments	Proportion of clients completing assessments with the clinical team	Number of clients referred for court-ordered assessment [DoH, DotAG]
	Proportion of clients found to be ineligible following initial assessment	Number of clients not clinically recommended for START following court-ordered assessment [DoH]
Recognition of involvement in treatment by the Court, being reflected in sentencing	Proportion of clients with an improved outcome after successfully completing the PATHS program	Final sentence [DotAG]
	Rate of successful completions from PATHS	Number of clients successfully completing PATHS [DotAG]
	Proportion of clients receiving a spent conviction	Number of clients applying for spent convictions [refer to data development]
		Number of clients successful in obtaining a spent conviction[iv] [DotAG]

Objective 2: Reduce offending behaviour by providing access to early assessment and interventions that address both defendants" offending behaviour and their psychosocial needs

Outcomes	Indicators	Output measures
Better access to clinical assessment	Proportion of clients found to be suitable for PATHS	Number of clients eligible for PATHS [DoH, DotAG]
		Number of clients declining to participate in PATHS (with reasons e.g. needs met, client decision) [DoH, DotAG][v]
	Average amount of time spent in PATHS program	Number of days/weeks/months each client is in PATHS for (Recorded as dates) [DoH]
Access to culturally appropriate intervention programs and services	Referral to culturally appropriate intervention programs/services	Which culturally appropriate services are clients referred to [DoH/NGO]
	Proportion of clients requiring an interpreter during court or clinical treatment	Number of clients requiring an interpreter during the court process[vi] [DotAG, Police]

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Improved clinical and social wellbeing outcomes	Rate of adverse events during the client's involvement with the Program	Number of incidents (e.g. deaths) that occur during involvement with the Program [DoH]
	Proportion of clients completing outcomes assessments HONOS/Camberwell/etc[vii]	Number of clinical outcome assessments completed [DoH]
	Proportion of clients with improved clinical outcomes as measured by HONOS/Camberwell/etc	Difference in scores measured at initial assessment and last contact with the clinical team or NGO [DoH/NGO]
	Proportion of clients working with Outcare	Number of clients referred to NGO [NGO]
		Amount of time NGO spends with Client (activities specified) [NGO]
Improved client interaction with the court	Proportion of clients compliant with court orders (e.g. clinical visits, court appearances)	Number of court appearances and clinical appointments missed [DotAG/DoH]
	Proportion of clients where the prosecution of a charge was discontinued	Number of clients where the prosecution of a charge was discontinued[viii] [DotAG, Police]
Reduced intensity and frequency of re-offending[ix]	Proportion of clients in the Program with new charges[x]	Number of clients in the Program re-appearing on new charges [DotAG]
	Frequency of offending after involvement in the Program	Time between charges[xi] (Recorded as dates) [DotAG]
	Seriousness of offences following involvement in the Program.	Change in seriousness of offences (Comparison of ASOC divisions) [DotAG]

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Objective 3: Provide assistance to the court in the identification and management of people with a mental illness who come before the courts		
Outcomes	**Indicators**	**Output measures**
Awareness of mental health issues among court staff/magistrates	Proportion of START court team staff who have received appropriate mental health training	Number of court staff who have received appropriate mental health training
Timely response by mental health team to needs identified by the court	Proportion of clients on hospital orders	Number of hospital orders [DoH, DotAG]
	Average amount of time between first court appearance and initial assessment	Amount of time (hours/days) between first court appearance and initial assessment (Recorded as dates and calculated later) [DoH, DotAG]
	Proportion of clients requiring psychiatric report (requested by court)	Number of Community Corrections Psychiatrist reports requested by the court [DotAG]
		Number of psychiatrist reports requested by the clinical team [DoH]
		Number of presentence reports requested from Community Corrections [DCS]

Objective 4: Provide diversion options in Magistrates Court for people with a mental illness		
Outcomes	**Indicators**	**Output measures**
Referral options to community based mental health support services	Proportion of clients with community care teams	Number of clients already with community care teams [DoH]
	Proportion of clients already engaged with community based mental health support services	Number of new referrals to Mental Health Services (i.e. those who don't have a PSOLIS record) [DoH]
Well established communication mechanisms between magistrate, START Court team, mental health services and other stakeholders.	Referral pathways developed and in place (Y/N)	Court process and clinical referral pathway has been developed (Y/N)
	Frequency of stakeholder meetings	Frequency of pre-court and case review meetings
	Briefings and presentations about START court to relevant stakeholders	Number of briefings by START Court Magistrate to judiciary, legal groups, DPP
		Number of presentations by START Court team to mental health services and other stakeholders (e.g. prisons) [DoH]
Partnership agreements/ communication protocols,	Proportion of agencies that have signed the	Which agencies have signed the information sharing MOU

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including information sharing MOUs established with relevant agencies.	Information sharing MOU	
Clearly defined roles and responsibilities of the START Court team	Roles and responsibilities established and in place (Y/N)	Roles and responsibilities documented by START Court team members

The following data items have been identified as requiring further development or discussion in regards to collection:

- Number of clients not receiving bail including reason (e.g. due to accommodation circumstances)[xii]
- Number of clients applying for a spent conviction [Police, DotAG[xiii]]
- Number of clients with a recorded conviction[xiv] [DotAG]
- Number of clients under MH Act when appearing in the court
- Indicated sentence[xv] [DotAG]
- Proportion of homeless clients placed in accommodation (i.e. Number of homeless clients placed in accommodation) [DoH/NGO]
- Proportion of clients where the negotiation of charges resulted in a lesser charge (i.e. Number of clients negotiating charges [Police]; Number of clients where the negotiation of charges resulted in a lesser charge [Police])

Additional data potentially available for impact evaluation. Requires Ethics approval and use of data linkage:

- Offending history: Age at first offence, number of previous charges, previous imprisonment, previous community corrections orders/probation
- Re-offending – number of offences, offence type, date/s of offences (to determine time since completion of program or duration in program if re-offending occurs during program)
- Number of incidents (e.g. self-harm, hospitalisations) that occur during participation in the Program [DoH]

Qualitative data: Interviews will be conducted to obtain qualitative data.

Semi-structured interviews will be used to gather information from staff and stakeholders involved in the Program. The semi-structured format allows a structured conversation around key topics, while still allowing the interviewee to influence the content and direction of conversation.
Key topics covered during the interviews will be:

- Roles, responsibilities and workload
- Polices, procedures and training
- Process issues, including both Court and clinical processes

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- Process changes, including both Court and clinical processes
- General views of the Court including strengths, weaknesses and areas of change, improvement and development

Endnotes

[i] Recorded as: Homeswest, Independent, Living with Family/partner, Not identified, Primary Homeless, Psychiatric Hostel, Secondary Homeless, Tertiary Homeless
ii This information is obtained at the initial assessment with the Clinical team
iii National offence index is used to determine the most serious offence type
iv It is noted that a court cannot make a spent conviction order if you are sentenced to: a term of imprisonment, a suspended term of imprisonment, a conditional suspended term of imprisonment, an intensive supervision order.
v In particular, the clinical team needs to record when a client isn't recommended because they're needs are met
vi CHIPS has the ability to record language spoken at home. It will only be recorded when an interpreter is requested. The clinical team does not collect information regarding interpreters, though they have confirmed if an interpreter is required for court, then they will typically be required for clinical appointments also.
vii Clinical team to advise which measure will be used
viii When recorded as a withdrawal, dismissal (withdrawn by prosecution).
ix This is a longer term outcome, and it may not be possible to fully examine this for the Evaluation. Previous evaluation studies of MH Court Diversion Programs have used data to examine a clients offending pre- and post- involvement with a Mental Health Court Diversion Program (usually-12 months pre- and post-program)
x Where the lodgement date of any new charges is after the date of acceptance onto the Program.
xi Discussion to occur to determine whether breach of bail charges are counted
xii Not currently collected but has been noted as an important measure that we should try to capture.
xiii Information is only available from DotAG when hearing is adjourned (i.e. more information required before decision can be made)
xiv Implied by an outcome that is classed as a sentence (including the No Punishment orders under the Sentencing Act)
xv Not routinely collected and no capacity in CHIPS to record. We will speak with Magistrate Stewart and determine whether we can manually record this for a period of time for the evaluation.

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ATTACHMENT 2 – CHILDREN'S PROGRAM MEASURMENT FRAMEWORK

Objective 1: *Reduce further offending behaviour by providing access to early assessment and interventions that address both defendants" offending behaviour and their psychosocial needs**

Outcomes	**Indicators**	**Output measures**
Better access to early interventions	Rate of referral to Links	Number of clients referred to Links
	Proportion of clients recommended for Links	Number of clients suitable for Links (when not suitable, reason to be recorded)
		Number of clients declining to participate
		Number of clients receiving ongoing support from Links
	Average amount of time in the Links	Amount of time between assessment and last contact with the clinical team (recorded as dates)
	Average amount of time between referral and initial assessment	Amount of time between referral and assessment with the clinical team (recorded as dates)
	Average number of contacts with Links	Number of contacts with the clinical team
	Average amount of contact with Outcare	Number of contacts/hours with Outcare
	Proportion of people who withdraw from Links	Number of clients no longer wanting to participate in Links
	Proportion of people who are non-compliant and withdrawn from Links	Number of clients not complying and withdrawn from Links
Improved clinical and social wellbeing outcomes	Rate of adverse events during the client's involvement with the Program	Number of incidents (e.g. deaths) that occur during involvement with the Program[xvi]
	Proportion of clients completing outcomes assessments HONOS	Number of HoNOSCA[xvii] assessments completed

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	Proportion of clients with improved clinical outcomes as measured by HONOS	Difference in scores measured at initial assessment and last contact with the clinical team
	Proportion of clients working with Outcare	Number of clients referred to Outcare [NGO]
		Number of clients not engaging with Outcare (including reason) [NGO]
		Amount of time Outcare spends with Client (activities specified) [NGO]
Access to culturally appropriate intervention programs and services	Referral to culturally appropriate intervention programs/services	Which culturally appropriate services are clients referred to (ART, CAMHS, YouthReach, etc)
	Proportion of clients requiring an interpreter	Number of clients requiring an interpreter during appointments with the Links team
Reduced intensity and frequency of re-offending[xviii]	Proportion of clients with new charges[xix]	Number of clients in the Links Program re-appearing on new charges [DotAG][1]
	Frequency of offending after involvement in the Program	Time between charges[xx] (Recorded as dates) [DotAG][2]
	Seriousness of offences following involvement in the Program.	Change in seriousness of offences (Comparison of ASOC divisions) [DotAG][2]
Objective 2: *Provide assistance to the court in the identification and management of young people with a mental illness who come before the courts*		
Outcomes	**Indicators**	**Output measures**
Timely response by clinical team to needs identified by the court	Proportion of clients requiring psychiatric assessment	Number of clients referred to a psychiatrist (organised by Links)
	Rate of risk assessment	Number of clients referred to Links for risk assessment
		Number of risk assessments completed by Outcare (NGO)
	Proportion of clients hospitalised (for mental illness)	Number of voluntary hospitalisations (for mental illness)

[1] To be confirmed with DotAG

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		Number of involuntary hospitalisations (for mental illness)
	Proportion of clients with a care plan	Number of clients with a care plan
	Proportion of clients accepted by a community mental health service	Number of clients referred to a community mental health service Number of clients accepted by a community mental health service
Awareness of mental health issues among Links staff	Proportion of Links team staff who have received appropriate mental health training	Number of Links staff who have received appropriate mental health training
Objective 3: *Record data which indicates the extent of mental health need within the children's court*		
Outcomes	**Indicators**	**Output measures**
Improved understanding of the demographic, clinical and offending profile of people attending Links Support Program	Participation rates by various clinical, demographic and offending characteristics	Demographic information (Age, Gender, Aboriginality, Country of Birth) Mental illness symptoms Current Alcohol and Other Drug Use Charge: most serious offence type or major offence (ASOC Division) [DotAG][2] Who the client referred by (Lawyer, Juvenile Justice Team, Youth Justice Officer, etc)
	Proportion of clients commenced on medication	Number of clients commenced on medication
	Proportion of clients with previous contact with a MH service	Number of clients with previous contact with a MH service (i.e. PSOLIS record indicating contact with a public mental health service) Number of clients already active with a MH service
	Proportion of clients active with CPFS[2]	Number of clients active with CPFS

[2] Department of Child Protection and Family Support

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	Proportion of clients actively open with a Youth Justice Officer	Number of clients actively open with a Youth Justice Officer (YJO) Number of YJO's that Links have ongoing communication with
	Proportion of clients active with DSC	Number of clients active with DSC
	Proportion of clients with unstable accommodation at the time of the initial assessment	Number of clients with unstable accommodation at the time of the initial assessment
Objective 4: Improve coordination between criminal justice agencies and mental health service providers		
Outcomes	**Indicators**	**Output measures**
Well established communication mechanisms between magistrate, Links Support Program team, mental health services and other stakeholders.	Referral pathways developed and in place (Y/N)	Clinical referral pathway has been developed (Y/N)
	Frequency of team meetings	Frequency of communication and case review meetings
	Briefings and presentations about Links Support Program to relevant stakeholders	Number of briefings by Links Support Program to judiciary, legal groups, DPP Number of presentations by Links Support Program team to mental health services and other stakeholders
	Reports prepared for the court by the clinical team	Number of reports prepared by the clinical team for the courts Number of court appearances by clinical team
Partnership agreements/ communication protocols, including information sharing MOUs established with relevant agencies.	Proportion of agencies that have signed the Information sharing MOU	Which agencies have signed the information sharing MOU

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Clearly defined roles and responsibilities of the Links team	Roles and responsibilities established and in place (Y/N)	Roles and responsibilities documented by Links Support Program team members

[xvi] This might only be available through data linkage (requiring ethics approval)
[xvii] Health of the Nation Outcome Scales for Children and Adolescents
xviii This is a longer term outcome, and it may not be possible to fully examine this for the Evaluation. Previous evaluation studies of MH Court Diversion Programs have used data to examine a clients offending pre- and post- involvement with a Mental Health Court Diversion Program (usually-12 months pre- and post-program)
xix Where the lodgement date of any new charges is after the date of acceptance onto the Program.
xx Discussion to occur to determine whether breach of bail charges are counted

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Department of Health

Question No. 9: Hon Adele Farina MLC asked –

I refer to Budget Paper No2 Vol.1 at page 395 "Significant issues impacting the agency", line item Mental Health Infrastructure, and ask -

a) *The State-wide Specialist Aboriginal Mental Health Service has been provided $29.1 million over the next three years, how much of this funding will be spent in the South West electoral district?*

Answer:
WA Health allocates funding by Health Service Region and the allocation to South West Health Region is $1.57 million over three (3) years commencing 2014/15 financial year.

b) *Of the South West funding, how much will be allocated to the Bunbury Service?*

Answer:
This funding is unable to be broken down at this level. It is to provide a South West Regional Service that includes Bunbury.

c) *How many towns fall under the jurisdiction of the Bunbury service?*

Answer:
The State-wide Specialist Aboriginal Mental Health Service is based in Bunbury and provides an outreach service to all communities in the South West Health Region. The towns include Bridgetown, Donnybrook, Harvey, Yarloop, Manjimup, Nannup, Busselton, Margaret River, Augusta, Northcliffe, Boyup Brook, Collie and Pemberton.

d) *How many clients accessed the Bunbury service in each of 2011, 2012 and 2013?*

Answer:
The total number of Aboriginal and Torres Strait Islanders who accessed the South West Mental Health Service is provided below:

2011 – 83
2012 – 120
2013 – 110

Approved

PUBLIC

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

11 June 2014

Mental Health Commission

Question No. 10: Hon Adele Farina MLC asked -

10. I refer to Budget Paper No2 Vol.1 at page 395 "Significant issues impacting the agency", line item Suicide Prevention, and ask –

a) Is the additional funding available for 2014/15 to enable a continuation of Suicide Prevention Strategy as it was implemented in 2013/14 or will there be changes to the program?

b) How much of the 14/15 allocation will be expended in the South West electoral district?

c) How much of the Suicide Prevention Strategy funding was spent in the South West in each of 11/12 and 12/13?

Answer:

a) The State Government is committed to continuing the Western Australian Suicide Prevention Strategy (Strategy) and the $3M allocated in 2014/15 will deliver:

- $1M to strengthen sustainability of CAPs, locally owned suicide prevention initiatives and strategic community partnerships; and
- $2M to continue the Response to Self-Harm and Suicide in Schools to address critical and ongoing needs in clinical treatment, suicide prevention and postvention support and education.

The $1M builds on the $250,000 that was allocated in 2014 to strengthen local community suicide prevention initiatives. Grants are open to existing Community Action Plan host agencies, Local Government and Local Drug Action Groups. The change to include Local Drug Action Groups acknowledges that alcohol and drug issues are a significant risk factor for suicide.

As part of the Strategy, 245 agencies across Western Australia have committed to implementing suicide prevention activities. The Agency Coordination will continue through Centrecare until December 2014, with new arrangements after this time.

The operational management of the State Strategy will shift from Centrecare to the Mental Health Commission (MHC) in 2014/15 and 2015/16.

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An evaluation of Community Action Plans by Edith Cowan University is currently being finalised to identify strengths and areas for improvement. The Ministerial Council for Suicide Prevention is overseeing an overall independent evaluation in 2014 to inform the next multi-year Strategy.

b) Eligible South West community groups are encouraged to submit suicide prevention small grants and training applications. The Ministerial Council for Suicide Prevention (MCSP) supports projects that:

- Build community awareness about suicide prevention, services and support
- Strengthen resilience to respond to the risks, signs and impacts of suicide
- Help sustain local suicide prevention strategies across the State
- Involve suicide prevention activities that are sustainable by utilising local initiatives, local resources and local people

The current round of grants closes on 31 July 2014 and more information is available on the Mental Health Commission website.

In April 2014, $32,000 in small grants was provided to the South West for suicide prevention projects delivered through the Injury Control Council of WA (ICCWA), and Collie and Harvey Local Drug Action Groups.

c) Under the Strategy four CAPs were funded in the South West region over 2012/12 to 2012/13:

- $132,343 for the Shire of Busselton and Margaret River/Shire of Augusta-Margaret River CAP hosted by LAMP Inc.
- $133,910 for the Nannup CAP hosted by the Nannup Community Resource Centre.
- $396,587 for ICCWA to deliver education and training across the SW including Bunbury, Busselton, Blackwood, Leeuwin, Leschenault, Warren and Wellington, and targeted strategies for Aboriginal communities.
- $282,820 for the Bunbury Stage 1 and 2 CAPs hosted by South West Vet Link and covering Bunbury, Harvey, Donnybrook, Capel and Dardanup.

CAPs generally delivered community activities over 12 months, rather than strictly within financial years.

Approved
[illegible]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE
QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 18 June 2014
Mental Health Commission

Question No 11 Hon Adele Farina MLC asked –

a) *How many clients have signed up to participate in the trials at each of the trial sites being Perth Hills, Cockburn/Kwinana and the lower South West?*

Answer
The trial sites in the Perth Hills and the lower South West commence from 1 July 2014. People with a psychosocial disability will have the opportunity to sign up after this date. The Cockburn/Kwinana trial site will not commence until 1 July 2015.

b) *How much funding is being provided by the State Government for the two years of the NDIS trial for the Cockburn/Kwinana trial site and for the lower South West trial site?*

Answer
The State Government is providing $87.7 million (approx. 60% of total funding for support packages) for the NDIS trials in Western Australia.

c) *How much funding is being provided by the Federal Government for the two years of the NDIS trial for Cockburn/Kwinana trial site and for the lower South West trial site?*

Answer
The Federal Government is providing $59.9 million (approx. 40% of total funding for support packages) for the NDIS trials in Western Australia.

Approved
[signature]

PUBLIC

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

11 June 2014

Mental Health Commission

Question No. 12: Hon Member Adele Farina MLC asked -

I refer to Budget Paper No 2, page 397 "Outcomes and key effectiveness indicators ", line item per cent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units, and ask –

a) The number of patients receiving contact within seven days of discharge is only 51% in 13/14 and this represents no improvements from 2012/13, is this acceptable?

b) What strategies are being implemented to increase the number of patients being contacted by community based public mental health non-admitted services within seven days of discharge?

c) Is contact within the prescribed seven days a KPI for community based public mental health non-admitted services receiving State Government funding?

Answer:

a) A high proportion of patients receiving post discharge contact from public community based mental health services (provided by WA Health) is desirable. However, patients may also be appropriately followed up by private sector mental health practitioners and support services provided by non government organisations. These contacts are not captured in the WA Health Mental Health Data Collection and not included in this indicator. A number of consumers also refuse follow up. The Mental Health Commission will continue to monitor this indicator and work with the Department of Health to ensure optimal follow up of patients post discharge.

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b)

Child and Adolescent Health Service

Child and Adolescent Mental Health Service (CAMHS) have a range of community based services that are available post discharge from a public mental health hospital.

For young people who are discharged from a CAMHS inpatient unit and are known to Community CAMHS (10 clinics across metropolitan area), they will be offered a follow up by Community CAMHS Clinic. If Community CAMHS cannot offer a service within 7 days (as per the national KPI), The Acute Community Intervention Team (ACIT) will step in and offer a follow up if required, until the Community CAMHS Clinic has available resources to safely manage the young person.

ACIT provides an intensive 6-8 week crisis intervention service, which bridges the gap between discharges from Emergency Departments and inpatient units when a suitable service cannot be found immediately post discharge.

Specialist CAMHS services also offer follow up post discharge from an Emergency Department or inpatient unit for known clients, and again ACIT will bridge the gap for unknown clients until they can be safely managed by the Specialist CAMHS service.

There are some young people who are discharged from an inpatient unit who go on to be seen by a Non-Government Organisation (NGO), private agency or GPs. CAMHS ensures an appointment has been made at the time of discharge from the inpatient unit and that this has been communicated to the young person and their family. Where possible the NGO private agency, GP would be invited to be involved in the discharge planning.

North Metropolitan Health Service

Electronic communication occurs between the Mental Health Inpatient Unit that patients are discharged from to the community based public mental health non-admitted service. The North Metropolitan Health Service Mental Health Adult Program (NMHS MH AP) monitors the Key Performance Indicator of contact within seven days after discharge, on a monthly basis. There has been further improvement in seven days follow-up rates from financial year 2013 to 2014 of 62.7% to 69.8%.

A trial is currently occurring where Peer Support Workers provide telephone contact to patients for up to six weeks following discharge from Graylands Hospital.

Earlier discharge for patients can now occur with referral to Hospital in the Home (HITH) providing a minimum of five face-to-face contacts per week.

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South Metropolitan Health Service

- There are a range of services that provide follow up, when required to patients who have been discharged from inpatient public mental health services. These include General Practitioners, private providers and public community mental health services.

- For those who require **follow up from public community mental health services:**

    - Community staff are made aware of known patients who have been admitted
    - Community staff attend inpatient ward rounds when practicable
    - A daily list of discharged patients is sent to the community teams at PaRK and a similar process is being developed at other sites
    - Follow up of patients from out of catchment is the immediate responsibility of the CATT (Crisis Assessment and Treatment Teams)

WA Country Health Service

- The number and percentage of patients being contacted by community based public mental health services (MHS) within seven (7) days of discharge is a National Key Performance Indicator (KPI). The WA Country Health Service (WACHS) reports and monitors the KPI on a quarterly basis.
- MHS continue to improve discharge planning, follow-up strategies and guidelines to enhance the handover process between Mental Health (MH) Inpatient Units and the local Community MH Teams. WACHS MHS actively work with patients prior to discharge to plan follow-up, and after discharge to make contact during the seven (7) day period. Strategies currently in place include:
- Seven (7) day post discharge follow ups is now a standing item for weekly Triage Multidisciplinary Team Meetings.
- Shared care arrangements with General Practitioners post discharge to reduce the need for medical follow up.
- Review of Community MH intake meeting process to improve patient continuum of care and allocation of case managers.
- Strengthening and improving referral/follow up and communication to/from district hospitals, other stakeholders and non-government organisations.
- The implementation across WACHS of the Statewide Standardised Clinical Documentation and related guidelines will improve practices in the area of handover transfer and follow up.

c) Yes. The KPI is for community based public mental health non-admitted services provided by WA Health funded by the Mental Health Commission.

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Department of Health

Question No. 13: Hon Adele Farina MLC asked –

I refer to Budget Paper No2, page 398 "Services and Key Efficiency Indicators", line item Specialist admitted patient services, and ask -

a) What was the funding allocation to the Bunbury Mental Health Inpatient Unit in each of 2011/12, 2012/13 and 2013/14?

Answer:

2011/12 $6,867,658
2012/13 $6,891,989
2013/14 $7,726,199 (Note: The 2013/14 allocation includes an allowance for Teaching Training and Research of $357,353 which was previously included in Base funding.)

b) What will the funding allocation to the Bunbury Mental Health Inpatient Unit be in 2014/15?

Answer:

The budget allocation for the Bunbury Mental Health Unit in 2014/15 is not known at this stage and is subject of a Regional Budget Build which will not be completed until the end of August 2014.

c) How many patients were admitted to the Bunbury Mental Health Inpatient Unit in each of 2011/12, 2012/13 and 2013/14 (to date)?

Answer:

2011 – 525
2012 – 684
2013 – 771

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

ADDITIONAL QUESTIONS FOR THE 2014-15 BUDGET ESTIMATES HEARING

Wednesday, 11 June 2014

Mental Health Commission

Question 14: Hon Member Adele Farina MLC asked -

I refer to Budget Paper No2, page 401, "Income Statement", line item *Supplies and Services,* and ask -

a) The narrative on page 400 states the supplies and services expense relates mainly to purchases of mental health and drug and alcohol services from non-government agencies, given the reduction in expenditure on supplies and services from the 2013-14 estimated actual to the 2014-15 budget, does that mean fewer services will be purchased from non-government agencies?
b) If yes to a), which non-government agencies will experience a reduction in government funding and how much of a reduction will each agency receive?

Answer:

a) Purchasing from non-government agencies will not be reduced.

   While the majority of Supplies and Services relates to non-government agencies, that expense line also includes funding to the Department of Health (DoH) that falls outside of the Service Agreement – WA Health expense line. It is this component of Supplies and Services that has decreased. In 2013-14, $8.5 million for National Partnership Agreement (Improving Public Hospitals) initiatives were included under Supplies and Services. The cost of the activities from 2014-15 is included in the Service Agreement – WA Health expense line as they are incorporated as part of total activity funded through Appropriation and National Health Reform Agreement funding.

   If the $8.5 million DoH payment in 2013/14 was excluded, supplies and services would show an increase from 2013-14 estimated actual ($155.5 million) to 2014-15 budget ($157.9 million).

b) Not applicable.

Approved
[illegible]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday 11 June 2014

Drug and Alcohol Office

Question No 15 Hon Adele Farina MLC asked -

I refer to Budget Paper No2, page 404 "Details of Controlled Grants and Subsidies", line item Department for Child Protection and Support – Youth Crisis Accommodation Support, and ask –

a) How much of the $427,000 budget will be expended in the South West Electoral District?

Answer: Nil.

Approved
[signature]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

ADDITIONAL QUESTIONS FOR THE 2014-15 BUDGET ESTIMATES HEARING

Wednesday, 11 June 2014

Mental Health Commission

Question 16: Hon Member Adele Farina MLC asked -

I refer to Budget Paper No2, page 404, "Net Appropriations", line item *Grants and Contributions from the Commonwealth,* and ask -

a) Commonwealth grants have declined by more than $15million for 2013-14 to 2014-15, what funding has been cut by the Commonwealth?

Answer:

a) In 2013-14, National Partnership Agreement (NPA) funding for Improving Public Hospitals of $12.6 million ceased, NPA funding for Mental Health Reform reduced by $2.2 million (from $8.6 to $6.4 million) and funding of $321,000 for the National Perinatal Depression Initiative also ceased.

Approved
[signature]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Mental Health Commission

Question No 17 The Standing Committee on Estimates and Financial Operations asked –

We refer to Budget Paper 2, page 393 - Mental Health Commission spending is expected to increase by $153.9 million over five years from activity and price growth, and ask –

(a) *What proportion of the $153.9 million over five years for Public Mental Health Services Activity and Price Growth relates to price growth and activity growth?*

Answer: The 2014/15 State Budget provides $585.97 million for the delivery of mental health services in hospital and community settings under the 'Service Agreement – WA Health' (page 401). As part of the Activity Based Funding model, $153.9 million was allocated over five years for activity growth of between 2.3 per cent and 2.8 per cent, and price growth of 3.9 per cent (exclusive of the Community Service Subsidy).

(b) *What is driving growth in these factors?*

Answer: Mental health services funded using the Activity Based Funding model are increased by age-weighted population activity growth and price growth consistent with the Government's policy to transition the State Price to the national Projected Average Cost over the forward estimates. Block funded services are funded using activity growth and price growth based on the Independent Hospital Pricing Authority's National Efficient Price indexation rate.

Approved
[signature]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

11 June 2014

Mental Health Commission

Question No. 18: The Standing Committee on Estimates and Financial Operations asked -

We refer to Budget Paper No 2, page 397 "The accessible and high quality mental health services and supports that are recovery focussed and promote mental health and wellbeing outcome has key effectiveness indicators that relate to the proportion of service funding directed to publicly funded community groups and community organisations. Please explain the link between the proportion of service funding directed to public funded community mental health services/community organisations key effectiveness indicators to the outcome of promoting mental health and wellbeing?"

Answer:

The Mental Health Commission purchases a range of clinical and support services including activities to improve and promote mental health and wellbeing from the Department of Health and community organisations (non government sector).

Two of the effectiveness indicators published in the Mental Health Commission's Budget Papers "Proportion of funding directed to publicly funded community mental health services" and "Proportion of funding directed to community organisations" monitor one of the state government's key reform directions articulated in the Mental Health Commission's strategic policy document *Mental Health 2020: Making it personal and everyone's business* – "Balanced investment", i.e., working towards a contemporary mental health system that provides a full range of supports and services including promoting mental health and moving from the reliance on acute care provided in inpatient (hospital) services.

Approved

PUBLIC

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

ADDITIONAL QUESTIONS FOR THE 2014-15 BUDGET ESTIMATES HEARING

Wednesday, 11 June 2014

Mental Health Commission

Question 19: The Standing Committee on Estimates and Financial Operations asked -

We refer to Budget Paper 2, page 399 – The decline in *Promotion and Prevention* service spending from $39.3 million in 2012-13 to $26.0 million in 2013-14 has partially been attributed to the transfer of Individualised Community Living Support initiatives to the *Accommodation, Support and Other Services* service, and ask -

a) What proportion of the decline is attributable to the transfer of the Individualised Community Living Support initiative to the *Accommodation, Support and Other Services* service?
b) Why wasn't the 2012-13 actual backcast to enable comparison over time?

Answer:

a) $7.6 million was budgeted for the ICLS in 2012-13. Transferring this to Service 4 accounts for approximately all of the change to 2013-14 Budget. It represents 57% of the difference between 2012-13 Actual and 2013-14 Estimated Actual.
b) The 2012-13 actual reflects the treatment at the time of preparation of the 2012-13 annual report which is audited by the Office of the Auditor General. It is considered most prudent for allocation of costs across services and subsequent calculation of efficiency indicators to maintain consistency between the annual report and budget papers for the prior year.

Approved

PUBLIC

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

11 June 2014

Mental Health Commission

Question No. 20: The Standing Committee on Estimates and Financial Operations asked -

At the Legislative Assembly Estimates Hearings, the Commission stated it hoped to fund the Goldfields facility from the savings from the building of the Rockingham and Broome sub-acute facilities, and ask-

a) What are the current savings associated with building the Rockingham and Broome sub-acute facilities?
b) Where are those buildings located on your Asset Investment Program table?

Answer:

a) I wish to clarify that the Goldfields facility is anticipated to be funded from the savings from the Rockingham and Joondalup subacute facilities.

   A total funding of $12.8 million was allocated by the State Government to the Department of Housing for the construction of the Joondalup and Rockingham facilities. Department of Housing has expended approximately $5 million for the construction of the 22 bed Joondalup facility. It is anticipated that the cost of establishing the 10 bed Rockingham facility will be approximately $4.5 million. However, this cannot be confirmed until the design planning is completed and the contracts issued for construction work. The expectation is that the balance of funding available from the Joondalup and Rockingham facilities will be sufficient to fund the construction of the 6 bed Goldfields facility.

   A total funding of $2.5 million has been provided to the Department of Housing for the construction of the Broome subacute facility. This funding comes from the Commonwealth Government through the National Partnership Agreement on Improving Public Hospital Services.

b) The funding of capital work for subacutes is included in the Asset Investment Program table in the Department of Housing's budget papers (page 526).

Approved
[signature]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

11 June 2014

Mental Health Commission

Question No. 21: Hon Stephen Dawson MLC asked -

I refer to page 399, "Accommodation, Support and Other Services", to the level of supported community housing for people with mental illness provide by the Government of WA. Will the Minister indicate –

a) What is the rates of places available per 1 000 000 people?
b) What is the rates of places available per 1 000 000 people for the past 5 years?
c) What is the current estimated number of people in acute hospitals who could be in supported community housing?

Answer:

a) The Mental Health Commission purchases a range of accommodation and other support services from non government organisations. Various units of measures are included in the contracts between the Commission and the non government organisations, including hours of service, beddays and packages of care. Four efficiency performance indicators related to these units are published in the Budget Papers. The Commission does not purchase on the basis of 'places', therefore 'Places available' is not monitored by the Commission.

b) See above.

c) The current estimated number of people in acute hospitals who could be in supported community housing is not known. The former Mental Health Division, Department of Health, estimated from an inpatient snapshot survey conducted in 2009 that approximately 44% of patients could have been discharged from specialised mental health inpatient units if appropriate accommodation and support services were available.

Approved

PUBLIC

ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Department of Health

Supplementary Information No. 22: Hon Stephen Dawson MLC asked –

I refer to page, 399, "Accommodation, Support and Other Services", and ask, how many psychiatrists worked in the public health system on 1 June 2014?

Answer:

As at 1 May 2014, 181 (133.9 FTE) qualified psychiatrists worked in the public health system.

Notes:

- Data Source: HR Data Warehouse.
- FTE is calculated as the monthly Average FTE and is the average hours worked during a period of time divided by the Award Full Time Hours for the same period. Hours include ordinary time; overtime; all leave categories; public holidays, Time Off in Lieu, Workers Compensation.
- FTE figures provided are based on Actual (Paid) month to date FTE.
- The selection of Psychiatrists was determined from Position Titles only. Medical staff who practice Psychiatry and who do not have this term referenced in their Position Title may therefore be omitted.
- Academic staff and clinical services directors (eg Heads of Dept, Directors, etc) are assumed to provide some clinical services as part of their role and are therefore included.
- Medical staff in training such as Interns and Registrars have been excluded.
- Budget Holders Drug & Alcohol Office, and Mental Health Commissions have been excluded.
- Data was only available as at 1 May 2014.

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

ADDITIONAL QUESTIONS FOR THE 2014-15 BUDGET ESTIMATES HEARING

Wednesday, 11 June 2014

Mental Health Commission

Question 23: Hon Member Stephen Dawson MLC asked -

I refer to page 396, "Significant Issues Impacting the Agency", and the Suicide Prevention strategy, and ask -

a) What level of funding was expended in 2013-14?
b) Are there any new funds in 2014-15 for suicide prevention strategies in Western Australia?

Answer:

a) $4.1 million was provided for the Suicide Prevention Strategy in 2013-14.
b) The Government has allocated an additional $2.9 million in 2014-15 to continue important initiatives under the Suicide Prevention Strategy in Western Australia. This is in addition to the $821,000 previously allocated to the program.

Approved
[signature]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Department of Health

Question No. 24: Hon Stephen Dawson MLC asked –

I refer to page 400, "Asset Investment Program" and the accessibility of community mental health staff and support services in Western Australia. Will the Minister indicate -

a) *The waiting times for access to community mental health centres in Western Australia?*

Answer:

Caution should be used in interpreting the data and comparing the Health Services. There is no state-wide definition for waiting time for community mental health services. There are no state-wide business rules for capturing referral data onto information systems.

Child and Adolescent Health Service
The average wait time varies across Acute, Community and Specialised Child and Adolescent Mental Health Service (CAMHS). All children on a waitlist are assertively managed and reviewed and if required the child would be referred to an acute program, which may include an inpatient admission or referral to the Acute Community Intervention Team (ACIT) of the Acute Response Team (ART). There are no waitlists for ACIT and ART.

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	Average length of wait time	
	<12 years	12 years and older
Specialised CAMHS		
Complex Attention and Hyperactivity Disorder Service	3 weeks; 14.6 days average waiting	1 week; time between referral and assessment
Eating Disorders Program	0	0
Multi-systemic Therapy	0	0
Pathways Outreach (Shenton)	29 days	26 days
Pathways Residential (Bentley)	0	0
Acute CAMHS		
Paediatric Consultation Liaison	8.4 weeks	9.1 weeks
Transition Unit Day Program	0	0
Community CAMHS		
*Clarkson	8 days	7 days
*Rockingham	5 weeks	5 weeks
*Warwick	9 days	5 days
Armadale	7 days	7 days
Bentley	13 days	18 days
Fremantle	3 months	2 months
Hillarys	Priority: 4 weeks Routine: 9 months	Priority: 4 weeks Routine: 9 months
Peel	2 weeks	0
Shenton	6 months	2 months
Swan	70 days	70 days

*The Community CAMHS Clinics that have moved to a Choice and Partnership Approach (CAPA) have a procedure for managing referrals. The procedure is as follows:

1. On the date of receipt of referral, an invitation letter is sent to the family inviting them to phone Clarkson CAMHS and book an appointment.
2. When the family contacts, an appointment is offered for an initial assessment.
3. For each family who have not responded, the referral is assessed and monitored by three senior staff and plans for follow up are developed according to the level of acuity that is known.
4. If the young person becomes Acute they are managed by ACIT, ART or an inpatient admission.

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North Metropolitan Health Service

	Average waiting time (days):	
Service	**2012-13**	**2013-14**
FORENSIC METAL HEALTH		
Community Forensic	NA Referrals are responded to directly from the Courts; no primary referrals received.	NA Referrals are responded to directly from the Courts; no primary referrals received.
ADULT MENTAL HEALTH		
City Catchment (Inner City & Subiaco Community Mental Health Services)	5.6	3.3
Joondalup Catchment (Joondalup & Clarkson Community Mental Health Services)	1.7	4.3
Stirling Catchment (Mirrabooka and Osborne Community Mental Health Services)	7.4	8.0
Swan Catchment (Swan Community Mental Health Service)	1.3	0.7
Average	4	4
OLDER ADULT MENTAL HEALTH		
Inner City *Older Adult* Community Mental Health Service	10.8	7.3

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Joondalup/Clarkson *Older Adult* Community Mental Health Service	0	7.8
Osborne *Older Adult* Community Mental Health Service	5.9	0.2
Selby *Older Adult* Community Mental Health Service	2.0	9.2
Swan *Older Adult* Community Mental Health Service	3.1	2.8
Average	4.4	5.4

Notes:

1) An individual's first port of call as a new client will be the Triage Officer and the activity will be recorded as a Triage Event.
2) This is access to face-to-face contact. The data does not reflect that many of these individuals may have received telephone based contact before face-to-face.
3) These individuals may have been triaged over the phone and the urgency response assessed. As such, the response times will be contingent upon the Triage Officer's determination.
4) A triage requirement will be reported on the Statewide Standardised Clinical Documentation (SSCD) triage document using a standardised method of ascertainment.
5) Data may be subject to minor variation (preliminary PSOLIS extract).

South Metropolitan Health Service

- All patients are triaged and seen according to risk. Patients are seen urgently if required.
- This is facilitated via triage during business hours. After hours triage occurs through Crisis Assessment and Treatment Team (CATT) in the evenings and by Weekend Community Nurses during the day on weekends and public holidays.
- The following tables outline the routine waiting time at each centre by occupational group:

PUBLIC

Armadale

Community Services at Eurdoria St	
psychiatrist	2-4 weeks depending on team workload. Care Coordinators contact patient 24hrs to 48hrs of allocation and provide follow up treatment and monitoring. Increased acuity of presentation is reprioritised with out-of-clinic appointment times being offered.
psychologist	2-4 weeks depending on caseload acuity and staff leave. Urgent referrals are prioritised.
occupational therapist, social worker, nursing	No wait time.

Community Services at Mead Centre	
psychiatrist	6 weeks.
psychologist	4 weeks depending on caseload acuity. Urgent referrals are prioritised.
occupational therapist, social worker, nursing occupational therapist	No wait time

Older Adult MHS	
psychiatrist	2-3 weeks at present.
psychologist	N/A.
occupational therapist, social worker, nursing	Appointment organised depending on level of need and risk, no wait times.

Bentley/RPH

CSRU Clients	
psychiatrist	4 weeks
psychologist	4 weeks
occupational therapist	1 week
social worker	2 days maximum.
nursing	No wait time.

PUBLIC

Jarrah Road	
Psychiatrist, psychologist, social worker, nursing	Nil
occupational therapist	Please refer notes

Older Adult - Community Team	
psychiatrist	0-3 weeks
psychologist	2-4 weeks
occupational therapist, social worker	Nil
nursing	0-1 week

Mill Street Adult Outpatient	
psychiatrist	1-3.5 weeks for initial 1 hr assessment and 1-2 weeks for routine appointments.
psychologist	10 weeks approximately.
occupational therapist	2 weeks general but can be seen earlier if required.
social worker	1-2 weeks but can be seen earlier if required.
nursing	Can be seen on the day.

Peel and Rockingham Kwinana MHS

Peel Community MHS (Adult)	
psychiatrist	2 weeks
psychologist	8 - 10 weeks
occupational therapist	2 weeks
social worker, nursing	no waiting list

Fremantle

Alma Street - Community	
psychiatrist	2-6 weeks. This would be dependent on the needs of the client. Clients presenting in crisis are seen ASAP.
psychologist	8-12 weeks.
occupational therapist	Immediate follow up as required - due to current capacity.
social worker	Routinely within 3-4 days - if urgent, immediately.

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WA Country Health Service
2012-2013 average waiting time for community mental health services is four (4) days.
2013-2014 (to date) average waiting time for community mental health services is 2.9 days.

b) *Professional group at each centre?*

Answer:

Child and Adolescent Health Service
CAMHS have a multidisciplinary team (MDT) approach to all services provided to children and young people which includes Psychiatrists, Social Workers, Psychologists, Nurses, Peer Support Workers, Youth Workers, Occupational Therapists, Dieticians and Speech Therapists. The MDT may vary across services, however if a young person requires a specific professional group this can be arranged.

North Metropolitan Health Service

Service	Professional groups represented at this service
Community Forensic	Consultant Psychiatry, Mental Health Nursing, Social Work, Clinical Psychology
City Catchment (Inner City & Subiaco Community Mental Health Services)	Consultant Psychiatry, Registrar, Mental Health Nursing, Occupational Therapy, Social Work, Clinical Psychology
Joondalup Catchment (Joondalup & Clarkson Community) Mental Health Services)	Consultant Psychiatry, Registrar, Mental Health Nursing, Occupational Therapy, Social Work, Clinical Psychology
Stirling Catchment (Mirrabooka and Osborne Community Mental Health Services)	Consultant Psychiatry, Registrar, Mental Health Nursing, Occupational Therapy, Social Work, Clinical Psychology
Swan Catchment (Swan Community Mental Health Service)	Consultant Psychiatry, Registrar, Mental Health Nursing, Occupational Therapy, Social Work, Clinical Psychology
Inner City *Older Adult* Community Mental Health Service	Consultant Psychiatry, Registrar, Mental Health Nursing, Occupational Therapy, Social Work,

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	Clinical Psychology
Joondalup/Clarkson *Older Adult* Community Mental Health Service	Consultant Psychiatry, Registrar, Mental Health Nursing, Occupational Therapy, Social Work, Clinical Psychology
Osborne *Older Adult* Community Mental Health Service	Consultant Psychiatry, Registrar, Mental Health Nursing, Occupational Therapy, Social Work, Clinical Psychology
Selby *Older Adult* Community Mental Health Service	Consultant Psychiatry, Registrar, Mental Health Nursing, Occupational Therapy, Social Work, Clinical Psychology
Swan *Older Adult* Community Mental Health Service	Consultant Psychiatry, Medical Officer, Mental Health Nursing, Occupational Therapy, Social Work, Clinical Psychology

South Metropolitan Health Service
See above.

WA Country Health Service
WA Country Health Service has defined community mental health centres as sites from which non-admitted public community mental health services are provided. Services provided from the community mental health centres are delivered by the following professional groups.

- Aboriginal Mental Health Workers
- Clinical Psychologists
- Community Mental Health Professionals (Occupational Therapist, Social Worker, Psychologist, Nurse)
- Medical Officers
- Mental Health Workers
- Nurses (Registered, Enrolled)
- Occupational Therapists
- Psychiatrists
- Psychologists
- Social Workers
- Welfare Officers

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Community Mental Health Support Services

(a-b) The Mental Health Commission does not include information relating to waiting times as part of its routine data collection processes for community support services provided by non-government organisations.

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ESTIMATES ANB FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 25 June 2014

The Mental Health Commission

Question No 25. Hon Stephen Dawson MLC Asked:

a) *What were the reasons for the delay in commencing bed occupancy at Joondalup sub-acute unit?*

Any new service requires time to integrate into the current service system and build trust within the community and the clinical/allied health workers so that the role, purpose and function are clearly understood by all stakeholders.

The contract between the Mental Health Commission and Neami National recognises this and commences a monthly occupancy provision of 85% in the second year of the contract.

To current monthly occupancy rate is 82%.

b) *What was the average occupancy for 2013-2014 financial year?*

The average monthly occupancy rate from the 1 June 2013 to 24 June 2014 is 60.5%.

Approved

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Department of Health

Question No. 26: Hon Stephen Dawson MLC asked –

I refer to page 399, "Accommodation, Support and Other Services", and ask -

a) How many admissions were made to specialised mental health units in 2012-2013 and so far in 2013-2014?

Answer:

The identification of ward on admission is not captured in the Hospital Morbidity Data Collection, therefore separation counts are provided.

In 2012-13 there were 11,262 patients who separated from specialised mental health inpatient units. In 2013-14 YTD (up 31 March 2014), there were 8,780 separations from specialised mental health inpatient units.

b) How is this year's figure tracking in relation to last year?

In the 1 July 2012 to 31 March 2013 period there were 8,634 separations from specialised mental health inpatient units. This is an increase of 1.7 per cent compared to the same period in 2013/14 YTD.

Data source: Hospital Morbidity Data System
Prepared by: Mental Health Data Collection, Data Integrity Directorate, Performance Activity and Quality Division, WA Health
Extraction Date: Monday, 23 June 2014

Notes:

- All data are preliminary.
- Separations include public patients treated in a private hospital with specialised mental health inpatient units.
- Data is subject to change to due lag in clinical coding. Caution should be undertaken in interpreting the data.

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday 11 June 2014

Drug and Alcohol Office

Question no 27 Hon Stephen Dawson MLC asked –

I refer to page 400, "Accommodation, Support and Other Services", and ask –

a) What percentage of Royalties for Regions funding makes up the asset investment program for 2014-2015?

Answer: 0%.

b) Where will the Royalties for Regions money be spent?

Answer: Royalties for Regions funding for service delivery will be expended on alcohol and other drug services in Carnarvon, Karratha, Newman, Tom Price, Port Hedland, Broome, Derby, Fitzroy Crossing, Halls Creek, and Kununurra.

c) What percentage of Royalties for Regions funding makes up the asset investment program for 2013-2014?

Answer: 77%.

d) Where was this money spent?

Answer: Carnarvon and Halls Creek.

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[signature]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday 11 June 2014

Drug and Alcohol Office

Question No 28 Hon Stephen Dawson MLC asked -

I refer to page 400, "Asset Investment Program", and ask –

a) What minor works were undertaken in 2012-2013?

Answer: The funding represents minor works for a facilities upgrade at the Drug and Alcohol Office's Next Step Clinical Unit.

b) What was the reason for under expenditure in minor works funding in 2012-13?

Answer: The facilities upgrade is being undertaken in a phased approach with further work being progressed in 2014/15.

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

ADDITIONAL QUESTIONS FOR THE 2014-15 BUDGET ESTIMATES HEARING

Wednesday, 11 June 2014

Mental Health Commission

Question 29: Hon Member Stephen Dawson MLC asked -

I refer to page 394, "Service Summary – Promotion and Prevention" and ask -

a) The budgeted amount in 2013-14 was $32.132 million, the estimated actual expenditure was $26.031 million, what is the reason for non-expenditure?
b) Why is the expenditure for the forward years decreasing?

Answer:

a) The budgeted amount included a provision of $3.6 million that was unallocated to a specific activity at the time of budget preparation. It also included a variety of other initiatives such as $1.4 million for workforce development initiatives that either came in under budget or were non-government services that were more appropriately allocated as Service 4 – Accommodation, Support and Other Services.
b) Funding for the Suicide Prevention Program peaked in 2012-13 at $8.8 million due to the slower than anticipated take-up of grants by non-government agencies and community groups in prior years. It is a more normal level of $4.1 million in 2013-14, the final year of the original program. The Government has allocated an additional $2.9 million in 2014-15 to continue important initiatives under the program while extensive evaluation is conducted prior to Government consideration of further funding.

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Drug and Alcohol Office

Question No 30 Hon Stephen Dawson MLC asked –

I refer to page 396, "Significant Issues Impacting the Agency – Engaging more people in Treatment", and ask -

(a) What is the reason for expansion of services in the northern metropolitan corridor?

Answer: The expansion will establish a new site for Integrated Services in the Joondalup area. Integrated Services is a model of alcohol and other drug outpatient treatment comprising a service partnership between DAO's own Next Step service and not-for profit service providers. The highest priority for expanding these services is the Joondalup area, primarily due to a large and growing population in the area.

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

11 June 2014

Mental Health Commission

Question No. 31: Hon Stephen Dawson MLC asked -

I refer to page 395, "Significant Issues Impacting the Agency - Mental Health Infrastructure" regarding Graylands Hospital, and ask -
a) How many reports of sexual assault were made by patients in the six months before the implementation of the clinical restructure in 2013 and in the period since the restructure?

Answer:

a) There were no reports of sexual assault made by patients in the six months prior to the clinical restructure (19 December 2013).

   There was one (1) sexual assault allegation made by a patient in the period since the restructure. Note that this patient has since retracted their allegation.

Approved
[signature]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday 11 June 2014

Drug and Alcohol Office

Question No 32 Hon Stephen Dawson MLC asked -

I refer to page 399, "Accommodation, Support and Other Services", and ask –

a) Where are the 15 houses that were purchased under the transitional housing program in the North West?

Answer: The Transitional Housing and Support Program (THASP), provides housing and support to assist people in their recovery post alcohol and other drug residential treatment. The THASP comprises 15 houses in total. Three (3) of these houses are in the North West. They are located in Broome (two houses), and Derby (one house).

b) What operational funds have been set aside in 2014-15 for transitional housing?

Answer: $482,674.

c) What is the anticipated shortfall in transitional beds to need in the community?

Answer: Any shortfall in transitional beds will be identified in the Mental Health and Alcohol and other Drugs Services Plan due for release later in 2014.

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[illegible]

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday 11 June 2014

Drug and Alcohol Office

Question No 33 Hon Stephen Dawson MLC asked -

I refer to page 396, "Significant Issues Impacting the Agency – Mental Health Activity in the Public Hospital System", and ask –

a) What are the levels of alcohol consumption in the Kimberley, Pilbara, Midwest and Goldfields regions?

Answer: In 2009/10 the estimated per-capita consumption for age 15 plus was:

- Kimberley health region – 16.2 litres
- Pilbara health region – 17.3 litres
- Midwest health region – 18.7 litres
- Goldfields health region – 13.8 litres

b) How much money is the DAO spending in each of the regions in 2014-15?

Answer: In 2014/15 DAO will spend:

- $8,211,569 in the Kimberley;
- $3,955,714 in the Pilbara;
- $3,059,897 in the Midwest; and
- $3,498,542 in the Goldfields.

c) What programs will be implemented in each of the regions?

A range of counselling, rehabilitation and prevention programs are offered in each region. These include:

- Community alcohol and other drug counselling, case management and support services
- Sobering-up Centres
- Specialist Alcohol and Other Drug Court Diversion services
- Residential rehabilitation programs
- Support to develop and implement alcohol and other drug management plans at a local and regional level
- Alcohol and other drug prevention campaigns with support to develop and implement localised strategies

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- Professional development programs available to clinical and prevention staff as well as community groups.

Services funded to deliver these programs will be:

Kimberley: Kimberley Community Drug Service Team (Kimberley Mental Health and Drug Service), Cyrenian House and Milliya Rumurra (CHMR) alcohol and other drug service, Nindilingarri Alcohol and Drug Service, Ngowar-Aerwah Community Centre and 7-Mile Rehabilitation Centre , Warmun Community Local Drug Action Group Service, Broome Sobering-up Centre, Derby Sobering-up Centre, Kununurra Sobering-up Centre, Wyndham Sobering-up Centre.

Pilbara: Bloodwood Tree Port Hedland Alcohol and other Drug Hub, Pilbara Community Alcohol and Drug Service, Roebourne Sobering-up Centre, Hedland Sobering-up Centre.

Midwest: Rosella House residential treatment service, Midwest Community Drug Service Team, Carnarvon Dual Purpose Centre Sobering-up Service, Wiluna Community Patrol, Geraldton Sobering-up Centre.

Goldfields: Goldfields Community Alcohol and Drug Service, Kalgoorlie Sobering-up Centre, Goldfields Rehabilitation Services (Prospect Lodge) residential treatment service, Teen Challenge Grace Academy, Ngaanyatjarra Health Service.

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

ADDITIONAL QUESTIONS FOR THE 2014-15 BUDGET ESTIMATES HEARING

Wednesday, 11 June 2014

Mental Health Commission

Question 34: Hon Member Stephen Dawson MLC asked -

I refer to page 393, "Spending Changes" and to the sub-acute services, and ask -

a) What is the $778,000 allocation in 2016-17 to be spent on?
b) What is the breakdown by sub-acute centres the $6.661 million allocation in 2017-18 will be spent on?
c) Which sub-acute centres is this allocation for?

Answer:

a) The $778,000 is the incremental amount required to fund services at the Joondalup, Rockingham and Broome subacute centres. Total operating cost of these centres in 2016/17 is estimated at $7.367 million. The remainder of the funding is from redirection of an amount no longer planned to be directed towards the Early Psychosis Youth Centre ($5.589 million) and other mental health initiatives ($1 million).
b) In 2017-18, the estimated total operating cost of the Joondalup, Rockingham and Broome subacute centres is $7.661 million. Of this, $1 million is to be found from redirection of other mental health initiatives. The remainder is the new allocation.
c) Joondalup - $4.152 million;
Rockingham - $1.847 million; and
Broome - $1.662 million.

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Mental Health Commission

Question No. 35: Hon Stephen Dawson MLC asked -

I refer to page 393 "Spending Changes" and the National Perinatal Depression Initiative Funding Transfer, and ask –

a) *What was the $321,000 allocated to in 2013-2014*

Answer:

The final NPDI payment from the 2008/09-2012/13 NPDI Agreement was used to extend some of the expiring NPDI government and non government contracts as follows:

- North Metropolitan Health Service, Osborne Park Hospital, NPDI Mental Health Nurse, contract extension 1 July 2013 – 30 September 2013, $12,574
- WA Country Health Service, Goldfields-Esperance Population Health, NPDI Perinatal Nurse and Babe Ease support group, contract extension 1 July 2013 – 30 June 2014, $62,996 and $16,445 respectively
- Australian Red Cross, practical in-home support service, contract extension 1 September 2013 – 30 June 2014, $152,746
- Save the Children, support group, contract extension 1 April 2013 – 30 June 2014, $8,888
- Ishar support group, contract extension 1 March 2013 – 30 June 2014, $19,604
- Playgroup WA, support group, contract extension, 1 January 2014 – 30 June 2014, $11,559
- Joondalup Women's Health, support group, contract extension 1 January 2014 – 30 June 2014, $22,489
- South Coastal Women's Health, support group, contract extension 1 January 2014 – 30 June 2014, $13,867

b) *What funding is allocated in this budget to Perinatal Mental Health by the State Government?*

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Answer:

The majority of Perinatal Mental Health state funded services are delivered by the Department of Health through a combination of:

- o maternal mental health services
  - King Edward Memorial Hospital, Psychological Medicine Clinical Care Unit which provides specialist mental health services to women through both the CAMI clinic and Mother and Baby unit,
  - King Edward Memorial Hospital , Women's Health Clinical Care Unit delivers perinatal mental health training, health promotion and conduct research and service planning,
  - Midwives in State maternity hospitals across the state provide perinatal depression screening.
- o child health services
  - Child and Adolescent Community Health Service, Child Health Nurses provide perinatal depression and child development screening and referral. They also support women with mild perinatal mental health issues and their children within the community.
- o adult mental health services
  - Women with severe mental health issues can be managed by adult mental health services where referral criteria are met.
- o adult health services
  - Women may present to emergency departments and other health services with health needs related to their mental health issues.

In 2014/15 the Mental Health Commission has offered Service Level Agreements with base non admitted funding of $101,364,000, $87,450,000 and $55,314,000 to the Department of Health, North Metropolitan (including KEMH), South Metropolitan and WA Country Health Services respectively for the provision of mental health services. It is not possible to know the amount specifically spent on perinatal mental health from the base non admitted funding. The Commission does not provide funding for the provision of other health services provided by the Department of Health such as the Child and Adolescent Community Health Service.

The Mental Health Commission recurrently funds five Women's Health Centres across the metropolitan area to deliver clinical and psychosocial support to women at risk of, or experiencing, perinatal mental health issues and the 2014/15 funding allocation is:

- o Fremantle Women's Health Service, clinical services, $113,852
- o Gosnells Women's Health Service, clinical services, $184,360
- o Midland Women's Health Service, clinical services, $214,873
- o South Coastal Women's Health Service, clinical services, $113,852
- o Women's Healthcare Association, clinical services and psychosocial support, $380,519

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c) Which programs were funded by the National Perinatal Depression Initiative in WA in the last 5 years?

Answer:

The Commonwealth Government provided $3.69million to Western Australia through the 2008/09 – 2012/13 NPDI. This funding provided 5 metropolitan and 5 country clinical positions in the Department of Health, and services provided through a number of non-government organisations. The key non-government organisations with Service Level Agreements that were funded through the NPDI National Partnership Agreement (NPA) are:

- Save the Children Fund,
- Australian Red Cross; and
- Ishar Multicultural Women's Health Care.

In addition, over the lifetime of the NPA, at least a further six non-government organisations received funding over a number of consecutive grants from a combination of Commonwealth NPDI and State funds. These organisations were funded to provide playgroups, home visiting, recovery and practical support and include:

- Joondalup Women's Health Service;
- South Coastal Women's Health Service;
- Playgroup WA;
- Independent Living Centre (formerly Noah's Ark Toy Library);
- Ishar Multicultural Women's Health Care.

d) Which of these programs will be affected by the Commonwealth funding cuts to the National Perinatal Depression Initiative?

The 2013/14 NPDI Project Agreement was not finalised until 13 May 2014 with funds not received until June 2014. Furthermore, a 2014/15 NPDI Agreement was not offered until 14 June 2014 for services as of 1 July 2014. This level of funding uncertainty meant that the full NPDI service could not be maintained by the state. In addition, the level of funding being offered by the Commonwealth for 2014/15 is $1.02 million which would be insufficient to continue to fund all of the Government and non-government services previously supported. The table provides an overview of the 2014/15 funding status of services funded through the 2008/09 – 2012/13 NPDI Agreement.

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Table 1: Overview of services funded through the 2008/09 – 2012/13 NPDI Agreement with service status until 2014/15

Services funded through 2008/09 – 2012/13 NPDI Agreement	NPDI Service Status in 2014/15
North Metropolitan Health Service • 2.4 FTE Clinical Nurse Specialist	Service discontinued*
South Metropolitan Health Service • 1.6 FTE Clinical Nurse Specialist	Service discontinued*
WA Country Health Service • 3.1 FTE Nursing (Goldfields, Midwest, Wheatbelt and Southwest) • 1.6 FTE Carnarvon Health Worker and Project Officer	Service reduced to 0.5 FTE Nursing in Goldfields (1 July 2014 – 30 June 2015) Other services discontinued*
3 Non Government Service Level Agreements • home visiting and support groups	All services maintained as grant agreements (1 July 2014 – 30 June 2015)
5 Non Government Grants • Playgroups, home visiting, recovery and practical support	All services maintained as grant agreements (1 July 2014 – 30 June 2015) One non government grant, provided by Independent Living Centre has been taken over by Goldfields Population Health

*Services that have been immediately maintained in 2014/15 are those that were currently staffed and operational as at June 2014.

The Commission will be giving consideration to funding previously discontinued services if future Commonwealth funding is assured taking account of the funding available and noting that it takes a number of months for such services to become operational.

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ESTIMATES AND FINANCIAL OPERATIONS COMMITTEE

QUESTIONS ON NOTICE SUPPLEMENTARY INFORMATION

Wednesday, 11 June 2014

Department of Health

Supplementary Information Question No. 36: Hon Stephen Dawson MLC asked –

I refer to page 399, "Accommodation, Support and Other Services" and ask -

a) *Were any clients turned away from the Mirrabooka Mental Health unit since 1 July 2013?*

Answer:

No.

Note: All community members who self-present to Mirrabooka Community Mental Health Service are assessed by the Triage officer. A determination of the appropriate course of action is made following assessment by the Triage officer in consultation with the Assessment and Treatment Team. If the referral is inappropriate for the service, the person will be re-directed to the appropriate agency.

b) *What is the average waiting time for treatment at the Mirrabooka Mental Health Unit?*

Answer:

The average wait time for the Stirling Adult Mental Health Catchment (which includes Mirrabooka and Osborne Community Mental Health Services) is 8 days (2013/14).

Notes:

- All referrals for this catchment area are triaged by the Mirrabooka Community Mental Health Service Triage Officer.
- Urgency of response to each referral is determined by severity of risk, patient acuity and intervention required.
- An individual's first port of call as a new client will be the Triage Officer and the activity will be recorded as a Triage Event. The wait time provided here refers to access as face-to-face contact. The data does not reflect that many of these individuals may have received telephone based contact before face-to-face.
- The wait time for review by a Psychologist is 3-4 weeks (applicable to Stirling Catchment – Mirrabooka and Osborne Community Mental Health Services). However this doesn't preclude interim care by another multidisciplinary team member, including a Consultant Psychiatrist, pending the psychology appointment.
- Should an individual feel they require emergency assistance, they are able to present to an Emergency Department or contact the Mental Health Emergency Response Line (MHERL) on 1300 555 755.

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