Government of **Western Australia**
Mental Health Commission

Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025

Plan Update 2018

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Feedback

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Acknowledgements

The Mental Health Commission acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of this country and its waters. The Mental Health Commission wishes to pay its respects to Elders past, present and emerging.

The Mental Health Commission would like to acknowledge the valuable participation of all employees, as well all external stakeholders, who have contributed to the development of the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 and the Plan Update 2018.

Accessibility

This publication is available in an easy ready version. Alternative formats can be made available upon request to the Mental Health Commission.

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Table of contents

Correction to the Plan Update 2018 as of 29 July 2020
Please note:- *Figure 7 and 14: Mental Health – Current Services* as a proportion of revised 2025 optimal levels*, were incorrect at the time of publication, with Community Bed-Based and Community Treatment percentages inadvertently substituted. The correct representation can now be seen in both figure 7 and 14, with Community Bed-Based 38% and Community Treatment 66% of optimal levels, respectively.
Content referencing these figures has also been updated on pages 7, 30 and 31.

Executive Summary

Executive Summary

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan) was released in December 2015 and outlines the optimal mix and level of mental health and alcohol and other drugs (AOD) services required to meet the needs of Western Australians until the end of 2025.

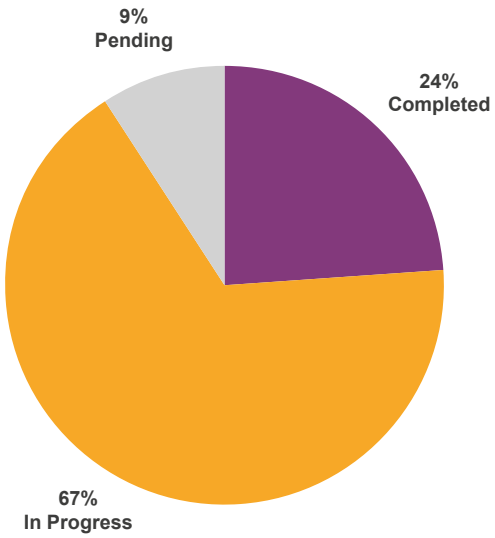
The Plan sets the strategic direction for the mental health and AOD sector. It provides a guide for investment decisions and priority setting for the Mental Health Commission (Commission) and all levels of Government and non-government stakeholders. It is based on rigorous modelling of the optimal mix of mental health and AOD services required for the population of Western Australia.

The Plan Update 2018 meets the commitment from the Commission to revisit the service modelling framework using nationally agreed planning tools every two years. This ensures the latest evidence and population demographics are taken into account, and that the Plan's implementation remains responsive to emerging trends. While the estimated optimal mix and levels of service have been revised, the Plan remains the primary reference for mental health and AOD services development, particularly as it relates to strategic priorities.

The Plan Update 2018 provides background information on changes in the strategic environment for the mental health and AOD sectors for each of the eight service streams. In addition, the Plan Update 2018 reflects updated modelling based on revised demographic estimates and also includes the addition of the East Metropolitan Health Service for the first time. As the national planning tools do not contain modelling for forensic services and AOD prevention services and as there is no comprehensively tested modelling for mental health prevention services, the 2015 modelling has been retained.

The Plan Update 2018 also includes a summary of key achievements towards implementation of the Plan. As the original time horizon in the Plan was 2017, the level of actual services and action status have been determined for 2017 in the Plan Update 2018. As at September 2017, of the 112 actions or sub actions identified for completion by the end of 2017, 27 (24%) had been completed, 75 (67%) were in progress and 10 (9%) were pending.

Figure 1: Action status as at September 2017



Current Levels of Service

The Plan was released in 2015 and outlined actual levels of service as at 30 June 2013. There has subsequently been a significant increase in expenditure in mental health and AOD services.

General Government expenditure has increased by

10%

Mental Health and AOD expenditure has increased by

21%

Actual levels of service reflected in the Plan were estimated as at 2013. Since 2013-14, the Commission's expenditure in the mental health, AOD sector has increased significantly, by 21% from $742 million in 2013-14 to $895 million in 2017-18. From 2013-14 to 2017-18, expenditure in the mental health sector alone has increased by 22% (from $656 million in 2013-14 to $803 million in 2017-18), with expenditure in the AOD sector increasing by 7% (from $86 million to $92 million). This compares with a 10% increase in general government expenditure[1] over the same period (from $27.2 billion to $29.9 billion), as outlined in **Figure 2** below.

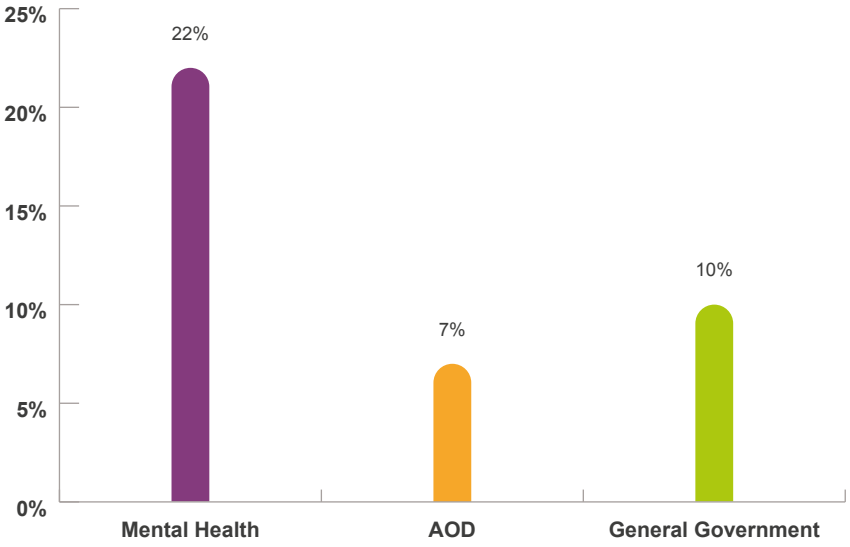
While there is still more work to do to meet optimal levels, **Figure 3** demonstrates that since 2013, levels of service have increased across all service streams, with the exception of AOD hospital beds. The current number of AOD hospital beds, which is a combination of private and public high medical withdrawal beds, has reduced in the Plan Update 2018 due to a reclassification of five private beds from high medical withdrawal to low/medium medical withdrawal (AOD community bed-based).

Figures 4 and **5** outline the progress made since the release of the Plan, to meet the originally estimated optimal levels of service for the end of 2017.

For mental health, all service streams have progressed towards meeting the original optimal levels for 2017 identified in the Plan. However, further increases are still required, particularly for community support hours and prevention services.

Figure 5 demonstrates that the AOD sector is more balanced across the optimal mix of services compared to the mental health sector. For example, actual levels of prevention services, community support hours and community treatment beds have met or exceeded original estimated optimal levels of service outlined in the Plan for 2017.

Figure 2: Changes to mental health, AOD and general government expenditure since the release of the Plan



[1] General Government expenditure drawn from Western Australian State Budget.

Figure 5 also demonstrates that current levels of service for community support beds, community treatment hours and hospital beds remain below the original estimated optimal levels in the Plan.

The Plan identified that the optimal level of AOD community support hours was 5,000 in 2017, maintaining existing levels as at 2013. However, AOD community support hours have increased to 60,000 hours since 2013, through the expansion of programs providing AOD harm-reduction and personal support services and AOD Community (Diversion) Services. While the optimal levels for 2017 have been exceeded, AOD community support hours are required to increase from 60,000 hours in 2017 to 395,000 hours by the end of 2025.

Similarly, while the number of AOD community beds (low medical withdrawal and residential rehabilitation beds) has exceeded the original 2017 optimal level of 434 beds, with 466 provided in 2017, an additional 366 beds will be required by the end of 2025 to meet the optimal level for AOD community beds.

Figure 3: Growth in estimated actual levels of service from 2013 to 2017

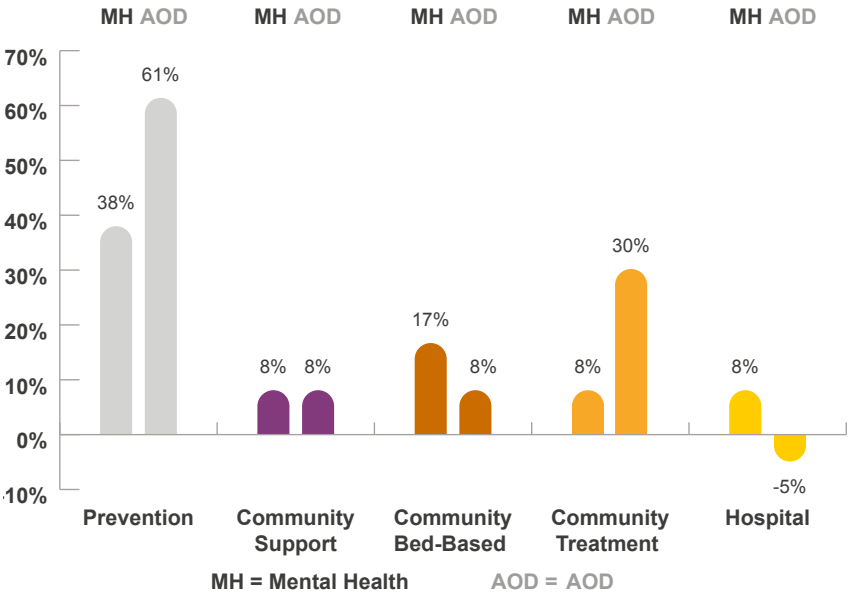


Figure 4: Mental Health – Current services* as a proportion of original 2017 optimal levels in the Plan

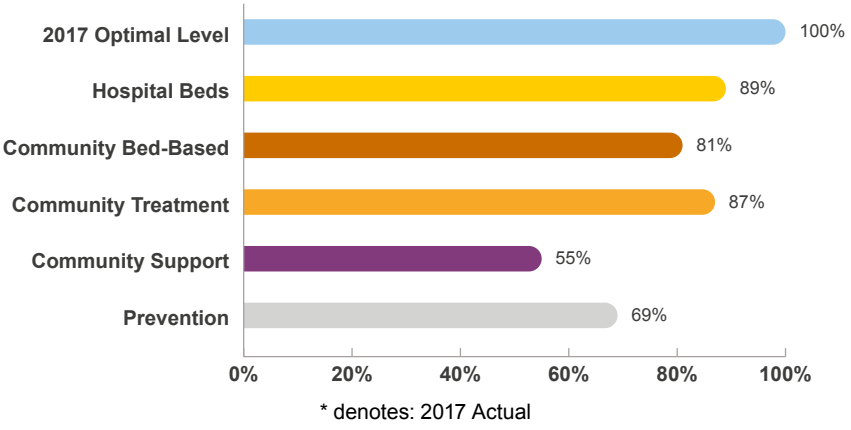
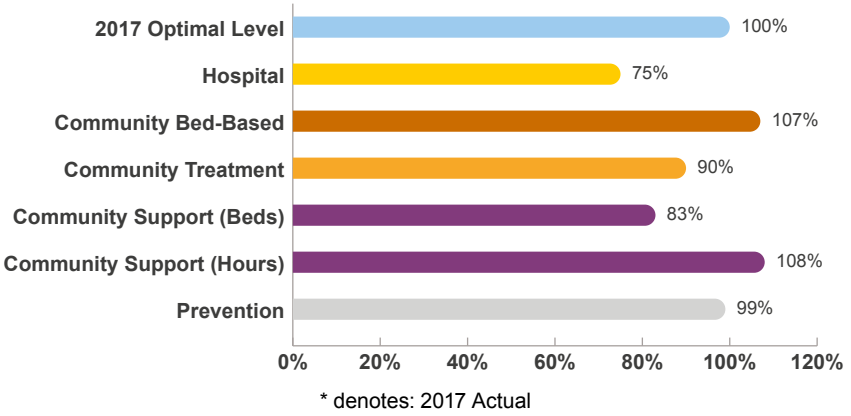


Figure 5: AOD – Current services* as a proportion of original 2017 optimal levels in the Plan



Revised Optimal Levels

The Plan identified estimated actual and optimal levels of service in the metropolitan area, across two geographical regions: North Metropolitan and South Metropolitan. Since the release of the Plan, and as a result of the *Health Services Act 2016*, the East Metropolitan Health Service has been formed. Whilst there are now three Metropolitan Health Services, the size of the geographical catchment for the metropolitan area has not changed. The Plan Update 2018 Matrix (see Section 7) now articulates estimated actual and optimal levels of service in the metropolitan region across three health service provider regions: North, South and East Metropolitan.

Key changes to optimal levels of services from the Plan by the end of 2025 are a result of:

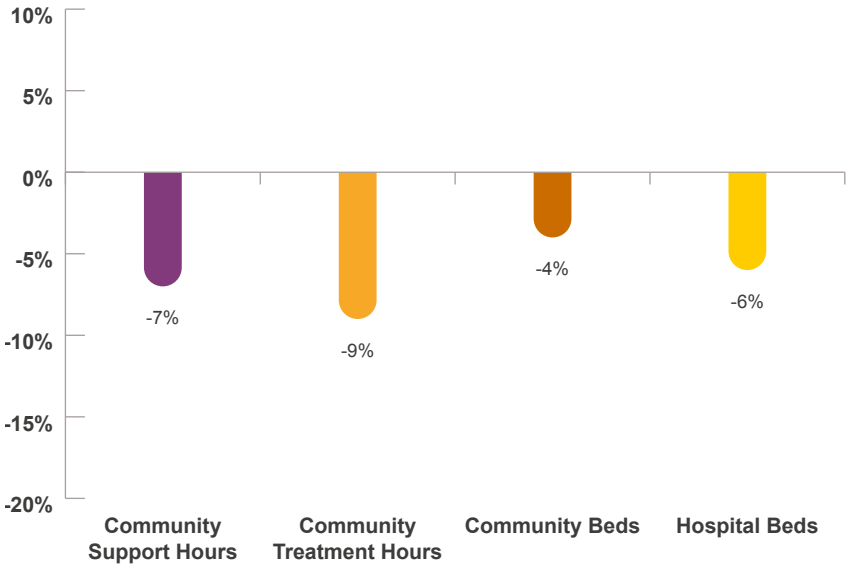
- a 7% reduction in Western Australian population estimates provided by the Department of Planning, Lands and Heritage (DPLH);
- revised weightings for the hospitalisation of Aboriginal people in Western Australia applied by the Australian Institute of Health and Welfare (AIHW) decreasing by 16%; and
- revised weightings applied by the Independent Hospital Pricing Authority (IHPA) increasing by 4% from 16% to 20% for remote areas and by 3% from 22% to 25% for very remote areas.

An updated version of the service matrix based on the revised modelled outputs and changes to optimal levels of service is provided on page 29.

Mental Health

Updated modelling demonstrates that optimal levels of service required for mental health services have decreased compared with the original estimates outlined in the Plan **(Figure 6)**.

Figure 6: Mental Health – Percentage change in 2025 optimal levels, compared with original 2025 estimates in the Plan



Whilst optimal levels are generally lower than originally estimated in the Plan, there is still a need for substantial growth across the prevention, community support and community treatment service streams as demonstrated in the figure.

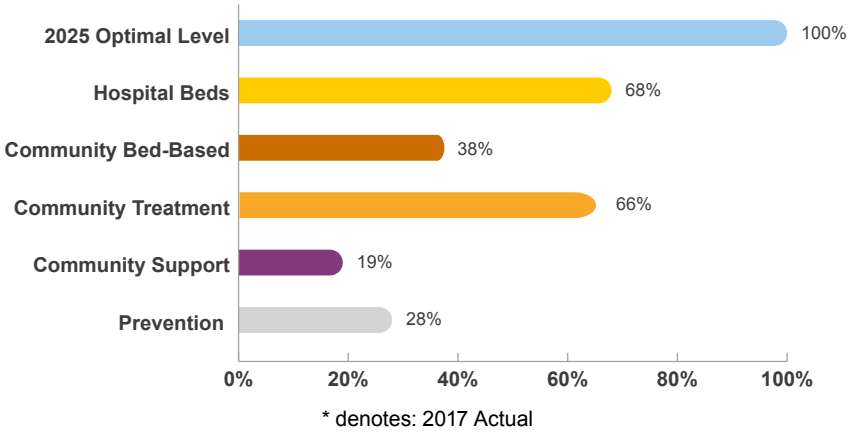
Current estimated levels of expenditure on mental health services continue to be heavily reliant on costly acute services and there is still a need to expand the system to boost community-based services and supported accommodation.

Figure 7 demonstrates that hospital and community treatment services require increases to meet the optimal level of services by the end of 2025. However, there continues to be a need to significantly increase investment in mental health promotion and prevention services, which is currently forecasted to meet 28% of optimal levels by the end of 2025. Community Support (19% of optimal levels) and Community Bed-Based (38% of optimal levels) also require a significant increase in expenditure to reach the modelled demand by the end of 2025.

In the absence of suitable alternatives, there remains a shortfall in supply in community-based services, and hence hospital services are currently experiencing higher demand. Hospital services will not experience excessive demand if all elements of the mental health and AOD service system are in balance and at reasonable levels relative to the optimal levels. While expanding services that focus on prevention, community-based care and supported accommodation will ultimately reduce the use of higher cost hospital-based services, responding to the increased demand remains a challenge within the context of a fiscally constrained environment.

Reducing hospital-based services to re-allocate funding to community services is not feasible in the current circumstance where demand already exceeds supply of hospital-based services. As more community-based services are established, demand will even out across services, and hospital services will not experience excess demand.

Figure 7: Mental Health – Current services* as a proportion of revised 2025 optimal levels



* denotes: 2017 Actual

Alcohol and Other Drugs

Figure 8 demonstrates the optimal levels of service required for AOD services, have decreased across all service streams, except community bed-based services, compared with the original estimates outlined in the Plan.

While expenditure in AOD services is more balanced, with some services reaching the 2017 optimal levels as identified in the Plan, there continues to be a need to increase services so that they meet optimal levels by the end of 2025.

Figure 8: AOD – Percentage change in 2025 optimal levels, compared with original 2025 estimates in the Plan

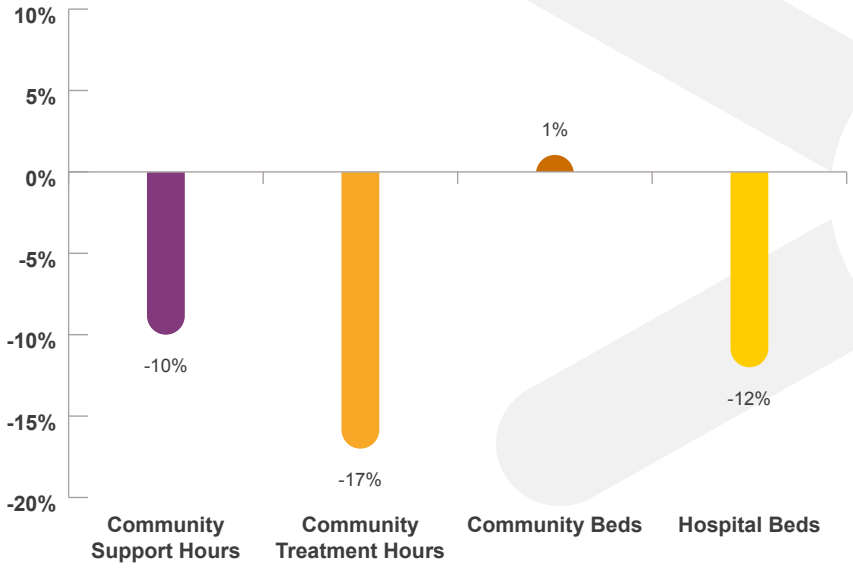
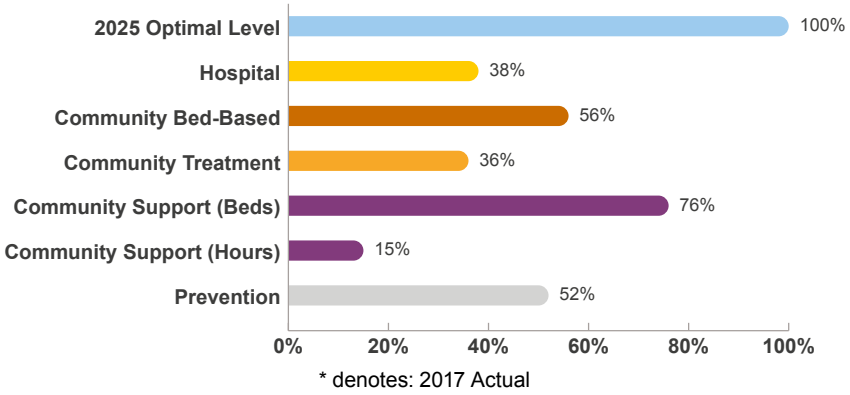


Figure 9 demonstrates that, to meet 2025 optimal level and mix of services, increases are required across all service streams, particularly for community support hours, community treatment and hospital-based services.

The Plan Update 2018 is an important first review in ensuring the most up to date modelling is used for future planning of mental health and AOD services in Western Australia. The Plan Update 2018 assists in laying the groundwork for the Plan's mid-term review, which is scheduled to commence in 2020. The mid-term review will include a comprehensive review of the modelling for all service streams and will address the evaluation objectives outlined in the Plan Evaluation Framework.

Figure 9: AOD – Current services* as a proportion of revised 2025 optimal level



Feedback on the Plan Update 2018

To ensure key stakeholders and consumers had an opportunity to contribute their thoughts and opinions of the Plan Update 2018, the Commission sought feedback in early 2019. Key stakeholders, including relevant peak and advisory bodies and government agencies were provided with an advance copy of the draft Plan Update 2018 in January 2019.

The draft Plan Update 2018 was released to the broader community for feedback on 26 February 2019, with the feedback period closing on 9 April 2019. Multiple platforms were used to elicit feedback on the draft Plan Update 2018, including:

- emails to key stakeholders inviting feedback on the draft Plan Update 2018;
- a Media Statement by the Minister for Mental Health announcing the release of the draft Plan Update 2018 for feedback;
- promotion of the feedback period on the Commission's website and Commission social media platforms including, Facebook and Twitter; and
- promotion via the Commission's newsletter, Commission engagement opportunities newsletter and the Mental Health Network newsletter.

A feedback guide, also hosted on the Commission's website, presented a range of questions to assist organisations in the development of their responses to the draft Plan Update 2018. Feedback could be provided by either email, reply paid post and/or by calling a dedicated phone number and leaving a recorded voice message.

A total of 26 submissions were received (the majority via email) and all submissions were classified into broad categories of respondent type. The content of each qualitative submission was logged and thematically analysed to elicit trends, using Pivot Tables. In general if the same or similar key subjects and issues were consistently raised by respondents or were frequently mentioned in responses (more than 6 times) it has been identified as a key feedback theme. Where relevant all feedback has been considered for inclusion in the Plan Update 2018, and/or to inform the scope of the mid-term review of the Plan, scheduled to commence in 2020.

Introduction

1.

Introduction

The Plan was released in December 2015 and outlines the optimal mix and level of mental health and AOD services required to meet the needs of Western Australians until the end of 2025.

The Plan sets the strategic direction for the mental health and AOD sector. It provides a guide for investment decisions and priority setting for the Commission and all levels of Government and non-government stakeholders. It is based on rigorous modelling and identifies the optimal mix of mental health, and AOD services required for the population of Western Australia.

The Plan includes an action for the Commission to revisit the service modelling framework every two years to ensure the latest evidence and population demographics are taken into account, and that the Plan's implementation remains responsive to emerging trends.

This Plan Update 2018 is the first remodelling of the optimal level and mix of services for the Western Australian mental health and AOD service system. At its foundation, the Plan Update 2018 uses two nationally agreed planning tools: the National Mental Health Services Planning Framework (NMHSPF); and the National Drug and Alcohol Service Planning Model (NDASPM).

In line with the Plan, the Plan Update 2018 details the service types, levels and locations required for mental health and AOD services until the end of 2025, based on the most current evidence regarding population, prevalence and epidemiology in Western Australia.

Revising activity targets, demographic data and resource estimates using the planning tools every two years helps to guide future investment in the right areas to the end of 2025, and keeps the Plan current and relevant. While the estimated optimal mix and levels of service have been revised, the Plan remains the primary reference for actions to drive mental health and AOD services development, particularly as it relates to strategic priorities.

The Plan Update 2018 provides: background information on changes in the strategic environment for the mental health and AOD sectors; an update of the service modelling presented in the Plan Matrix; and key reasons for any changes to the modelling. As the original time horizon in the Plan was 2017, the level of actual services has been determined as at 30 June 2017. Any additional achievements, or changes to action status and levels of service as at 30 September 2018 are also stated in this document, where appropriate.

Whilst recognising the inherently collaborative nature of the Commission's work with a wide range of stakeholders, the Plan Update 2018 outlines key achievements and challenges since the Plan was released in December 2015, primarily from the perspective of the Commission, aligned to the following service streams:

- Prevention services;
- Community support services;
- Community treatment services;
- Community bed-based services;
- Hospital-based services;
- Specialised statewide services;
- Forensic services; and
- System-wide reform.

The national planning tools do not provide modelled outputs for forensic services and do not contain comprehensively tested outputs for mental health and AOD prevention services. As such the 2015 modelling of services has been retained for these services in the Plan Update 2018. For all other service streams, the estimated requirement has been amended in line with updated Western Australian population projections, as at July 2017, sourced from the Western Australian DPLH in October 2017, and updated weightings for Aboriginal population and remoteness area estimates as provided by the IHPA.

The Commission's Outcome Based Management (OBM) has been restructured so that the Performance Management Framework reflects outcomes, services, and key performance indicators (KPIs) that consider both the service streams and future directions proposed by the Plan. The OBM is reported annually through Commission Annual Reports and Budget Papers.

The intention of the Plan Update 2018 is to revisit the service modelling framework and reflect Commission achievements. The mid-term review of the Plan will be a more comprehensive evaluation and include broader community consultation.

The mid-term review of the Plan is scheduled to commence in 2020 and will provide an update of the modelling for all service streams as well as further refinement of future priority areas and actions for service development.

The mid-term review will also address the objectives of the Plan's Evaluation Framework. The Plan's Evaluation Framework outlines key indicators for the key service streams covering inputs, outputs and outcomes featured in the Commission's Annual Reports and Budget Papers.

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 can be downloaded from the Commission's website: www.mhc.wa.gov.au

Overview of the Plan

2.

Overview of the Plan

Background

The Plan was launched on 7 December 2015 and was developed in response to a key recommendation of the Stokes Review[2] to develop a mental health clinical services plan.

The development of the Plan was a collaborative endeavour involving consumers of mental health and AOD services, their families and carers as well as service providers, clinicians, expert groups, and government and non-government agencies.

Extensive public consultation was undertaken in drafting the Plan. This involved more than 2,300 individuals and organisations across the State in the form of written submissions, an online survey, consultation forums, expert reference groups and other meetings and presentations.

The Plan uses nationally agreed modelling tools to estimate the optimal level and mix of mental health and AOD services over the short-term (by the end of 2017), medium term (by the end of 2020) and long term (by the end of 2025) to best meet the changing needs of a growing population.

The Plan is provider and funder neutral, articulating the types and levels of services required across the State without identifying the source of funding or the type of provider to deliver the service. By overlaying this modelling with information about current services, the Plan provides options for investment over a 10 year period from 2015 to 2025 that is consistent with the modelled demand.

The Plan is not prescriptive about how programs and services will be delivered, but rather provides a guide for investment decisions and priority setting for all levels of government and non-government stakeholders to act on the optimal mix of mental health and AOD services required in Western Australia. Subsequent investment required is dependent on Government's fiscal capacity and subject to Government approval through normal budgetary processes.

Optimal mix

The optimal mix shows the variety of services required across the whole service spectrum (e.g. community support, community treatment, hospital-based services and so on).

Optimal level

The optimal level shows how much of each service is required to meet 100 per cent of demand for a given population (e.g. number of service hours, number of beds). In the case of mental health services, it includes the level of service required to meet 100 per cent of the needs of people with a severe mental illness. In the case of AOD services, it includes the level of service required to meet the needs of people with mild, moderate and severe AOD problems.

[2] Government of Western Australia (2012). Review of the admission or referral to and discharge and transfer practices of public mental health facilities/services in Western Australia.

Reform Agenda

The Plan identifies the need for transformation and ongoing investment in Western Australia's mental health and AOD systems. Figure 10 below outlines the time horizons in the Plan.

On entering the second phase (by the end of 2020), it is intended that the system be rebalanced by investing in community-based services, in order to achieve the optimal service mix and best outcomes for individuals.

From 2013/14 to 2017/18, expenditure on mental health and AOD services increased by $152 million or 21%.

At present, expenditure on mental health services continues to be heavily weighted towards acute services. Whilst it is recognised that acute services form part of a comprehensive system, there is a continuing need to rebalance the system by expanding community-based and supported accommodation. Increasing access to community mental health and AOD services is aimed at helping keep people well, out of hospital and connected to their family, friends and community. However, until a more balanced system is developed, hospital services will continue to experience excess demand and, as a result, reducing hospital services to increase community services is not feasible. Increasing community-based services will even out demand across services, and hospitals will ultimately not experience excess demand.

Optimal Service Mix

Figure 11 shows the prevalence of mental health and AOD problems, subdivided into grades of severity and distress (labelled severe, moderate and mild). It is estimated that over 440,000 people will experience mental illness and almost 70,000 people will experience AOD-related problems, with different levels of severity and distress.

Individuals with mild mental illness will usually, in an optimal system, receive treatment from primary care providers (for example General Practitioners (GPs)). Those experiencing a moderate mental illness will receive treatment from primary care services and other private practitioners. These services include specialist interventions delivered by GPs, nurses and

Figure 10: Overview of system reform

allied health professionals with additional training in mental health. In the optimal mix, individuals with a mild or moderate mental illness are not expected to need specialist community services or inpatient services; however, it is understood this is currently not the case.

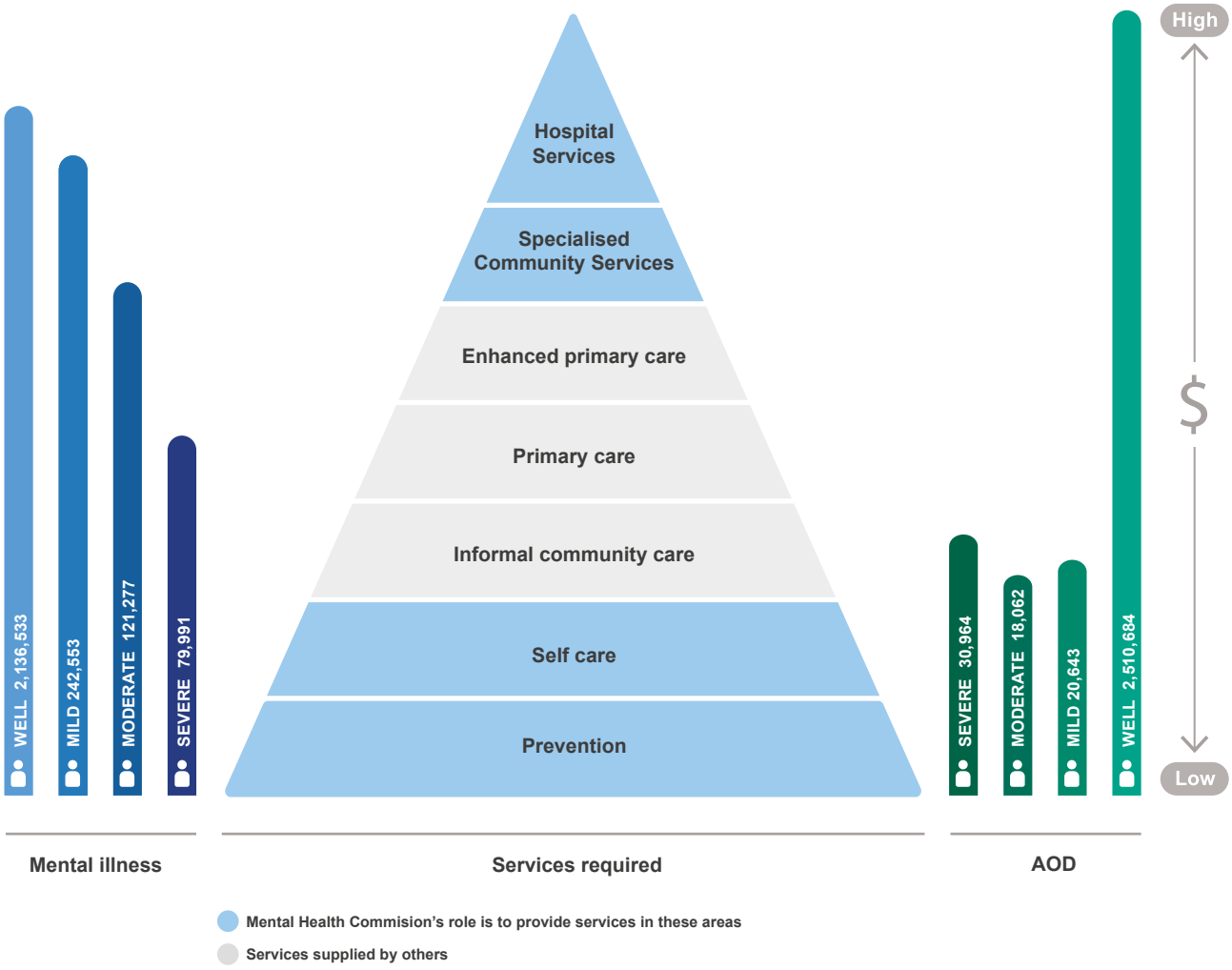
Individuals experiencing severe mental illness will require access to specialised community-based services (e.g. community support, community treatment and community beds) and inpatient services.

People with AOD problems (mild, moderate and severe) are predominately seen in publicly funded services, with few seeking treatment privately or in the Commonwealth funded primary care sector.

The Commission's role is to provide mental health and AOD services to the small proportion of the Western Australian population who experience severe mental illness and/or AOD issues in hospital and specialised community-based services.

In addition, the Commission provides prevention and promotion services to the general community. People who are well or experience mild or moderate mental illness or AOD problems will access treatment in the community from private or Commonwealth funded primary care services, as demonstrated in **Figure 11.**

Figure 11: Optimal service mix and severity continuum



Governance, Accountability and Reporting

Achieving widespread reform requires the commitment of all stakeholders.

This includes all levels of Government, the private and non-government sectors, health and social services. The support and genuine engagement of consumers, carers and their families in the co-design and co-production of programs and services is critical to achieving long term, sustainable system reform. The Commission has worked collaboratively with these stakeholders to progress implementation of the Plan and will continue to do so.

Implementation of reform activities has been monitored as part of ongoing organisational business planning and reporting, such as the Commission's Annual Report and ongoing data collection via the Mental Health Establishments National Minimum Data Set and the Alcohol and Other Drug Treatment Services National Minimum Data Set.

Providing ongoing updates on the progress of the Plan's implementation has been a key aspect of a number of local, regional and statewide governance structures in which the Commission participates. This includes partnership meetings with: the Department of Health (DoH); Health Service Providers; peak bodies; key non-government organisations (NGOs); the Mental Health Advisory Council; and the Alcohol and Other Drug Advisory Board. Progress on key projects are disseminated through Commission networks and provided through its website.

The Plan includes a commitment to revisit the modelling every two years. In addition the Plan outlines a commitment to complete a comprehensive mid-term review that will evaluate the appropriateness of the underlying performance framework and will refresh the actions related to implementing the Plan, including which actions remain a priority for implementing the Plan, as appropriate.

Performance Management Framework

Following the amalgamation of the Commission and the Drug and Alcohol Office on 1 July 2015, a review of the OBM reporting structure was conducted.

This review resulted in the development of a combined Performance Management Framework with outcomes, services, and KPIs that consider both the future directions proposed by the Plan and the range of activities previously undertaken by both agencies.

The KPIs contained within the OBM are used to assess the effectiveness and efficiency of services purchased by the Commission, and are categorised into service streams as outlined in the Plan.

The KPIs aim to: describe the current situation; help track performance and progress towards the objectives stated in the Plan; and act as a guide to inform decision making. They assist in assessing service performance and in informing consumers', service providers' and funders' impressions of services.

These KPIs are reported to the Department of Treasury, audited by the Office of the Auditor General and are made publicly available within the Commission's Annual Report. A summary of the Commission's KPIs is provided in **Appendix 4**.

The Commission's 2017-18 Annual Report is available at www.mhc.wa.gov.au. Future annual reports will also be made available via the Commission's website.

Current Strategic Context

3.

Current Strategic Context

The Plan progresses the implementation of State and National strategic priorities for the mental health and AOD sectors. The following documents, some of which have been released or updated since publication of the Plan in 2015, are key strategic references alongside the Plan:

- Mental Health 2020: Making it Personal and Everybody's Business;
- Suicide Prevention 2020: Together we can save lives (Suicide Prevention 2020);
- Fifth National Mental Health and Suicide Prevention Plan 2017-2022 (Fifth Plan);
- National Drug Strategy 2017-2026;
- First Interim State Public Health Plan for Western Australia;
- National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028;
- National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014-2019; and
- National Alcohol and other Drug Workforce Development Strategy 2015-2018.

In addition, the following strategic documents have been progressed by the Commission as early priority actions:

- Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (Prevention Plan);
- Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025 (Consumer, Family and Carer Engagement Framework);
- Western Australian Alcohol and Drug Interagency Strategy 2018-2022 (WAADIS);
- Draft Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025 (Accommodation and Support Strategy); and
- Draft Mental Health, Alcohol and Other Drug Strategic Workforce Strategic Framework: 2018-2025 (Workforce Strategy).

These strategic documents provide an important foundation and framework to ensure transparency and provide a robust guide for the Government and the Commission in prioritisation, resource allocation, evaluation and implementation of actions across the mental health and AOD sector.

A summary of key strategies related to the Plan, as well as those which have been updated or released are provided in **Appendix 1**.

The influences of recent changes to national strategic priorities are highlighted in later sections of this document, where relevant. Other State and Australian Government initiatives impacting on the implementation of the Plan are described in the next section.

State Government Initiatives

Mental Health Act 2014

The commencement of the *Mental Health Act 2014* (Act) in 2015 has resulted in new rights and protections for people experiencing mental illness and the promotion of recovery-oriented practice within mental health services.

In addition, the Act recognises the important roles of families and carers by providing rights to information and involvement.

Since the commencement of the Act, the Commission has focussed on providing guidance on legal issues that have arisen, compiling proposed amendments to the Act, and providing assistance to resolve operational issues.

Implementation of the Act is underpinned by a broad cultural shift in the management and treatment of those with mental health issues. The Act includes details of the treatment, care, support and protection of people who have a mental illness, the protection of their rights, and the recognition of the role of families and carers in providing the best possible care and support, in the least restrictive environment.

It is acknowledged that increased safeguards on the rights of consumers, families and carers may have increased the administrative requirements on mental health services. However, increased safeguards are considered essential and embody the 'spirit' of the Act, through protecting the rights of consumers and their personal support persons, and ensuring collaboration with and involvement in their treatment and care is mandated.

The Commission has completed a two year Post-Implementation Review (PIR) of the Act. The PIR focuses on the regulatory impact of the Act; in particular, whether the Objects set out in Part 3 of the Act are being achieved. The Objects provide for the treatment, care, support and protection of people who have a mental illness; the protection of the rights of people who have a mental illness; and recognition of the role of families and carers in providing the best possible care and support to people who have a mental illness, in the least restrictive environment.

A more comprehensive statutory review of the Act, to be commenced as soon as practicable after 30 November 2020, will evaluate the overarching operation and effectiveness of the Act and Mental Health Regulations 2015.

In undertaking the PIR, the Commission consulted with a wide range of stakeholders, including government and non-government agencies, peak bodies, advisory groups, mental health clinicians and staff, and consumers, families and carers.

Health Services Act 2016

On 1 July 2016, WA Health (DOH and the five Health Service Providers) underwent significant reform with the commencement of the *Health Services Act 2016*.

The Commission entered into bilateral agreements with the new Health Services Boards in 2016-17. These agreements adhere to the legal framework outlined in the *Health Services Act 2016* and provide a further mechanism for improvement and accountability in the delivery of public mental health services.

Mental Health Network

The Mental Health Network (MHN) was established in October 2014 as a partnership between DOH and the Commission. The aim of the MHN is to improve outcomes for people with mental health issues by enabling consumers, carers, health professionals, hospitals, health services, the Commission and DOH to engage and collaborate effectively to facilitate health policy and increase coordination of care across the State. The MHN currently includes 10 Sub Networks, in the areas of youth, eating disorders, forensic, perinatal and infant, multicultural, neuropsychiatry and developmental disability, older adult, personality disorders, Joondalup/Wanneroo region, and Peel and Rockingham/Kwinana region, with each coordinated by a Steering Committee.

On 1 July 2017, a transition process commenced to transfer the governance of the MHN from DOH to the Commission. To coincide with the transition process, the Commission coordinated a review of the MHN to examine the current structure and operations and to identify ways to optimise functions aligned to the overarching goal to support collaboration, reform and innovation across the mental health sector. The MHN has a dedicated page on the Commission's website which provides more information on the work of the MHN and a link to register as a member.

Public Sector Reform

Three Inquiries have been undertaken by the Government – the Special Inquiry into Government Programs and Projects (Langoulant Inquiry), the Service Priority Review and the Sustainable Health Review

The Commission is responding to the findings of the Langoulant Inquiry by ensuring transparency, robust project planning, business case development, evaluation and where possible, the simplification or standardisation of its procurement arrangements. The final report is available on the Public Sector Commission's website.

The Service Priority Review 'Blueprint for Reform', identifies four directions for reform, with 17 recommendations and 37 action items. The Commission is working with the Department of the Premier and Cabinet and other government agencies in the delivery of the reform directions. Ongoing, and strengthening, engagement with consumers, families and carers will be a major focus of the Commission's implementation of the reforms. The final report on the Service Priority Review is available on the website for the Department of the Premier and Cabinet.

The Sustainable Health Review will prioritise the delivery of patient centred, high quality and financially sustainable healthcare across the State. Following extensive engagement with stakeholders across Western Australia, the Sustainable Health Review Panel (SHR Panel) has published its Interim Report. The Interim Report presents the SHR Panel's initial observations, preliminary directions and recommendations for immediate action and areas for further work to develop a more sustainable Western Australian health system. The Commission has provided feedback to the SHR Panel for possible inclusion in the Final Report which was submitted to Government for consideration. The SHR Interim Report is available at DOH website.

The Commission remains focussed on best practice in matters of financial and risk management, governance, procurement, contract management, project planning and evaluation, relative to attendant scale, risk and complexity.

Methamphetamine Action Plan

There is significant community concern regarding the prevalence and impact of methamphetamine use. This is reflected in treatment data, which shows that amphetamine-type stimulants have overtaken alcohol as the primary drug for which people seek treatment.

The implementation of the State Government's Methamphetamine Action Plan has expanded the Commission's work in the AOD sector, as part of an across government effort to reduce the supply, demand and harms of methamphetamine use in Western Australia. The implementation of the Methamphetamine Action Plan has required significant investment from the Commission, for the coordination, development and implementation of initiatives to reduce the demand for, supply of and harm from methamphetamine. The development of these programs and services continue to be aligned to the Plan and the priorities of the State Government.

Further information regarding the Commission's contribution to implementing the Methamphetamine Action Plan is available on the Commission's website.

Supporting Communities Forum

The community services sector is a key government partner in the delivery of services and a significant contributor to economic growth, employment and community wellbeing, particularly for vulnerable Western Australians.

The Supporting Communities Forum's (Forum) function is to support implementation of the State Government's Supporting Communities Policy.

Membership of the Forum consists of senior leadership from government agencies and 14 leaders from the community services sector.

The State Government is committed to working with the community sector to maximise opportunities to deliver quality services by building a relationship based on partnership, collaboration and mutual respect between both sectors. This work will also support the directions of the Machinery of Government reforms and the recommendations emerging from the Service Priority Review. The Forum convenes four times per year, and reports regularly to the Community Safety and Family Support Cabinet Sub Committee and annually to the Premier. Further information is available on the DPC website.

Commonwealth Initiatives

WA Primary Health Alliance and Primary Health Networks

The Australian Government provides funding to Primary Health Networks (PHNs) to commission services in response to locally identified needs in line with the Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services[3]. Additionally, PHNs were funded to commission AOD services arising from the National Ice Taskforce's Final Report[4].

The WA Primary Health Alliance (WAPHA) oversees the strategic commissioning functions of the three Western Australian PHNs: Perth North, Perth South and Country WA.

The Commission is working collaboratively with WAPHA, particularly in relation to statewide planning and commissioning of services, including development of Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services.

Other priority areas for collaboration include improved service navigation and integration in the mental health and AOD sectors, and expanded training and engagement of GPs in managing mental health and AOD problems.

National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) has been introduced in Western Australia in stages and has involved the trialling of two models, the State delivered My Way NDIS (also known as Western Australian NDIS) and the federally delivered National Disability Insurance Agency (NDIA) NDIS.

Western Australia joined the nationally delivered NDIS on 1 July 2018. All current participants in the Western Australian NDIS are transferring from the Department of Communities to the nationally delivered scheme between April 2018 and 31 December 2018.

The NDIS will continue to roll out on a geographic basis and it is planned that it will be fully rolled out across Western Australia by the end of 2020.

The Commission will be carefully monitoring the impact of Western Australia's transition to the nationally delivered NDIS on individuals currently participating in Commission-funded programs, and the supports they receive.

The transition to the NDIS is complex and may affect different programs in various ways and to differing degrees, based on the eligibility assessment for individuals for NDIS within the programs. In response to this changing environment, a National Psychosocial Support Bilateral Agreement was developed to address the provision of psychosocial support funding for people with a mental illness, who are not eligible for the NDIS.

The Commission is working in partnership with WAPHA on the implementation of services using this funding, to ensure the initiative achieves positive outcomes.

[3] Commonwealth of Australia (2015a). Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services.
[4] Commonwealth of Australia (2015b). Final Report of the Prime Minister and Cabinet, National Ice Taskforce.

National Partnership Agreement on Homelessness

The 2017-18 Commonwealth Budget identified significant changes to housing and homelessness funding arrangements post June 2018.

From 1 July 2018, the current funding under the National Affordable Housing Agreement and the National Partnership Agreement on Homelessness will be combined to fund a new National Housing and Homelessness Agreement (NHHA).

The NHHA will target jurisdiction-specific priorities including supply targets, planning and zoning reforms, renewal of public housing stock and supporting the delivery of frontline homelessness services. Bilateral schedules will be developed, with clear targets aimed to ensure each State is accountable for outcomes that recognise the different housing markets across the jurisdictions.

As in previous years, there will be a continued focus on people affected by domestic violence and vulnerable young people who are homeless or at risk of homelessness.

The Department of Communities is the lead agency responsible for the development of a Western Australian Homelessness Strategy to support the implementation of NHHA.

Prioritising and Progressing Actions

4.

Prioritising and Progressing Actions

The Plan is highly ambitious, recommending comprehensive service expansion and systemic change.

Changes relating to system reform require long term planning and implementation. To reflect this, as well as implementing existing commitments, actions within the Plan are phased over three time horizons, by the end of 2017, 2020 and 2025.

Some of the factors that have influenced the prioritisation and progression of the actions in the Plan include:

- the prioritisation of investment is focussed on areas and services of highest need;
- clinical safety and human rights remain a priority;
- planning time, including sufficient time for ongoing meaningful involvement of consumers, families and carers and thorough options analysis;
- establishment of achievable timeframes;
- interdependencies between actions;
- where practical, reconfiguration and improvement of existing services is undertaken prior to focussing on additional investment;
- consideration of economies of scale when implementing small programs, and programs in areas of small populations; and
- transparency and accountability in relation to decision making and the delivery of the actions and outcomes of the Plan.

Achievements

5.

Achievements

The Plan includes a total of 187 actions and sub actions across seven service streams and the system-wide reform section.

A total of 112 actions or sub actions were identified for completion by the end of 2017. Of these actions, 27 (24%) were fully completed, 75 (67%) were in progress and 10 (9%) were pending, as detailed in **Figure 12.**

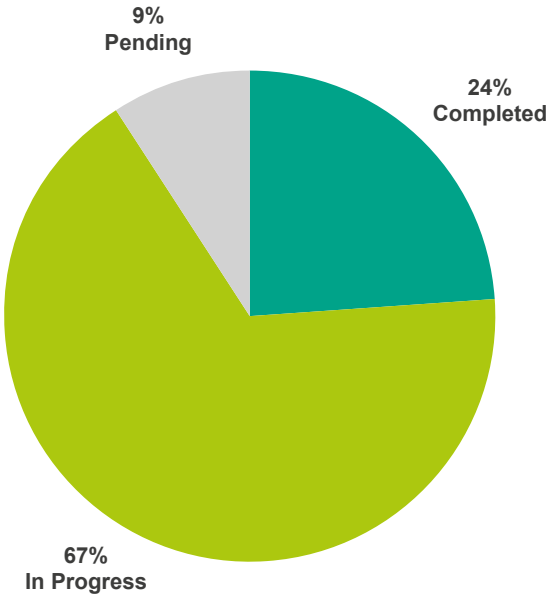
As at 30 September 2018, of the 112 actions and sub actions due for completion by the end of 2017, 44 (39%) were fully completed, 58 (52%) were in progress and 10 (9%) were pending.

A number of actions scheduled for completion by the end of 2017 have been identified as having ongoing strategic and operational actions across the life of the Plan, and therefore cannot be marked as 'completed'. Rather these are allocated 'in progress'. For example, actions such as 'continuing to support effective systemic advocacy organisations' (action 75), and 'progressing the development of community partnerships to optimise the health and wellbeing of people with mental health and AOD problems' (action 34) are considered ongoing actions and are therefore allocated as 'in progress'.

The Commission is committed to continuing to implement these actions in collaboration with stakeholders over the longer term rather than as time limited actions. Reporting on actions that have been identified as ongoing areas of investment across service streams will continue in the Commission's ongoing reporting, including future updates of the Plan.

The implementation status of each of the 2017 Plan actions as at 30 June 2017 is provided in **Appendix 2.**

Figure 12: Implementation status of 2017 actions at 30 June 2017



Modelling Update

6.

Modelling Update

Background

The Plan details the service types, levels and regional locations required by the end of 2025, based on population, prevalence and epidemiology, and was predicated on the nationally recognised planning tools: NMHSPF and the NDASPM[5].

The demand modelling process involves the application of statistical methods, epidemiological data, evidence-based practice and stakeholder expertise to estimate the type and quantity of service need, based on population size and features. Further information regarding the modelling process can be found in Appendix 3 Technical Notes.

The Plan Matrix 2018 has been developed using updated Western Australian population projections, July 2017, sourced from the Western Australian DPLH in October 2017 - and updated weightings for Aboriginal population and remoteness area estimates as provided by the IHPA.

The Plan Update 2018 was developed using the same versions of the NMHSPF and the NDASPM applied in developing the Plan.

Western Australia was the first jurisdiction in Australia to use the NMHSPF for its 10 year statewide strategic planning document. Since the release of the Plan in 2015, the Commission has been collaborating with other jurisdictions on further refining the NMHSPF.

The Plan Update 2018 describes how the modelling for each of the service streams presented in the Plan has changed, the optimal levels required by the end of 2025 and how current levels of service are tracking in relation to these revised optimal levels of service.

The modelling tools' outputs are provided in hours of service, hours of support or bed numbers as a proxy for the levels of service that will be provided in any given location. The exact location and distribution of services at an operational level will continue to be determined by a combination of consultation processes and the assessment of relative feasibility to deliver the service.

Actuals 2017

As the original time horizon in the Plan was 2017, the level of actual services has been determined as at 30 June 2017 using a number of methodologies. Where possible, the number and location of beds for 2017 were based on an actual count of beds maintained by funding to State Government Health Service Providers and to NGOs.

The calculation of hours of service for mental health and AOD community support and community treatment services was a more complex task requiring an analysis of growth in the Commission's budget from 2013-14 to 2016-17, (estimated at 16.39%) adjusted for growth in the wage price index during this period.

The Commission embarked on the development of the Plan Update 2018 with the intention of using the Integrated Atlas of Mental Health and Alcohol and Other Drugs of Western Australia - Volume I and II (Atlas) resource, a jointly funded project by the Commission and WAPHA. The Atlas Project aims to map all Western Australia's mental health and AOD actuals against the optimal mix of services outlined in the Plan.

[5] Excludes use of separate modelling for Aboriginal population as per the Plan 2015 due to application limited to adult alcohol treatment only.

The quality of data used by the Atlas has been extensively reviewed to determine if the data can be confidently utilised for this purpose. Due to the limitations of the methodology there are challenges with determining actuals, therefore in its current format the Atlas is best utilised to assist in identifying service duplication within regions. To further determine actuals the mid-term review of the Plan will aim to align the classification of services in the Atlas to the NMHSPF and NDASPM, ensuring that both mental health and AOD services' planning tools are able to be used together in future Plan updates.

A significant change in the Plan Update 2018 is the inclusion of the East Metropolitan Health Service region. The East Metropolitan Health Service was not established when the Plan was released in 2015 and the introduction of the East Metropolitan Health Service by the enactment of the Health Services Act 2016 in July 2016 is reflected in the remodelled matrix for the Plan Update 2018. Where possible, estimates of current levels of service as at 30 June 2017, and of optimal levels at future time horizons 2020 and 2025, were calculated across the North, South and East Metropolitan Health Services based on population and catchment areas.

There are limitations to the estimated actuals in the Plan Update 2018, as a result of the addition of the East Metropolitan Health Service and the inability to utilise the Atlas.

Revised 2025 Modelling

Key changes to optimal levels of service by the end of 2025 from the Plan are a result of:

- a 7% reduction in Western Australian population estimates provided by the DPLH;
- revised weightings for the hospitalisation of Aboriginal people in Western Australia applied by the AIHW decreasing by 16%; and
- revised weightings applied by the IHPA increasing by 4% from 16% to 20% for remote areas and by 3% from 22% to 25% for very remote areas.

While the overall state population estimate has decreased by 7%, the age profile of the population has also changed due to an ageing population. For example, in the Plan, older adults were estimated to account for 14.9% of the 2025 population. This has increased to 17.6% in the Plan Update 2018. As a result, areas with a higher proportion of older adults receiving services, for example, community support and bed-based services, are not impacted as significantly by the reduced population estimates. Services comprised of a large proportion of youth, have a greater reduction in the estimated services required.

To reach optimal levels, the proportional increases for each service stream from 2020 to 2025 remain the same or similar to those outlined in the Plan.

The impact of revised modelling on the optimal level of services by the end of 2025, as shown in the Plan Matrix 2018 (see page 33) is shown in **Figure 13** and **Figure 14**[6]**.**

Mental Health

Changes to the estimated demand for mental health services at the end of 2025 shown in **Figure 13** highlight a relatively minor reduction compared to the modelling estimate provided in the Plan, including:

- a decrease in community support hours (7% or 394,000 hours);
- a decrease in community treatment services (9% or 330,000 hours);
- a decrease in community bed-based services (4% or 36 beds); and
- a decrease in hospital beds (6% or 60 beds).

Overall, the updated modelling indicates that compared to the Plan optimal levels for 2025, there is a slight decrease in the levels of mental health services required to meet the optimal levels over the life of the Plan. These variations reflect a 7% reduction to the estimate of the total population of Western Australia by 2025 and a 2.7% increase in the proportion of the population over 65 years.

Figure 14 demonstrates that despite minor reductions in optimal levels of mental health services, there is still a need to increase service provision across all service streams by the end of 2025, but particularly for prevention, community support and community bed-based services.

[6] These changes are relative to the previous estimates of optimal levels as at 2025, not relative to the actual levels as at 2017.

The updated modelling continues to highlight that further investment in community support and community bed-based services is required to close the gap between current and optimal levels. Rebalancing the mental health system can be achieved by focusing investment in community services over time but would require funding to grow at a stronger rate than for hospital bed-based and community treatment services.

There remains a shortfall in supply in community-based services, and in the absence of suitable alternatives, hospital services are currently experiencing higher demand. Hospital based services will not experience excess demand if all elements of the mental health and AOD service system are in balance and at reasonable levels relative to the optimal levels. While expanding services that focus on prevention, community-based care and supported accommodation will ultimately reduce the use of higher cost hospital-based services, responding to the increased demand remains a challenge within the context of a fiscally constrained environment. Reducing hospital-based services to reallocate funding to community services is not feasible in the current circumstance where demand already exceeds supply of hospital-based services. As more community-based services are established, demand will even out across services, and hospital services will not experience excess demand.

Figure 13: Mental health - Percentage change in 2025 optimal levels, compared with original optimal levels in the Plan

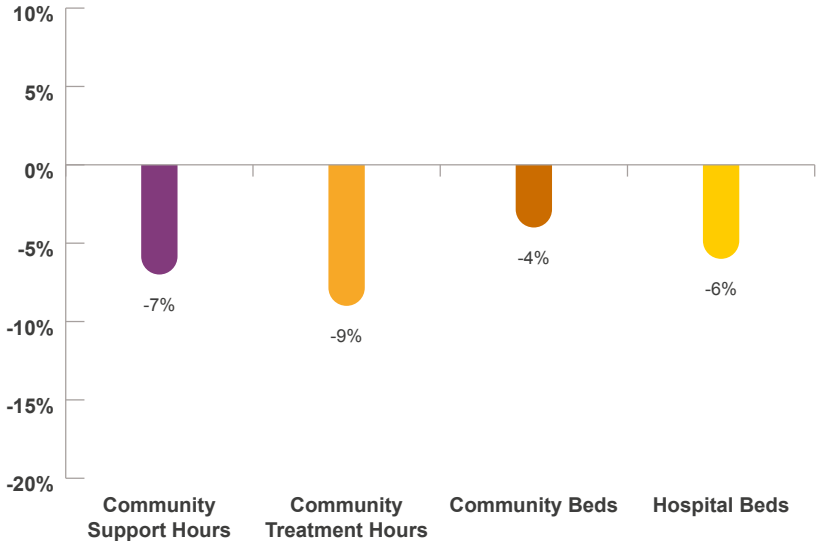
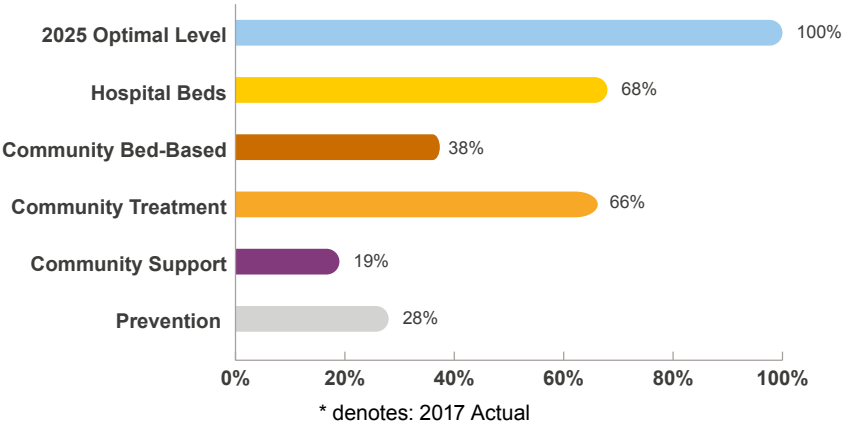


Figure 14: Mental health – Current services* as a proportion of revised 2025 optimal levels



Alcohol and Other Drugs

Changes to the estimated demand for AOD services at the end of 2025 shown in **Figure 15** highlight some increases and decreases compared to the modelling estimate for 2025 provided in the Plan, including:

- a decrease in community support hours (10% or 26,000 hours);
- a decrease in community treatment services (17% or 360,000 hours);
- an increase in community bed-based services (1% or 8 beds); and
- a decrease in hospital beds (12% or 14 beds).

Revisions to the modelling of required levels of AOD services are mostly the result of changes to the estimated rate of population growth (a decrease of 7%) and reduced weightings applied to rural and regional areas (increases from 3% to 25%) and Aboriginal population groups (a decrease of 16%).

In addition, the 17% decrease to required levels of AOD community treatment services by the end of 2025 has resulted from a correction to the double counting of screening and brief intervention services in the 2015 modelling.

The 1% increase in AOD community-bed-based services is the average of a decrease in low medical withdrawal beds resulting from a reduced population estimate for 2025; and from an increase in residential rehabilitation beds resulting from the inclusion of bed activity related to the use of cannabis and benzodiazepines not reflected in the 2015 modelling.

Expenditure across community and hospital-based services in the AOD sector is more balanced compared with the mental health sector. The remodelling indicates that optimal levels of community-based AOD support and treatment services to meet population needs over the life of the Plan have decreased from initial modelling, while there is a slight increase in numbers of community beds required

Whilst optimal levels for AOD services are generally lower than originally estimated in the Plan, there is still a need for substantial growth across the prevention, community support (hours) and community treatment service streams (Figure 16).

Across the AOD and mental health sectors, there is still a need to increase services, particularly in community support and community treatment.

Figure 15: AOD – Percentage change in 2025 optimal levels, compared with original estimates in the Plan

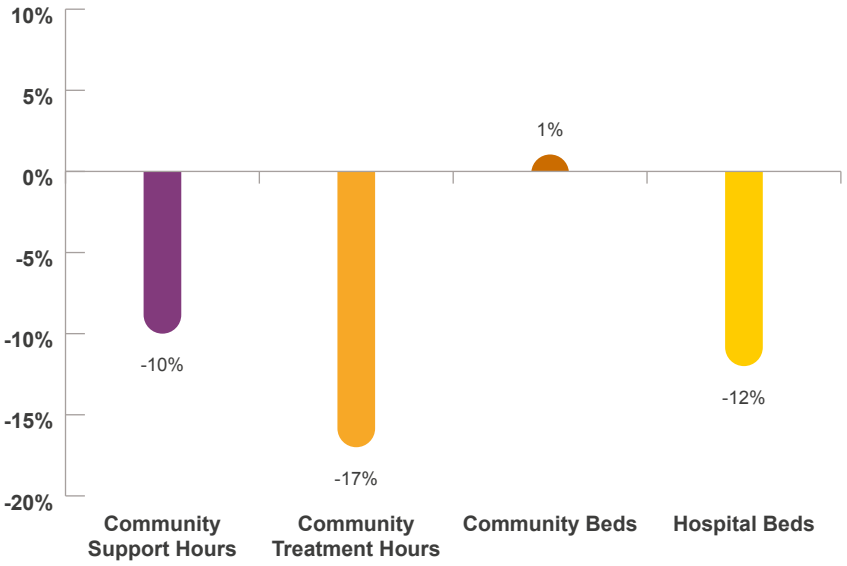
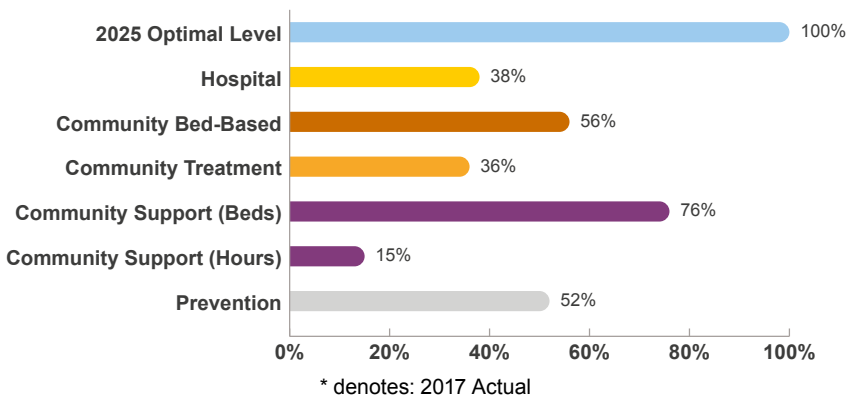


Figure 16: AOD – Current services* as a proportion of revised 2025 optimal levels



7. Plan Update 2018 Matrix

Service Type		State Total				Statewide Services				Graylands				East Metropolitan				North Metropolitan				South Metropolitan			
		2013 Actual	2017 Actual	2020 Optimal	2025 Optimal	2013 Actual	2017 Actual	2020 Optimal	2025 Optimal	2013 Actual	2017 Actual	2020 Optimal	2025 Optimal	2013 Actual	2017 Actual	2020 Optimal	2025 Optimal	2013 Actual	2017 Actual	2020 Optimal	2025 Optimal	2013 Actual	2017 Actual	2020 Optimal	2025 Optimal
Prevention and Promotion	Hours ('000) (total)	66	107	192	208	52	85	112	122	-	-	-	-	-	-	4	4	-	-	4	4	-	-	3	3
MH *	Percentage	1.0%	1.4%	4.0%	5.0%	1.0%	1.4%	4.0%	5.0%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AOD	Hours ('000)	66	107	192	208	52	85	112	122	-	-	-	-	-	-	4	4	-	-	4	4	-	-	3	3
Community Support Services	Hours ('000) (total)	847	916	3,144	5,124	2	2	49	54	-	-	-	-	1	1	805	1,318	1	1	807	1,322	1	1	717	1,175
	Beds (total)	242	256	312	338	-	-	-	-	-	-	-	-	30	30	38	52	7	7	35	35	10	10	30	42
MH	Hours ('000)	842	910	2,935	4,892	-	-	-	-	-	-	-	-	-	-	762	1,270	-	-	765	1,275	-	-	681	1,134
AOD (Harm reduction and personal support)	Hours ('000)	5	6	209	232	2	2	49	54	-	-	-	-	1	1	43	48	1	1	42	47	1	1	36	40
AOD (Post Residential Rehabilitation) **	Beds	74	74	107	133	-	-	-	-	-	-	-	-	16	16	21	35	7	7	35	35	10	10	18	30
AOD (Safe places for intoxicated people)	Beds	168	182	205	205	-	-	-	-	-	-	-	-	14	14	17	17	-	-	-	-	-	-	12	12
Community Treatment Services	Hours ('000) (total)	2,713	2,933	4,113	5,129	-	-	-	-	-	-	-	-	756	818	1,077	1,340	844	912	1,090	1,345	535	579	943	1,171
MH Infant, Child and Adolescent	Hours ('000)	373	404	1,179	1,388	-	-	-	-	-	-	-	-	96	104	306	360	118	128	314	369	84	91	267	314
MH Youth	Hours ('000)	339	366	379	408	-	-	-	-	-	-	-	-	91	98	98	106	112	121	107	107	80	86	86	92
MH Adult	Hours ('000)	1,200	1,297	1,054	1,067	-	-	-	-	-	-	-	-	299	323	285	285	369	399	281	281	262	284	240	240
MH Older Adult	Hours ('000)	236	255	481	566	-	-	-	-	-	-	-	-	68	73	117	138	84	91	121	142	60	64	120	141
AOD - All (non-residential treatment)	Hours ('000)	565	611	1,020	1,700	-	-	-	-	-	-	-	-	204	220	270	451	160	173	267	445	50	54	230	384
Community Bed-Based Services	Beds (total)	639	794	1,179	1,705	-	-	-	-	-	-	-	-	235	245	361	445	186	239	326	443	84	118	216	394
MH Community Based Beds	Beds	281	328	548	873	-	-	-	-	-	-	-	-	145	167	223	223	62	67	113	225	24	40	103	207
AOD - Low Medical Withdrawal	Beds	14	27	32	46	-	-	-	-	-	-	-	-	14	19	12	12	-	-	7	12	-	4	6	10
AOD - Residential rehab	Beds	344	439	598	786	-	-	-	-	-	-	-	-	76	59	126	209	124	172	206	206	60	74	106	177
Hospital Based Services	Beds (total)	710	761	863	1,094	45	41	42	45	176	177	157	-	219	234	270	274	112	131	162	274	94	116	145	245
	Hours ('000) (total)	218	265	479	525	35	38	61	61	-	-	-	-	56	61	110	122	50	55	109	121	74	81	96	106
MH Infant, Child and Adolescent	Beds	26	19	20	26	26	19	20	19	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MH Youth Acute	Beds	-	14	26	74	-	-	-	-	-	-	-	-	-	-	12	20	-	-	-	19	-	14	14	17
MH Youth Subacute/Non-acute	Beds	-	-	-	12	-	-	-	-	-	-	-	-	-	-	-	4	-	-	-	4	-	-	-	3
MH Youth HITH***	Beds	-	8	10	21	-	-	-	-	-	-	-	-	-	-	1	6	-	8	8	6	-	-	1	5
MH Adult Acute	Beds	384	404	396	358	-	-	-	-	54	54	54	-	120	143	135	96	78	77	77	94	68	68	68	80
MH Adult Subacute/Non-acute	Beds	102	79	59	76	-	-	-	-	82	67	47	-	20	12	12	20	-	-		20	-	-		17
MH Adult HITH***	Beds	12	32	61	109	-	-	-	-	8	16	16	-	-	-	15	29	4	16	16	29	-	-	8	24
MH Older Adult Acute	Beds	144	144	144	84	-	-	-	-	32	32	32	-	62	62	62	20	24	24	24	21	26	26	26	21
MH Older Adult Subacute/Non-acute	Beds	-	-	-	122	-	-	-	-	-	-	-	-	-	-	-	30	-	-	-	31	-	-	-	31
MH Older Adult HITH***	Beds	-	8	19	52	-	-	-	-	-	8	8	-	-	-	6	13	-	-	2	13	-	-	3	13
Mental Health Observation Area (MHOA)	Beds	6	14	32	56	-	-	-	4	-	-	-	-	-	-	8	16	6	6	16	16	-	8	8	16
MH Private ^	Beds	231	269	269	269	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-	-	-	-	-
AOD (High/Complex Medical Withdrawal) incl private ^^	Beds	36	39	96	103	19	22	22	22	-	-	-	-	17	17	19	22	-	-	19	21	-	-	17	18
MH/AOD Consultation Liaison	Hours ('000)	218	265	479	525	35	38	61	61	-	-	-	-	56	61	110	122	50	55	109	121	74	81	96	106
Specialised Statewide Services (inpatient) ****	Beds (total)	8	16	50	65	8	16	16	65	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Eating Disorders	Beds	-	-	34	40	-	-	34	40	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Perinatal beds	Beds	8	16	16	25	8	16	16	25	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Forensic Services	Beds (total)	38	37	37	92	-	-	-	92	38	37	37	-	-	-	-	-	-	-	-	-	-	-	-	-
	Hours ('000) (total)	83	90	212	302	33	36	112	140	-	-	-	-	11	12	19	31	1	1	4	7	19	20	20	30
MH Acute Hospital	Beds	30	30	30	62	-	-	-	62	30	30	30	-	-	-	-	-	-	-	-	-	-	-	-	-
MH Subacute Hospital	Beds	8	7	7	30	-	-	-	30	8	7	7	-	-	-	-	-	-	-	-	-	-	-	-	-
MH Community	Hours ('000)	33	36	112	140	33	36	112	140	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AOD Community (Diversion)	Hours ('000)	50	54	100	163	-	-	-	-	-	-	-	-	11	12	19	31	1	1	4	7	19	20	20	30
Forensic Services (in-prison)	Beds (total)	-	-	70	70	-	-	70	70	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
In-prison MH/AOD beds	Beds	-	-	70	70	-	-	70	70	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

NOTES

* Percentage of total Commission budget.

** In the Plan 2015 this was reported as hours of service. It was deemed more appropriate to report as beds for the Plan Update 2018.

*** HITH beds are a substitution for both Acute and Subacute/Non-acute hospital beds. HITH beds by age cohort was not available in 2015 but are provided in Plan Update 2018.

**** Specialised Statewide Services refer to those services that are accessible to the entire State's population, but may be located in one specific location (e.g. the metropolitan area).

^ Current MH private beds, unknown whether they will grow and are not reflected in Hospital Bed-Based Services sub-total.

^^ AOD private beds were separately calculated in 2015. As services provided in the private sector are similar, they are treated as the same service. AOD private beds are included in total Hospital Based Bed Total.

MH = Mental Health
AOD = Alcohol and Other Drugs
n/av: Data is not available.
n/a: Data is not applicable.
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Note: Some total columns may not add, due to rounding.
Note: Exact locations and distributions will be determined by a combination of consultation process and the assessment of relative feasibility to deliver the service.
Note: All hours are reported as "hours of service". Mental Health Community Support is the only exception, with the hours represented as "hours of support".
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Define: Hours of Service: includes face-to-face time between consumers/carers and staff, travel time, and time for other duties such as administrative requirements, training and research.
Note: The 2012-13 mental health community support actuals (as outlined in the matrix) were determined by the Mental Health Commission. Please note that further work is required in the analysis of the actuals figures which may result in some variance, therefore impacting on the service gap identified.
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Note: 2013 residential rehabilitation figures revised as part of audit of services.

Plan Update 2018 Matrix continued

Service Type		State Total				Statewide Services				Northern and Remote								Southern Country						
										Northern and Remote Total				Goldfields	Kimberley	Pilbara	Midwest	Southern Country Total				Great Southern	South west	Wheatbelt
		2013 Actual	2017 Actual	2020 Optimal	2025 Optimal	2013 Actual	2017 Actual	2020 Optimal	2025 Optimal	2013 Actual	2017 Actual	2020 Optimal	2025 Optimal	2025 Optimal	2025 Optimal	2025 Optimal	2025 Optimal	2013 Actual	2017 Actual	2020 Optimal	2025 Optimal	2025 Optimal	2025 Optimal	2025 Optimal
Prevention and Promotion	Hours ('000) (total)	66	107	192	208	52	85	112	122	12	17	38	42	10	12	9	10	2	5	31	33	10	12	10
MH *	Percentage	1.0%	1.4%	4.0%	5.0%	1.0%	1.4%	4.0%	5.0%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AOD	Hours ('000)	66	107	192	208	52	85	112	122	12	17	38	42	10	12	9	10	2	5	31	33	10	12	10
Community Support Services	Hours ('000) (total)	847	916	3,144	5,124	2	2	49	54	-	-	390	639	135	159	176	169	-	-	376	616	122	333	161
	Beds (total)	242	256	312	338	-	-	-	-	185	199	194	194	22	89	52	32	10	10	14	14	3	8	4
MH	Hours ('000)	842	910	2,935	4,892	-	-	-	-	-	-	371	619	131	154	170	163	-	-	356	594	118	321	156
AOD (Harm reduction and personal support)	Hours ('000)	5	6	209	232	2	2	49	54	-	-	19	21	4	5	6	6	-	-	20	22	4	13	5
AOD (Post Residential Rehabilitation) **	Beds	74	74	107	133	-	-	-	-	31	31	18	18	4	5	6	4	10	10	14	14	3	8	4
AOD (Safe places for intoxicated people)	Beds	168	182	205	205	-	-	-	-	154	168	176	176	18	84	46	28	-	-	-	-	-	-	-
Community Treatment Services	Hours ('000) (total)	2,713	2,933	4,113	5,129	-	-	-	-	288	311	531	683	145	180	190	167	290	313	472	590	117	321	152
MH Infant, Child and Adolescent	Hours ('000)	373	404	1,179	1,388	-	-	-	-	32	35	161	190	43	54	48	44	43	46	131	154	31	84	39
MH Youth	Hours ('000)	339	366	379	408	-	-	-	-	26	28	49	57	12	16	16	13	31	33	39	46	9	25	12
MH Adult	Hours ('000)	1,200	1,297	1,054	1,067	-	-	-	-	124	134	134	147	30	39	45	33	145	157	114	114	22	63	29
MH Older Adult	Hours ('000)	236	255	481	566	-	-	-	-	8	8	47	55	13	10	11	22	17	19	76	89	18	46	25
AOD - All (non-residential treatment)	Hours ('000)	565	611	1,020	1,700	-	-	-	-	98	106	140	233	47	62	70	54	54	58	112	187	36	103	48
Community Bed-Based Services	Beds (total)	639	794	1,179	1,705	-	-	-	-	98	134	165	219	46	55	62	57	36	58	111	204	40	110	53
MH Community Based Beds	Beds	281	328	548	873	-	-	-	-	14	18	52	104	22	24	27	30	36	36	57	115	23	61	31
AOD - Low Medical Withdrawal	Beds	14	27	32	46	-	-	-	-	-	2	4	6	1	2	2	1	-	2	3	5	1	3	1
AOD - Residential rehab	Beds	344	439	598	786	-	-	-	-	84	114	109	109	22	29	33	25	-	20	51	84	16	47	21
Hospital Based Services	Beds (total)	710	761	863	1,094	45	41	42	45	21	19	31	133	27	32	37	38	43	43	55	121	23	66	32
	Hours ('000) (total)	218	265	479	525	35	38	61	61	3	8	55	61	13	15	18	15	-	23	49	54	11	29	14
MH Infant, Child and Adolescent	Beds	26	19	20	26	26	19	20	19	-	-	-	4	1	1	1	1	-	-	-	3	1	2	1
MH Youth Acute	Beds	-	14	26	74	-	-	-	-	-	-	-	10	2	3	3	2	-	-	-	8	2	4	2
MH Youth Subacute/Non-acute	Beds	-	-	-	12	-	-	-	-	-	-	-	1	-	-	1	0	-	-	-	1	-	1	0
MH Youth HITH***	Beds	-	8	10	21	-	-	-	-	-	-	-	3	1	1	1	1	-	-	-	2	-	1	1
MH Adult Acute	Beds	384	404	396	358	-	-	-	-	21	19	19	49	10	13	15	11	43	43	43	38	7	21	10
MH Adult Subacute/Non-acute	Beds	102	79	59	76	-	-	-	-	-	-	-	11	2	3	3	2	-	-	-	8	2	5	2
MH Adult HITH***	Beds	12	32	61	109	-	-	-	-	-	-	2	15	3	4	5	3	-	-	4	12	2	6	3
MH Older Adult Acute	Beds	144	144	144	84	-	-	-	-	-	-	-	8	2	1	2	3	-	-	-	13	3	7	4
MH Older Adult Subacute/Non-acute	Beds	-	-	-	122	-	-	-	-	-	-	-	12	3	2	2	5	-	-	-	19	4	10	5
MH Older Adult HITH***	Beds	-	8	19	52	-	-	-	-	-	-	-	5	1	1	1	2	-	-	-	8	2	4	2
Mental Health Observation Area (MHOA)	Beds	6	14	32	56	-	-	-	4	-	-	-	4	-	-	-	4	-	-	-	-	-	-	-
MH Private ^	Beds	231	269	269	269	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AOD (High/Complex Medical Withdrawal) incl private ^^	Beds	36	39	96	103	19	22	22	22	-	-	10	11	2	3	3	3	-	-	8	9	2	5	2
MH/AOD Consultation Liaison	Hours ('000)	218	265	479	525	35	38	61	61	3	8	55	61	13	15	18	15	-	23	49	54	11	29	14
Specialised Statewide Services (inpatient) ****	Beds (total)	8	16	50	65	8	16	16	65	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Eating Disorders	Beds	-	-	34	40	-	-	34	40	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Perinatal beds	Beds	8	16	16	25	8	16	16	25	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Forensic Services	Beds (total)	38	37	37	92	-	-	-	92	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Hours ('000) (total)	83	90	212	302	33	36	112	140	12	13	35	58	12	17	12	16	7	8	22	37	9	16	12
MH Acute Hospital	Beds	30	30	30	62	-	-	-	62	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MH Subacute Hospital	Beds	8	7	7	30	-	-	-	30	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MH Community	Hours ('000)	33	36	112	140	33	36	112	140	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AOD Community (Diversion)	Hours ('000)	50	54	100	163	-	-	-	-	12	13	35	58	12	17	12	16	7	8	22	37	9	16	12
Forensic Services (in-prison)	Beds (total)	-	-	70	70	-	-	70	70	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
In-prison MH/AOD beds	Beds	-	-	70	70	-	-	70	70	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

NOTES

* Percentage of total Commission budget.

** In the Plan 2015 this was reported as hours of service. It was deemed more appropriate to report as beds for the Plan Update 2018.

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Note: 2013 residential rehabilitation figures revised as part of audit of services.

Update by Service Stream

8.

Prevention Services

Mental health and AOD prevention refers to initiatives and strategies to reduce the incidence and prevalence of mental health problems and delay the uptake and reduce the harmful use of AOD and associated harms. Mental health promotion strategies aim to promote positive mental health and resilience.

Our annual investment in Prevention Services was

$20.5m in 2017-18

In 2017-18 the Commission invested $20.5 million in prevention services, a decrease of 9% or $1.9 million since the last Pre-Plan year (2013-14).

Expenditure in Prevention Services has reduced by 9% since 2013-14, due to a number of factors, including reduced funding and expenditure for some federally funded programs and efficiencies found within the Commission as a result of the amalgamation of the Drug and Alcohol Office with the Commission and the Agency Expenditure Review.

Key Achievements since the release of the Plan

Implemented AOD and mental health campaigns.

10 new suicide prevention community coordinator positions established across the state.

Developed and released the Mental Health, Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025.

The Commission continues to support a range of evidence-based prevention initiatives aimed at the whole population and specific priority target groups.

Strategies include:

- public education campaigns such as the Alcohol.Think Again, Strong Spirit Strong Mind Metro Project, Meth Can Take Control and Think Mental Health campaigns;
- creation of supportive environments for example, through monitoring of liquor licensing applications; and
- building community capacity to promote optimal mental health, and prevent mental illness, suicide and AOD harm through training for communities.

Modelling Update – Prevention Services

As national planning tools do not contain modelling that have been comprehensively tested to guide an optimal level of service for prevention the 2015 modelling for mental health and AOD prevention services has been retained for the Plan Update 2018.

Current services compared with 2025 estimates

The Plan includes targets for the proportion of the Commission's budget that should be dedicated to mental health prevention and promotion activity and the hours of service dedicated to AOD prevention strategies required by the end of 2025 as recommended by expert reference groups. The mid-term review of the Plan will review the modelling for prevention services.

Mental Health

The Plan identified the need for the proportion of the Commission's budget dedicated for mental health prevention and promotion services to increase to 2% by the end of 2017 and 5% by the end of 2025. **Figure 17** shows that the proportion of the Commission's budget allocated to mental health prevention and promotion was 1.4% in 2017 (a 40% increase from 2013 actuals). This includes additional funding of $25.9 million from 2015-16 to 2018-19 to continue implementation of the State suicide prevention strategy for Western Australia – Suicide Prevention 2020.

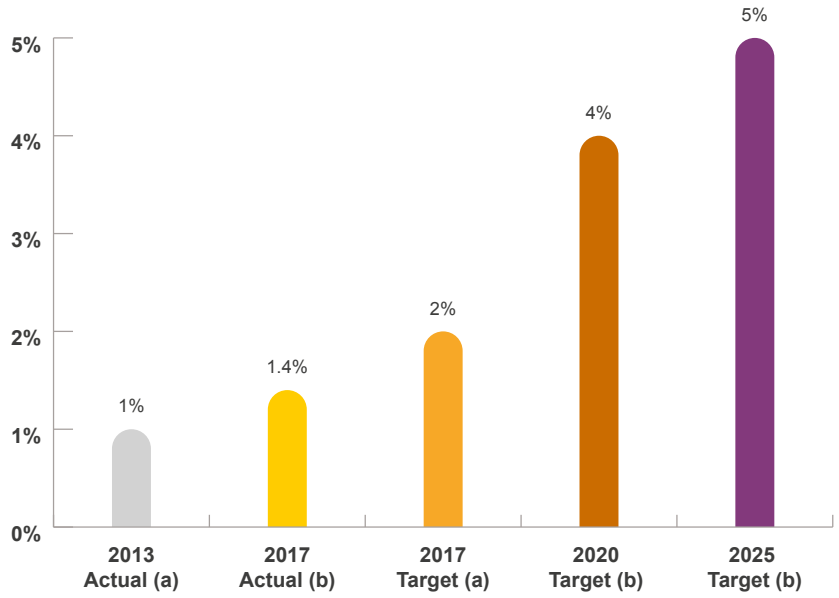
Alcohol and Other Drugs

The Plan outlined the need to increase optimal hours of service for AOD prevention to 108,000 by the end of 2017, increasing to 208,000 hours by the end of 2025. **Figure 18** shows an estimated 107,000 hours of service were provided in 2017 and that a growth of 94% (an additional 101,000 hours) is required to achieve optimal levels of 208,000 hours by the end of 2025.

Changes to current levels of service from 30 June 2017 to 30 September 2018

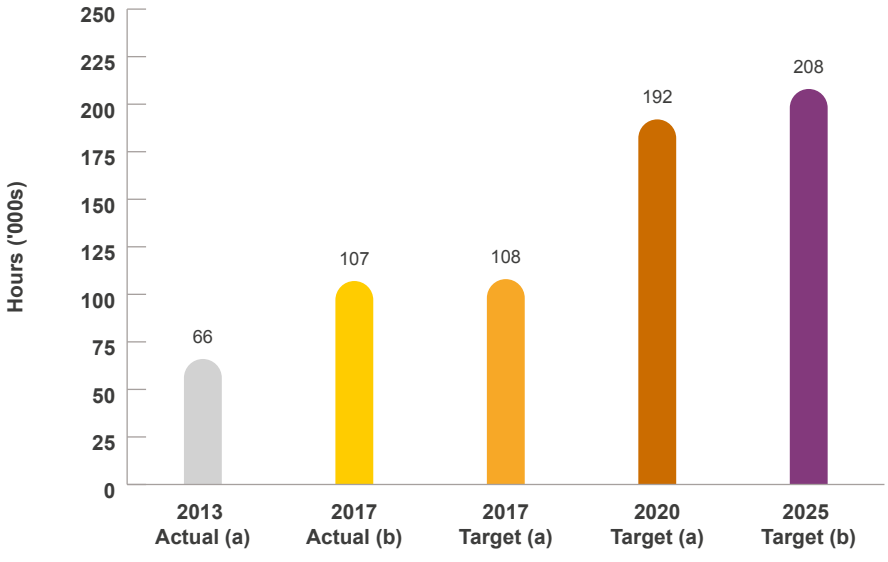
While expenditure between 2016/17 and 2017/18 for mental health prevention and promotion services has not reduced, the proportion of the Commission's budget dedicated to mental health prevention has decreased from 1.4% at 30 June 2017 to 1.3% at 30 June 2018. This is largely due to an increase to the overall mental health budget, resulting in a reduced proportion of investment in mental health prevention and promotion services.

Figure 17: Mental health – Prevention – Actual levels of service and targets



(a) Plan and (b) Plan Update

Figure 18: AOD – Prevention – Actual levels of service and targets



(a) Plan and (b) Plan Update

Achievements – Prevention Services

Effective strategies for prevention services can include raising community awareness of mental health issues and AOD-related harms, the creation of supportive environments and communities that are also low-risk, enhancing healthy community attitudes and skills, and building the community's capacity to address mental health and AOD problems.

A central achievement in both the mental health and AOD areas is the development and release of the Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (Prevention Plan) in October 2018.

The Prevention Plan provides an overview of the recommended programs, strategies and initiatives that promote optimal mental health, can reduce the incidence of mental illness, and suicide, and prevent and/or reduce drug use and harmful alcohol use. It provides an evidence-based and informed guide for government, non-government and the community to assist with the planning and promotion of prevention activities. The implementation of evidence-based and evidence-informed strategies as presented in the Prevention Plan will help to guide future investment in prevention and promotion initiatives across the State.

A summary of achievements in the Prevention Service Stream to 30 June 2017 is provided in **Figure 17**.

Mental Health

The Commission's focus on suicide prevention continues, guided by Suicide Prevention 2020.

The Commission will support and help guide the introduction of a multilevel, multifactorial systems approach to suicide prevention across Western Australia, that aligns to the Fifth Plan.

These initiatives and other mental health promotion activities that have been implemented include (but are not limited to):

- Annual provision of suicide prevention grants to community organisations, which boost community capacity for suicide prevention, particularly focussing on at risk groups;
- Continuation of the Response to Suicide and Self-Harm in Schools Program, providing specialist staff and support to schools to address depression, self-harm and grief that occurs following suicide attempts and suicide;
- Contracting the Centre For Transformative Work Design to deliver the statewide Thrive@Work Strategy, which encompasses a comprehensive set of mental health support resources for Western Australian workplaces;
- Implementation of the Regional Men's Health Project to provide suicide prevention education to rural and remote communities;
- Establishment of 10 new Suicide Prevention Community Coordinator positions across the State to act as a central point for communication, to assist services on the ground to build their capacity in suicide prevention and work in partnership to improve support and care for those affected by suicide and intentional self-harm;
- Implementation of a social and emotional wellbeing training program for Aboriginal people across Western Australia, by the Aboriginal Health Council of Western Australia (the peak body for Aboriginal Medical Services in the State), with training expected to be completed in the Central Desert, Perth Metro, Southwest and the Goldfields regions by the end of 2018; and
- A continued focus on community-based prevention services by commissioning initiatives that support the promotion of mental health and work to reduce suicide in the community, such as:
    - 360 Health + Community;
    - Act Belong Commit;
    - Anglicare WA;
    - Beyondblue;
    - Lifeline WA;
    - MATES in Construction WA; and
    - Youth Focus.

Additional Achievements to 30 September 2018

- Launch of the Think Mental Health campaign, targeting men aged 25-54 years old and their family and friends, with the initial post-campaign evaluation yielding positive results. Future bursts of the campaign are scheduled, with ongoing evaluation in place; and
- Drug Aware was established in 1996 as part of a state framework of educational strategies designed to address illicit drug use among young people in Western Australia. The Drug Aware education program encourages help seeking and acknowledges that stigma creates barriers to people getting help earlier. As such the program does not use judgemental language or inappropriate stereotypes in campaign and other education materials.

Alcohol and Other Drugs

The Commission continues to deliver a range of AOD prevention initiatives, including the statewide AOD public education campaigns: Drug Aware, Alcohol.Think Again and Strong Spirit Strong Mind Metro Project.

The campaigns include public awareness education and training, television advertisements, digital media, radio and outdoor media.

The Commission's prevention activities include:

- The Drug Aware Meth Can Take Control campaign, which achieved greater awareness in its first and second years than any previous Drug Aware campaign. The third year evaluation found that this high rate of awareness had been sustained;
- High rates of awareness of the Meth Helpline campaign amongst parents, family and friends of those at risk of or using methamphetamine;
- High rates of awareness amongst Western Australians (73% in 2017) of national low-risk drinking guidelines;
- Evaluation of the Strong Spirit Strong Mind campaign in 2017, which found 83% of young Aboriginal people were more aware of AOD harms;
- Assisting with the development, implementation, review and evaluation of AOD management plans (AODMPs) that seek to address local AOD-related harm across the State;
- Continued monitoring of liquor licence applications across the State and investigating matters regarding the potential for, and minimisation of, alcohol-related harm and ill-health;
- Developing and implementing a public education campaign to communicate secondary supply law changes to parents, young people, and industry prior to school leavers' celebrations;
- Contributing to the implementation of the *Misuse of Drugs Amendment (Psychoactive Substances) Act 2015*; and
- Expanding public education campaigns, school based programs and target initiatives for at risk young people incorporating a greater focus on AOD overdose prevention.

Additional Achievements to 30 September 2018

- A new Drug Aware Safer Events and Venues Campaign developed and scheduled throughout the 2017/18 music festival season aimed to reduce illicit drug-related harm at high-risk settings including music festivals, events and night venues. The first year evaluation found that the campaign was effective in influencing the safety behaviour of event patrons;
- New Drug Aware Illicit Drug Prevention Campaign launched in September 2018, linking young people at risk of drug use to credible information on illicit drugs and related health effects and risks;
- Study published in April 2018 demonstrating the value of the Alcohol.Think Again 'Parents, Young People and Alcohol' program and its ability to continuously produce high performance campaigns;
- Continued expansion of amphetamine treatment and support across the metropolitan area with the development of a Model of Care and resource kit for amphetamine treatment and support; and
- Increased service awareness and promotion of harm-reduction information through the establishment and management of a youth specific Next Step Community Alcohol and Other Drug Services (CADS) Facebook page.

Current Strategic Context – Prevention Services

A number of significant achievements have been made in the mental health and AOD prevention space to impact sustained behaviour change.

There has been encouraging progress with increasing knowledge, attitudes/beliefs and intentions to change behaviour in regards to harmful alcohol use.

Evaluations have shown that sustained behaviour change is challenged by competing environmental influences such as how and where alcohol is made available in the community and the drinking culture. These factors make it difficult for drinkers to abstain from, or reduce, their alcohol consumption.

There are challenges to effectively monitor and evaluate knowledge, attitudes/beliefs and intentions for behaviour change and overall program effectiveness of prevention programs at a statewide level, given the difficulty in attributing the impact of individual programs.

There have previously been a number of prevention initiatives funded for a finite period. However, increased funds to expand mental health and AOD initiatives have contributed to significant improvements.

As mentioned in achievements, the Prevention Plan is a key strategic document that will guide the future provision and delivery of mental health promotion, mental illness prevention and AOD prevention initiatives and services across the State, including the activities of the Commission.

Future Directions – Prevention Services

In accordance with the Plan, additional investment in evidence-based and evidence informed prevention initiatives will be focussed on areas such as (but not limited to):

- Public awareness education;
- Supporting regional and remote areas across the State to develop, implement and evaluate AODMPs;
- Building community capacity to develop, implement and evaluate mental health promotion, mental illness and suicide prevention activities;
- Monitoring liquor licensing applications and providing information to inform Licensing Authority decisions to reduce alcohol-related harm to communities;
- Developing and supporting safe and healthy settings to reduce alcohol related harm to communities;
- Future suicide prevention planning for Western Australia will be developed in line with the Fifth Plan, which includes consideration of culturally secure strategies in suicide prevention;
- Promoting community connection and social inclusion, pre-natal and early years resilience building; and
- Conducting a review of Commission funded services against the recommendations of the Prevention Plan to identify gaps in prevention services and guide future investment for delivering evidence-based or informed prevention services.

Table 1: Summary of Plan Matrix, Prevention

Service Type		State Total				
		2013 Actual (a)	2017 Target (a)	2017 Actual (b)	2020 Target (b)	2025 Target (b)
Prevention and Promotion						
MH*	Percentage	1.0%	2.0%	1.4%	4.0%	5.0%
AOD	Hours ('000)	66	108	107	192	208

(a) 2015 Plan and (b) Plan Update 2018

* Percentage of total Commission budget.

Community Support Services

Community support services include programs that help people to identify and achieve their personal goals and include:

- personalised support programs;
- peer support;
- initiatives to promote good health and wellbeing;
- home in-reach support to attain and maintain housing;
- family and carer support (including support for young carers and children of parents with a mental illness);
- flexible respite;
- individual advocacy services; and
- AOD harm-reduction programs.

Our annual expenditure in Community Support was

$44.8m in 2017-18

In 2017-18 the Commission spent $44.8 million in community support services. This is a decrease of 7% ($3.2 million) since 2013-14.

Expenditure in community support services has reduced by 7% since 2013-14 due to a number of factors, including efficiencies found through the Agency Expenditure Review, and also the closure of Franciscan House Licensed Private Psychiatric Hostel (Franciscan House), resulting in the transfer of funding and expenditure associated with a number of the former residents, to community-bed-based services. Regardless, the Commission has continued to focus on improving the quality of services provided in the community services sector.

Key Achievements since the release of the Plan

A co-designed model of service for Recovery Colleges has been developed.

Residents from Franciscan House were successfully relocated to alternative supported accommodation.

A pilot to deliver peer support and mentoring to at risk LGBTI+ youth has been established.

The service elements of the community support service stream featured in the Plan include:

Mental health community support services:

- individual and group based services, and subsidised schemes;
- modern recovery focused services, including in-reach services;
- support for people living in hostels and other independent living arrangements;
- examples include Individualised Community Living Strategy (ICLS) and Project 50; and
- personalised independent accommodation and supportive landlord services.

AOD harm-reduction and personal support services:

- needle and syringe programs; and
- overdose prevention programs including the peer naloxone project.

AOD post residential rehabilitation:

- short to medium term accommodation in the community;
- home in-reach support;
- individual support and recovery services; and
- includes support through the Transitional Housing and Support Program (THASP).

AOD safe places for intoxicated people:

- includes sobering up centres.

Modelling Update – Community Support Services

Changes to 2025 optimal levels

Figure 19 outlines changes to optimal levels of community support services required by the end of 2025 compared with original optimal levels in the Plan.

Mental Health

The Plan indicated a requirement for mental health community support[7] hours to increase to 5.29 million hours by the end of 2025. The updated modelling shows that the optimal requirement for mental health community support services by the end of 2025 has decreased by 7% to 4.89 million hours (**Figure 19**). The assumption that the Commonwealth and State fund approximately 50% each has been maintained.

The change to the optimal level of mental health community support service from the Plan is the result of a 7% decrease in the population estimate for 2025.

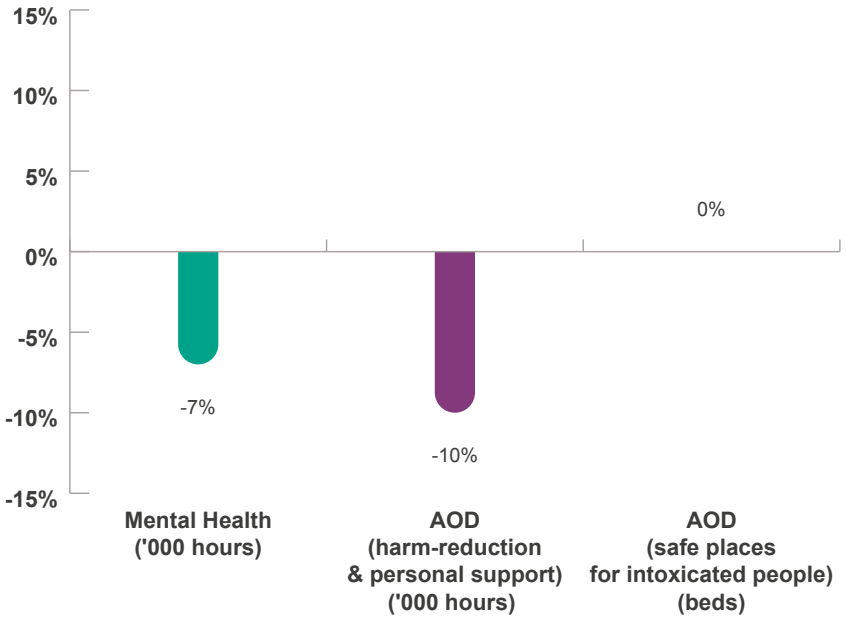
Alcohol and Other Drugs

The modelling from the Plan indicated a requirement for community support services for AOD harm-reduction to increase to 258,000 hours of service by the end of 2025. Updated modelling for the Plan Update 2018 shows the optimal level by the end of 2025 has decreased by 10% to 232,000 hours (**Figure 19**) in line with changes to estimates of population growth and weightings applied in the modelling to regional and Aboriginal population groups.

AOD post residential rehabilitation services such as transitional housing programs were shown in the Plan as hours of service. The AOD sector consistently and more accurately describes the capacity of this service element using bed numbers and this is now reflected in the Plan Update 2018 matrix with 133 beds required by the end of 2025.

As modelling for safe places for intoxicated people did not form part of the modelling tool, optimal levels have not been revised since the release of the Plan in 2015, with an estimated 205 beds required by the end of 2025 **(Figure 19).**

Figure 19: Community Support – Percentage change in 2025 optimal levels, compared with original optimal levels in the Plan



[7] Mental health hours of support include service provider and consumer face-to-face time only

Current services compared with 2025 estimates

Estimates of current levels of community support services compared with updated optimal levels by the end of 2025 are outlined in **Figures 20 and 21**.

Mental Health

While the level of services has increased from 842,000 to 910,000 from 2013 to 2017, mental health community support services are required to increase more than four-fold to 4.89 million hours, by the end of 2025 to reach optimal levels (**Figure 20**).

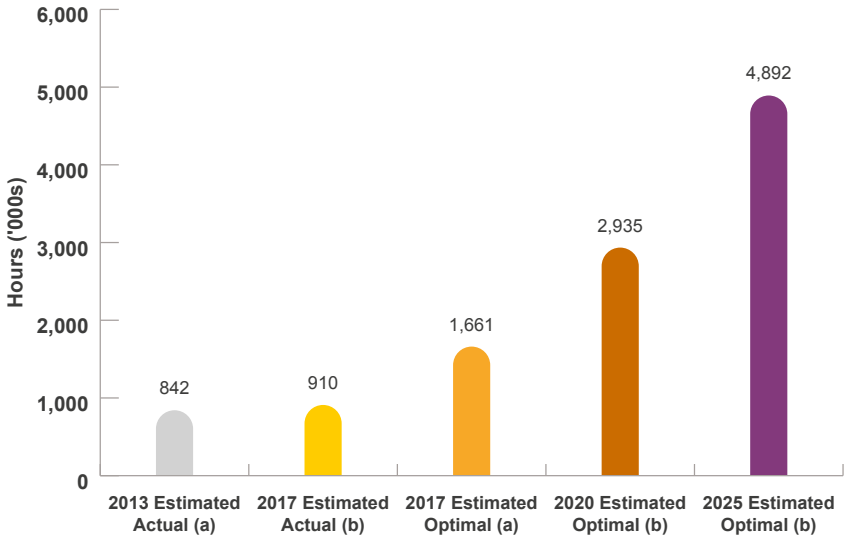
Alcohol and Other Drugs

Compared with estimated actuals in 2017 of 6,000 hours, significant expansion of 226,000 hours in AOD harm-reduction and personal support is required, to reach optimal levels by the end of 2025 (**Figure 21**).

Figure 21 shows 74 post residential rehabilitation beds were provided in 2017 with an increase of 80% or 59 beds required to reach the optimal number of 133 beds by the end of 2025.

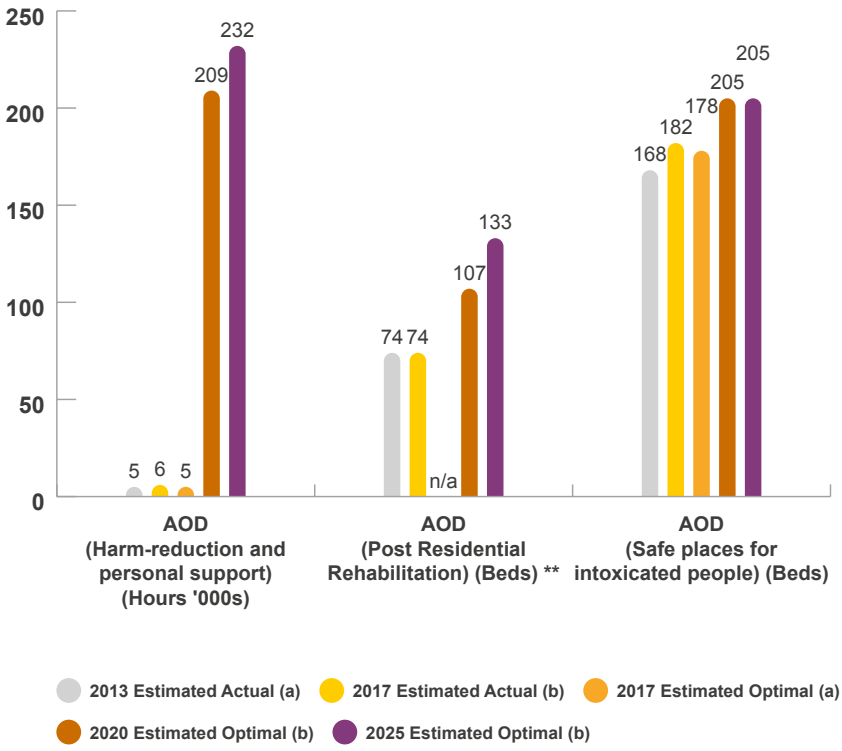
A 13% (23 beds) growth is required to reach the optimal number of 205 beds by the end of 2025 for AOD safe places for intoxicated people (also known as sobering up centres).

Figure 20: Mental health – Community Support – Optimal and actual levels of service



(a) 2015 Plan (b) Plan Update 2018

Figure 21: AOD – Community Support – Optimal and actual levels of service



(a) 2015 Plan (b) Plan Update 2018

** In the 2015 Plan, this was reported as hours of service, it was deemed more appropriate to report as beds as part of the Plan Update 2018.

Achievements – Community Support Services

Strategic priorities in the Plan for community support services aim to keep people connected and close to home, and rebalance the focus of the system towards community support services for people experiencing mental health and AOD issues. The Commission's key achievements as at 30 June 2017 are outlined below.

Mental Health

- Recommendations from the evaluation of the ICLS program that supports people with severe mental illness to live independently in the community, including supporting broader opportunities for social inclusion, were incorporated into the Commission's service provider agreements upon renewal;
- Redesign of community support services, including the establishment of a Recovery House which provides a 15 week intensive residential program personalised to support an individual's recovery journey;
- Continued participation by the Commission in strategic partnerships to support people with complex needs. This includes chairing the Interagency Executive Committee (IEC) for Adults with Extremely Complex Needs (previously People with Extremely Complex Needs) and participating in the IEC for the Young People with Extremely Complex Needs Program. Both these committees include representation from the NDIA in order to support effective transition to the NDIS;
- The Commission, WAPHA and Youth Focus have worked collaboratively to establish the Wheatbelt Tele-health Counselling Pilot Project that provides e-counselling via Skype to three high schools in the Wheatbelt; and
- Implementation of peer support weekend workshops for rural and remote LGBTI+ by the WA AIDS Council's Freedom Centre.

Additional Achievements to 30 September 2018

- Released the draft Accommodation and Support Strategy for public consultation. The draft Accommodation and Support Strategy outlines a range of contemporary approaches to the delivery of mental health and AOD accommodation and support services;
- The co-design of an evidence-based Recovery College Model of Service[8] in Western Australia, which aims to create positive change and hope through bringing together individuals from various backgrounds and communities in a safe and welcoming learning environment to share experiences to support personal recovery and promote social and emotional wellbeing and physical health; and
- Securing alternative accommodation and supporting 70 residents following the closure of a psychiatric hostel to access public mental health services and community managed organisations, by working collaboratively and engaging with individuals to keep them housed in the community and improve the recovery focussed quality of their care.

[8] Australian Healthcare Associates (2018). Literature Review to inform the development of Recovery Colleges in Western Australia.

Alcohol and Other Drugs

- Establishment of the Meth Helpline run by counsellors to provide 24 hour support and referral to treatment services for anyone seeking help for their own or another person's methamphetamine use;
- Provision of a Meth Peer Education Support Program to increase the capacity of peer educators to effectively provide early intervention and harm-reduction education and information for individuals who are currently using methamphetamine or who are at risk of using;
- Continuation of the Western Australian Peer Naloxone Project following positive evaluation findings by the National Drug Research Institute, indicating that 32 lives were saved that may have otherwise been fatalities;
- Development of training resources for AOD and other frontline workers to improve recognition of, and response to, amphetamine intoxication/toxicity and opioid overdose;
- Expansion of the Parent and Family Drug Support (PFDS) service to include the Be SMART program that assists parents cope with the challenges of supporting a person who has an AOD issue. This program complements the peer led Parent Support Groups provided by PFDS;
- Continuation of the Alcohol and Drug Support Service (ADSS) community call back support line for those who have undertaken AOD withdrawal at Sir Charles Gairdner Hospital; and
- Continuation of the THASP with $2.5 million funding from 2016-17 to 2018-19.

Additional Achievements to 30 September 2018

- Continued provision of the Meth Helpline; and
- Initiation of the Pharmaceutical Opioid Dependence Pathway in response to changes to the Scheduling of codeine nation-wide from Schedule 3 to Schedule 4 (i.e. from over the counter to prescription only).

Current Strategic Context – Community Support Services

Quality Services

In order to ensure Western Australians with mental health problems or mental illness receive the best available evidence-based care, with the best value for money given scarce resources, the Commission continues to implement the Quality Evaluation Framework.

As a result, services included in the community support service stream are currently in a period of transition as independent quality evaluations of all individual, group based and residential community support service types are completed.

This includes managing the impact of the services not meeting the standards set out in the National Standards for Mental Health Services and the Commission's Mental Health Outcomes Statement. Where the ongoing operation of any service has been found to be inconsistent with the minimum standard of care, the Commission has worked collaboratively with services to improve their standards and/or to identify appropriate alternative options for affected individuals as well as their family and carers.

For example, in response to the closure of Franciscan House, the Commission worked collaboratively with public mental health services and community managed organisations to assess the needs of 70 residents and to secure alternative accommodation and support. This required additional resourcing from the Commission, additional funding to the East Metropolitan Health Service to implement the relocation and strong collaboration between all involved.

NDIS

Changes related to the implementation of the NDIS in Western Australia have impacted on the implementation of the Plan in the mental health community support sector. The Commission has maintained levels of funding for community support services while avoiding duplication of services as the NDIS is rolled out statewide by the end of 2020. Western Australia's participation in the national scheme will influence the Commission with planning for the ongoing psychosocial support needs of individuals, as well as their family and carers, who are not eligible for NDIS.

Accommodation and Support Strategy

The Plan identifies the development of the Accommodation and Support Strategy as a priority, and when finalised will be the first of its kind in Western Australia. The draft Accommodation and Support Strategy establishes a framework to guide stakeholders in the development of appropriate accommodation and support for people with severe mental health issues and/or mild, moderate or severe AOD issues until the end of 2025. The high level document will identify priorities for Government agencies, NGOs and the private sector in working together with consumers, families and carers to develop effective partnerships for providing an integrated accommodation and support system.

Fifth National Mental Health Plan

The Fifth Plan and National Drug Strategy 2017-2026 were endorsed by the Council of Australian Governments Health Council on 4 August 2017 and 29 May 2017 respectively. These national strategy documents present challenges and opportunities to further guide the future directions of community support services.

Future Directions – Community Support Services

The Plan's updated modelling outlines that there has been a reduction (7%) in the 2015 estimated demand for mental health community support services by the end of 2025.

The gap between current levels and 2025 optimal levels for community support services has also narrowed but remains significant.

Enhancing the quality of community support services, as well as increasing the amount of investment, will continue as a key strategic focus over the life of the Plan.

Some of the key strategic priorities for mental health and AOD community support services in the future include to:

- Implement the Commission's community service procurement schedule to expand and enhance service alignment with the Plan and based on the principles of co-design and co-production;

- Continue integrated planning with expanded NDIS and Commonwealth funded services to avoid gaps or duplication and to address the service needs for those ineligible for NDIS;
- Continue to develop and expand local recovery services, specifically telehealth community support services;
- The development and implementation of an evidence-based, co-designed model of service for Recovery Colleges;
- Review existing consumer and carer access to advocacy services and where appropriate identify opportunities to expand access;
- Finalise and support the implementation and monitoring of the Accommodation and Support Strategy;
- Explore options to expand the provision of the Alcohol and Drug Support Line call back support to hospitals. The Alcohol and Drug Support Line currently works in partnership with the Mental Health Unit (MHU) and Sir Charles Gairdner Hospital to assist in supporting individuals with co-occurring mental health and AOD issues post-discharge from the MHU;
- Continue the implementation of the Western Australian Peer Naloxone Project;
- Consult with key stakeholders to explore how youth-friendly safe places for youth with AOD use issues (including volatile substances) can be established in regional and remote areas; and
- Planning for the development of a one-stop system navigation service that provides specialist information, support and referral for AOD and mental health service issues to better support people in crisis.

Table 2: Summary of Plan Matrix, Community Support Services

Service Type		State Total				
		2013 Actual (a)	2017 Actual (b)	2017 Optimal (a)	2020 Optimal (b)	2025 Optimal (b)
Community Support Services	Hours ('000) (total)	847	916	1,666	3,144	5,124
	Beds (total)	242	256	178	312	338
MH	Hours ('000)	842	910	1661	2935	4892
AOD (Harm-reduction and personal support)	Hours ('000)	5	6	5	209	232
AOD (Post Residential Rehabilitation) **	Beds	74	74	0	107	133
AOD (Safe places for intoxicated people)	Beds	168	182	178	205	205

(a) 2015 Plan and (b) Plan Update 2018

** In the Plan 2015 this was reported as hours of service. It was deemed more appropriate to report as beds for the Plan Update 2018.

Community Treatment Services

Community treatment services provide non-residential, clinical care in the community for people with mental health and AOD issues including families and carers.

The service elements of community treatment services featured in the Plan include:

- mental health infant, child and adolescent;
- mental health youth;
- mental health adult;
- mental health older adult; and
- AOD (all non-residential treatment).

Our annual expenditure in Community Treatment Services increased to

$399.7m in 2017-18

In 2017-18, the Commission expended $399.7 million in community treatment services, which is a 19% or $63.9 million increase in expenditure since 2013-14.

Key Achievements since the release of the Plan

Provision of AOD treatment services for the new Alcohol Interlock Scheme.

Expansion of Community Alcohol and Drug Services across the State to assist in addressing methamphetamine related issues.

Continued provision of the Specialised Statewide Aboriginal Mental Health Service.

Community treatment services aim to provide appropriate mental health and AOD treatment and care in the community closer to where people live and where connections with, and support from, families and carers can be maintained.

Mental health community treatment services are primarily provided by the public health system. AOD community treatment services include pharmacotherapy programs, screening and assessment programs and counselling and are predominantly delivered through the non-government sector.

As with community support services, community treatment services provide recovery oriented and trauma informed care, supporting the inclusion of family members and/or carers in relevant treatment decisions in the context of person centred care.

Modelling Update – Community Treatment Services

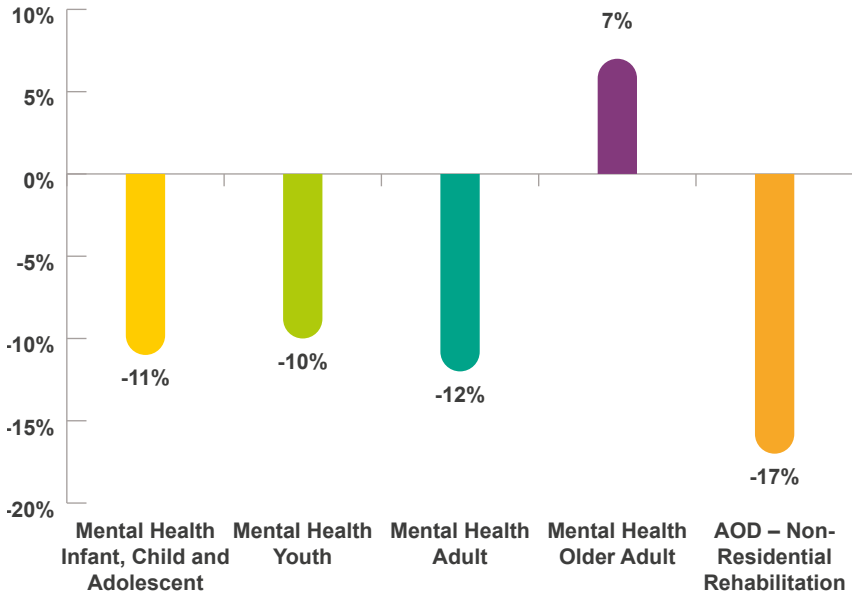
Changes to 2025 optimal levels

Figure 22 outlines changes to optimal levels of community treatment services at the end of 2025 compared with the 2015 optimal levels.

Mental Health

The Plan indicated a requirement for community treatment mental health services across all age cohorts to increase to 3.8 million hours by the end of 2025. Updated modelling shows the overall requirement for mental health community treatment services by the end of 2025 has reduced by 9% to 3.4 million hours of service due to the aggregate impact of a lower population estimate at 2025 (down by 7%) and weightings for the Aboriginal population (down by 16%) and for the population living in remote and regional areas (increases from 3%-25%).

Figure 22: Community Treatment – Percentage change in 2025 optimal levels, compared with original optimal levels in the Plan



An ageing population has resulted in an increase in the estimated proportion of the population over 65 years and a decrease for younger people, impacting on revised 2025 optimal levels of service for different age cohorts.

Figure 22 shows that the optimal levels for infant, child and adolescent mental health community treatment services by the end of 2025, including early intervention services has decreased by 11% from 1.6 million to 1.4 million hours. The optimal level required by the end of 2025 for youth, has decreased by 10% from 453,000 to 408,000 hours; for adults it has decreased by 12% from 1.2 million to 1.1 million; and for older adults it has increased by 7% from 528,000 to 566,000 hours.

Levels of youth and adult mental health community treatment services at 2020 have been the subject of minor adjustments at a regional level to reflect the trend required to match the updated optimal levels by the end of 2025. For all regions, with the exception of Northern and Remote, estimated actuals in 2017 are greater than the optimal levels required by the end of 2025 and the required trend for these services is to decrease toward 2025 optimal levels. The overall statewide decrease in the optimal levels of youth and adult services compared with the Plan is partially offset by an increase in optimal statewide levels required for older adult mental health community treatment services.

Where the modelling identifies a lower estimated optimal level in 2025 than current services, and given the system is not currently balanced, it is not intended that services would be divested at this stage.

Alcohol and Other Drugs

The Plan indicated that AOD community treatment services would need to increase to 2.1 million hours of service by the end of 2025.

Updated modelling indicates that the optimal level of AOD services by the end of 2025 has decreased by 17%, to 1.7 million hours.

Revisions to the modelling of required AOD community treatment services are the result of changes to the estimated rate of population growth (a decrease of 7%) and weightings applied to rural and regional (increases from 3%-25%) and Aboriginal population groups (a decrease of 16%). In addition, revisions have been made to correct an issue with double counting of screening and brief intervention in the 2015 modelling.

Current services compared with 2025 estimates

Estimates of current levels of community treatment services compared with updated optimal levels by the end of 2025 are outlined in **Figure 23**.

Mental Health

As shown in **Figure 22** the reduced estimated requirement for infant, child and adolescent services has narrowed the gap between the current level of service and the optimal level of service required by the end of 2025.

However, **Figure 23** outlines that current services still need to more than triple to meet the estimated optimal level of service for the end of 2025. Growth of 122% in older adult services is required and youth services will need to expand by 11%. This is largely due to the ageing population, with a higher than expected increase to the older adult cohort, particularly compared to youth.

The revised data indicates that the overall optimal level of adult community treatment services has been met.

Alcohol and Other Drugs

As shown in **Figure 23**, compared with estimated actual levels of AOD non residential community treatment services in 2017, an increase of 178% from 611,000 hours to 1.7 million hours is required to meet optimal levels by the end of 2025.

Figure 23: Community Treatment – Optimal and actual levels of service

Achievements – Community Treatment Services

Strategic priorities identified for community treatment services in the Plan include engaging with the primary care sector, providing integrated models of care for people with co-occurring mental health and AOD problems, expanding AOD treatment services, maintaining access to appropriate Aboriginal mental health services and assisting with system navigation.

The key achievements implemented to address these priority areas are listed below as at 30 June 2017.

Mental Health

- Establishment and continued provision of a Youth Community Assessment and Treatment service. The service provides assessment and intensive case management for young people between the ages of 16 to 24 years in the South Metropolitan region who are at risk of developing mental health issues;
- Expansion of the ALIVE program to provide additional services for people at risk of suicide following discharge from hospital in the North Metropolitan area, and the establishment of a new ALIVE program in the South Metropolitan area. This includes collaborative commissioning by the Commission and WAPHA;

- Establishment of a new child, adolescent and youth psychiatrist position in the Kimberley; and
- Collaboration between the Commission and WAPHA including the expansion of training and engagement of GPs and other primary care providers to increase screening, brief interventions, early interventions, and referrals for mental health and AOD problems such as the:
    - development of an alcohol brief intervention online learning package and dissemination of resources on screening and brief interventions;
    - delivery of Fetal Alcohol Spectrum Disorder training which is attended by nurses/ midwives and other primary health staff and focuses on asking women about their alcohol use and providing brief interventions;
    - collaborative commissioning with NGOs to support GPs to complete mental health treatment plans; and
- Commission representation on the Treating Alcohol and Other Drugs in Primary Care Expert Technical Advisory Group.

Additional Achievements to 30 September 2018

- The continued provision of the Statewide Specialised Aboriginal Mental Health Service that includes specific strategies to enhance access for Aboriginal children, families and people with co-occurring AOD problems by embedding the service within the Commission's mainstream mental health funding, spending $18.2 million from 2018-19 to 2020-21. The Commission will be working with Health Service Providers over this three year period to ensure continued service delivery beyond 2021;
- Funding for the reform and expansion of the Midwest Community Mental Health Team;
- Introduction of after-hours and weekend services for community mental health in the South West; and
- Enhancement of Child and Adolescent Community Mental Health Services in Katanning, Narrogin and Wheatbelt.

Alcohol and Other Drugs

- Establishment of a new integrated AOD treatment service in Joondalup, with a new CADS facility established in 2015;
- Evaluation and continued provision of the North West Drug and Alcohol Support Program including nine service hubs across the Kimberley and Pilbara providing both AOD treatment and prevention services. The program is continuing with additional funding of $24.5 million from 2016-17 to 2019-20 through the Royalties for Regions program;
- Implementation of an Alcohol Interlock Assessment and Treatment Scheme to help offenders stop harmful drink driving, as part of the *Road Traffic Amendment (Alcohol Interlocks and Other Matters) Act 2015*;
- Establishment and continued provision of the Meth Helpline. The Helpline continues to provide free specialist information, support, counselling and referral for individuals and families affected by methamphetamine use;
- In response to the need for specialist clinical treatment for methamphetamine use, a dedicated methamphetamine treatment service trial was established at the Next Step Drug and Alcohol Service (Next Step) in 2016. The aim of the service was to trial the provision of specialised medical outpatient assessment and intervention for problematic methamphetamine use and to improve access to treatment and treatment outcomes. Treatment

of methamphetamine problems is now incorporated into the treatment program offered through Next Step East Perth and the Integrated CADS, where prioritised assessments may be provided;

- A significant increase in the number of Hepatitis C clients referred, tested and treated with Direct Acting Antiviral medications since they were listed on the Pharmaceutical Benefits Scheme in March 2016. The program is managed by Next Step;
- Life-saving Naloxone was made widely available with a total of 709 naloxone kits distributed through Next Step Drug and Alcohol Service and Metropolitan CADS. In 2017-18 there were 120 reported opioid overdose reversals using the Next Step distributed naloxone kits; and
- Establishment and continued provision of additional prevention and outpatient treatment services for methamphetamine users provided by the expansion of existing CADS across the State (13 full-time equivalents) to support individuals pre and post-residential rehabilitation, retain people in treatment and prevent relapse.

Current Strategic Context - Community Treatment Services

Implementation of the reform agenda described in the Plan has produced a range of significant achievements across various elements of the mental health and AOD Community Treatment Service stream.

These advancements have been supported through additional funding provided to continue AOD services in the Kimberley and Pilbara, as well as the expansion of CADS to respond to methamphetamine use. New funding in 2016-17 was also directed to additional telephone counselling and support services through the Meth Helpline, and the establishment of a specialist methamphetamine clinic.

Challenges remain in expanding mental health community treatment services. In particular, progress in expanding infant, child and adolescent services was impacted by the delayed opening of the Perth Children's Hospital (PCH). PCH will allow for the further expansion of non-admitted community treatment programs for children and youth less than 16 years of age, including evidence-based intervention to help young people who are struggling to cope with relationships, mood difficulties and impulsive self-harming behaviours.

Reforms in the public mental health sector such as the enactment of the *Health Services Act 2016* and the establishment of the East Metropolitan Health Service from July 2016 has been a significant undertaking. The establishment of East Metropolitan Health Service and the restructuring of Health Service Providers to create separate legally accountable statutory authorities have been successfully completed. However, the subsequent reconfiguration of resources across the metropolitan area temporarily impacted on the further reform of non-admitted activity including the expansion of older adult community treatment services.

The undersupply and underutilisation of primary care services continues to be a challenge for providing community treatment services. In 2015-16[9] the rate of patients per capita in Western Australia (62.5 per 1,000 population) and the rate of services per capita (105.6 per 1,000 population) were lower than the national average for patients (77.2 per 1,000 population) and services (135.5 per 1,000 population) and is the second lowest of all states and territories behind the Northern Territory.

The importance and value of continuing to increase access to and use of primary mental health and AOD care services is reflected in the Commission's future directions for community treatment services and is one of the one of the stated core functions of WAPHA.

[9] Australian Institute of Health and Welfare (2017). Mental health services – In brief 2017.

The Commission is planning for the development of a proposal for a one-stop-shop for mental health, AOD that includes services provided by the Alcohol and Drug Support Service and the Mental Health Emergency Response Line.

Future Directions – community treatment services

The updated modelling shows that the optimal levels of all community treatment services have decreased marginally compared with modelling provided in 2015.

The updated modelling identifies a significant reduction in the gap between current levels of service and optimal levels at the end of 2025 for infant, child and adolescent health while the gap for adult and older adult community mental health treatment services has increased. The impact of these changes on required levels of service across age cohorts, and an ongoing commitment to key priorities described in the Plan, feature clearly in the future priorities for developing community treatment services.

Key strategic priorities identified in the Plan for community treatment services in the mental health and AOD sectors include:

- Expanding community treatment services for older adult mental health services to meet the needs of an ageing population;
- Reconfiguring community mental health treatment services across the State to provide treatment to 16 and 17 year olds previously supported by the Child and Adolescent Health Service (CAHS);
- Collaborating with DOH and the Health Service Providers on developing a youth service stream, including addressing the different youth cohort age ranges specific to the mental health and AOD sectors, and examining options to improve the provision of services to individuals who are experiencing co-occurring mental health and AOD issues;
- Reconfiguring existing services to improve access to mental health community treatment services after hours and system navigation supports;
- Continuing to work towards expanding public and non-government AOD community treatment services across the State, including integration with mental health services;
- Engaging with the primary care sector, including exploring how pharmacists can become more involved in medication dispensing and monitoring of mental health and AOD problems;
- Continuing engagement with GPs and other primary care providers to support integrated community treatment services;
- Consideration for further expansion of specialist Methamphetamine Clinics through AOD community treatment services; and
- Further explore the need and demand for community treatment services for people in the Kimberley region with AOD problems.

Table 3: Summary of Plan Matrix, Community Treatment Services

Service Type		State Total				
		2013 Actual (a)	2017 Actual (b)	2017 Optimal (a)	2020 Optimal (b)	2025 Optimal (b)
Community Treatment Services	Hours ('000) (total)	2,713	2,933	3,302	4,113	5,129
MH Infant, Child and Adolescent	Hours ('000)	373	404	747	1,179	1,388
MH Youth	Hours ('000)	339	366	360	379	408
MH Adult	Hours ('000)	1,200	1,297	1,183	1,054	1,067
MH Older Adult	Hours ('000)	236	255	335	481	566
AOD - All (non-residential treatment)	Hours ('000)	565	611	677	1,020	1,700

(a) 2015 Plan and (b) Plan Update 2018

Community Bed-Based Services

Community bed-based services provide 24 hour, seven days per week recovery oriented services in a residential style setting (in the case of mental health services), and withdrawal services and structured, intensive residential rehabilitation for people with an AOD problem.

The service elements of the Community Bed-Based Service stream that feature in the Plan include:

- Mental health community beds;
- AOD (low medical withdrawal); and
- AOD (residential rehabilitation).

Key Achievements since the release of the Plan

Additional 60 AOD residential rehabilitation and low medical withdrawal beds

New step up/step down services opened in Rockingham and Albany

Funding to establish up to 33 AOD beds in the South West

In mental health, community bed-based services provide support to enable individuals to move to more independent living. The primary aim of interventions is to improve functioning and reduce difficulties that limit an individual's independence. There are four types of mental health community beds: short stay; medium-stay; long-stay and long-stay (nursing home).

Our annual expenditure in Community Bed-Based Services increased to

$48.5m in 2017-18

During the 2017-18 period, the Commission expended $48.5 million in community bed-based services, an increase of 20%, or $8.1 million since 2013-14.

Mental Health Community Beds

Short-stay

- Youth and adult;
- Maximum of 30 days;
- Residential care;
- Intensive clinical treatment and support; and
- Step up/step down is an example of a short-stay service.

Medium-stay

- Youth, adult and older adult;
- Maximum 6 month stay;
- Residential in nature;
- Delivered in a partnership between clinical and community support services;
- Accommodation, and staffing is available on-site 24-hour; and
- Recovery-oriented psychosocial rehabilitation.

Long-stay

- Youth, adult and older adult;
- Average stay is one year;
- Similar to medium stay services, for people who require longer term support; and
- Includes youth and adult homeless services and Community Supported Residential Units.

Long-stay: nursing home

- For older adults who have severe and persistent symptoms of mental illness, and who are unable to live in mainstream aged care settings;
- Service includes assessment, ongoing treatment, rehabilitation and residential support for consumers; and
- AOD Community Beds.

AOD Community Beds

Low medical withdrawal beds

- 24-hour supervised;
- AOD detoxification or withdrawal; and
- Average stay five to seven days.

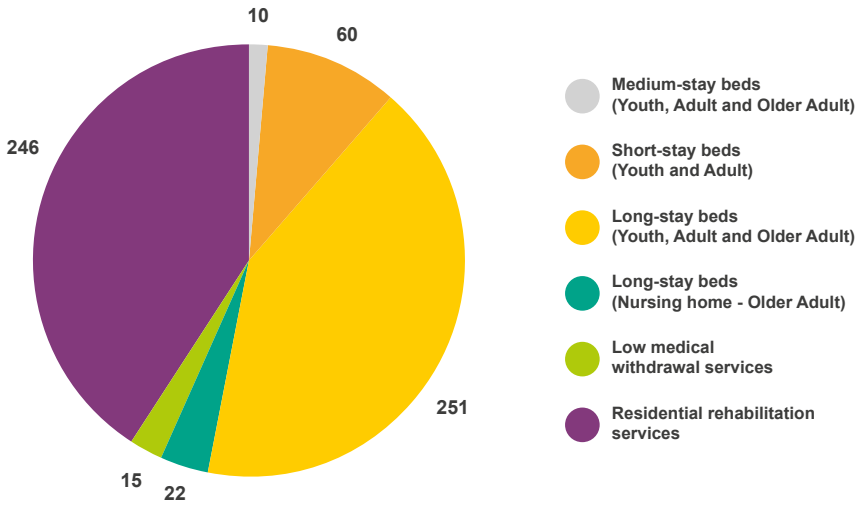
Residential rehabilitation beds

- 24-hour;
- Community-based;
- Residential treatment programs, including intensive and structured interventions;
- Psychological therapy, education, development of skills and peer support;
- Therapeutic communities are considered a type of this service; and
- Dedicated services for specific groups such as women, young people and Aboriginal people.

All community bed-based services are expected (where appropriate) to have the capability of meeting the needs of people with co-occurring mental health and AOD issues.

Figure 24 outlines the number and type of community-based beds provided at February 2018.

Figure 24: Community-based beds at February 2018



Modelling Update – Community Bed-Based Services

Changes to 2025 optimal levels

Figure 25 outlines changes to the optimal levels of community bed-based services required by the end of 2025 compared with optimal levels in the Plan Update 2018.

Mental Health

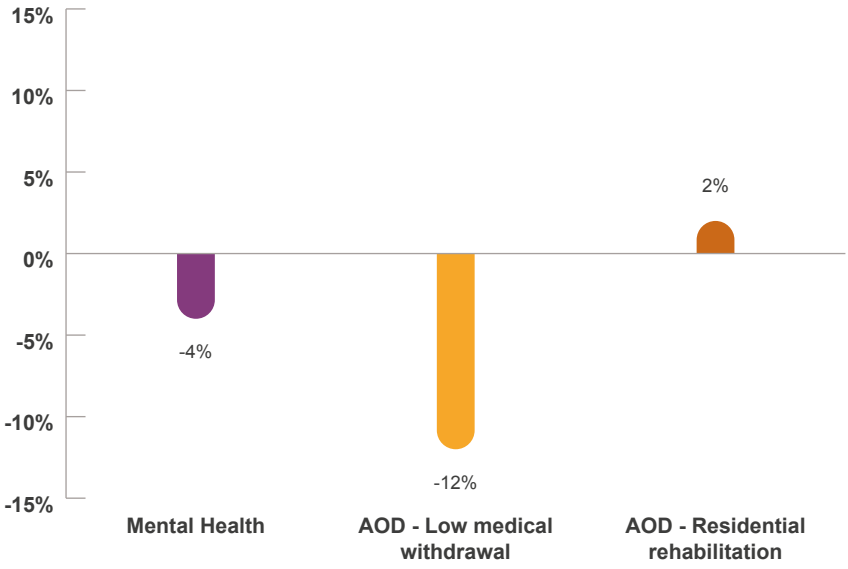
Modelling for the Plan indicated a requirement for all community mental health bed-based services to increase to 909 beds by the end of 2025. Updated modelling outlined in **Figure 25** indicates that the optimal level of community beds by the end of 2025 has reduced by 4% to 873 beds due to the decrease in the estimated population by the end of 2025. However, as 50% of community beds are required for older persons, the decrease is offset by an estimated 2.7% increase in the proportion of the population over 65 years due to the ageing population.

Alcohol and Other Drugs

Modelling from the Plan indicated a requirement for community bed-based AOD low medical withdrawal services to increase to 52 beds by the end of 2025. Updated modelling for the Plan Update 2018 provided in **Figure 25** indicates that the revised optimal level for low medical withdrawal beds has reduced by 12% to 46 beds mainly due to the reduction in the population estimate for 2025 (7%) and weightings for remote and regional areas (increases varying from 3%-25%) and Aboriginal populations (decrease of 16%).

For AOD residential rehabilitation beds, the Plan showed that by the end of 2025, 772 beds would be required. The revised optimal number of community AOD residential rehabilitation beds has increased by 2% to 786 beds (see Figure 25). The increase is due to the removal of a post modelling assumption applied in the Plan which had reduced the bed activity related to the use of cannabis and benzodiazepines.

Figure 25: Community Bed-Based – Percentage change in 2025 optimal levels, compared with original optimal levels in the Plan



Current services compared with 2025 estimates

Estimates of current levels of community bed-based services compared with updated optimal levels by the end of 2025 are outlined in **Figure 26**.

Mental Health

Compared with mental health community bed-based bed numbers at 2017, a growth of 166% (545 beds) is required by the end of 2025 to reach the optimal level of 873 mental health community beds (see **Figure 26**).

As at 30 September 2018, an additional six bed step up/step down service has commenced operation in Albany, raising the total number of community mental health beds from 328 to 334.

Alcohol and Other Drugs

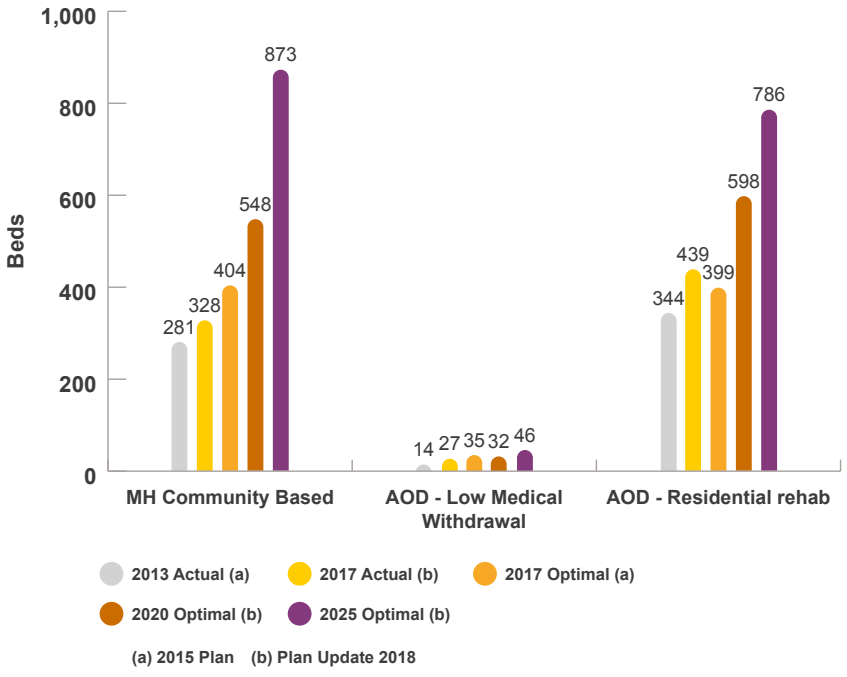
Compared with bed numbers at 2017, a growth in low medical withdrawal beds of 70% (19 beds) is required by the end of 2025 (see **Figure 26**).

Compared with bed numbers at 2017, growth in residential rehabilitation beds of 79% (347 beds) is required by end of 2025 (see **Figure 26**).

Achievements – Community Bed-Based Services

Key strategic priorities identified in the Plan for community bed-based services include increasing the availability of withdrawal and residential rehabilitation services, expanding bed-based services in the regions, as well as increasing the availability of older adult community bed-based services.

Figure 26: Community Bed-Based – Optimal and actual levels of service



The Plan key achievements in this area are highlighted below as at 30 June 2017.

Mental Health

- A new 10 bed step up/step down service in Rockingham was opened in October 2016; and
- Commenced projects to establish regional step up/step down services in Karratha (six beds), Bunbury (10 beds), and Broome (six beds), with ongoing community and stakeholder consultation.

Additional Achievements to 30 September 2018

- Commenced projects to establish regional step up/step down services in Kalgoorlie (10 beds), Geraldton (10 beds) and Albany (six beds). The first step up/step down service in regional Western Australia opened in Albany in October 2018.

Alcohol and Other Drugs

- Establishment and continued provision of an additional 52 residential rehabilitation beds (10 beds in the North Metropolitan area, 14 beds in the South Metropolitan area and 28 regional beds) and eight low medical withdrawal beds (four metropolitan beds and four regional beds) as part of the expansion of existing AOD services for methamphetamine users;
- Planning for future AOD service provision in the Kimberley, including community bed-based and community treatment services; and
- Extensive community consultation to develop an Exposure Draft Bill and Summary Model of Service for a proposed compulsory AOD treatment program in Western Australia.

Additional Achievements to 30 September 2018

The establishment of up to 30 additional AOD residential rehabilitation beds and three low medical withdrawal beds in the South West with $9.3 million in operational funding from 2018-19 to 2021-22.

Current Strategic Context – Community Bed-Based Services

A range of achievements have been made to date in the community bed-based sector, however some challenges remain across the mental health and AOD community bed-based service stream, particularly in regional locations.

Methamphetamine Action Plan

Providers of community bed-based services in the AOD and mental health sectors have responded positively to initiatives that have expanded their capacity to provide methamphetamine focussed services. Further development of the sectors' capabilities, particularly in regional areas, will remain a priority as implementation of the State Government's Methamphetamine Action Plan continues.

Current priorities identified within the Methamphetamine Action Plan include additional AOD residential rehabilitation services within the South West, as well identifying and developing AOD services to address community priorities across the Kimberley region.

AOD Services in the Kimberley

The need identified in the Plan for a total of 44 residential rehabilitation beds in the Kimberley by the end of 2025 has been almost met by the existing Commonwealth funded beds in Broome (18 beds) and in Wyndham (22 beds). With the modelled demand for residential rehabilitation beds in the Kimberley region almost met, the Commission is in the process of ascertaining other AOD service requirements for the Kimberley region, to ensure a comprehensive system of services are planned for future implementation.

Step up/step down services

The development and implementation of a number of community-based mental health step up/step down services across a range of locations presents challenges relating to the availability of community supports and suitability of site locations; however, focus will continue to be directed to the development of regional services to which Government has committed funding, and ensuring step up/step down services are located across Health Service Providers to ensure a balanced bed mix.

Graylands Hospital and Selby Older Adult Mental Health Service Sites

The Commission continues to progress the decommissioning of services from the Graylands Hospital and Selby Older Adult Mental Health Service sites, and plan their replacement with contemporary acute inpatient and community-based infrastructure and services including the development of services by region as supported by the Plan modelling.

Contemporary replacement services will be established prior to the decommissioning of any existing services, and are likely to include a continuum of treatment and support, that may include inpatient beds, hospital in the home beds (HiTH), community bed-based services, and community support (accommodation).

Compulsory AOD Treatment

In September 2016, the Commission released Background and Discussion Papers relating to the proposed provision of compulsory AOD treatment in Western Australia. The Exposure Draft Compulsory Treatment (Alcohol and Other Drugs) Bill 2016 (Exposure Draft Bill) and Summary Model of Service were developed taking into account feedback from the Discussion Paper and advice from the Western Australian Compulsory Alcohol and Other Drug Treatment Community Advisory Group and Steering Committee. The Exposure Draft Bill and Summary Model of Service were released for public comment on 9 December 2016. This second phase of consultation ended on 31 January 2017.

Taking into consideration stakeholder feedback, the State Government will further consider a trial of compulsory AOD crisis intervention, including consideration of the outcomes of the evaluation of a similar program in New South Wales, when it is released.

Future Directions – Community Bed-Based Services

Updated modelling indicates that the overall estimated demand for community bed-based services by the end of 2025 has moderately decreased.

However, the gap between current levels and updated optimal levels remains for community bed-based and the need for further investment in this service type is reflected in the future directions below.

Key strategic priorities for community bed-based services include:

- Opening new mental health community bed-based services in Broome, Kalgoorlie/Boulder, Karratha and Bunbury;
- Delivering step up/step down beds in the Midwest area that will be supported by services in the community and in hospital;
- Planning relating to the requirements and availability of community bed-based in areas such as non-acute long-stay (nursing home) places and/or services for older adults with mental illness;
- Further planning for the decommissioning of services at Graylands Hospital and Selby Older Adult Mental Health Service, to determine and then establish contemporary replacement mental health community-based services, prior to any services closing at these two sites;
- Better integration of existing community support services and community bed-based services, aligned to the draft Accommodation and Support Strategy;
- The development and implementation of AOD residential treatment services for Aboriginal people and their families in the south of the State;
- Continuing the development and implementation of new AOD residential treatment and rehabilitation services in the South West;
- Planning for the provision of AOD services in the Kimberley including consideration of community bed-based services;
- Expanding AOD low medical withdrawal services in regional areas; and
- Improving access to residential rehabilitation services for people with multiple complex needs such as co-occurring mental health problems, AOD problems, and physical health conditions.

Table 4: Summary of Plan Matrix, Community Bed-Based Services

Service Type		State Total				
		2013 Actual (a)	2017 Actual (b)	2017 Optimal (a)	2020 Optimal (b)	2025 Optimal (b)
Community Bed-Based Services	Beds (total)	639	794	838	1,179	1,705
MH Community-based	Beds	281	328	404	548	873
AOD - Low Medical Withdrawal	Beds	14	27	35	32	46
AOD - Residential rehabilitation	Beds	344	439	399	598	786

(a) 2015 Plan and (b) Plan Update 2018

Hospital-Based Services

Hospital-based services include acute, subacute and non-acute inpatient units, emergency departments, consultation and liaison services, mental health observation areas (MHOAs), and inpatient AOD withdrawal services.

Our annual expenditure in Hospital-Based Services increased to

$381.4 m in 2017-18

In 2017-18, the Commission spent $381.4 million on hospital-based services; an increase of 29% ($86.3 million) from the last pre-Plan year (2013-14).

Key Achievements since the release of the Plan

Additional 12 youth mental health inpatient beds opened.

Funding to establish a MHOA service at Royal Perth Hospital.

Commencement of a youth HiTH service.

Hospital-based services provide treatment and support in line with mental health recovery oriented service provision, including promoting good general health and wellbeing.

The following specialties apply to the hospital-based services stream:

Mental Health Inpatient Beds

- Infant, child and adolescent;
- Youth (acute and subacute/ non-acute);
- Adult (acute and subacute/ non-acute); and
- Older adult (acute and subacute/non-acute).

Other

- HiTH;
- Mental Health Observation Areas;
- Private inpatient beds;
- AOD (high/complex medical withdrawal)[10] ; and
- Mental health/AOD consultation liaison hours.

[10] Includes private AOD medical withdrawal beds

Modelling Update – Hospital-Based Services

Changes to 2025 optimal levels

Figure 27 outlines changes to the optimal number of hospital-based services required by the end of 2025 as a result of updated optimal levels in the Plan Update 2018.

Mental Health

Modelling from the Plan indicated a requirement for mental health hospital-based services to increase to 1,051 beds by the end of 2025. Updated modelling for the Plan Update 2018 indicates that the required total number of overall hospital beds estimated has reduced by 6% (61 beds) to 990 by the end of 2025.

This compares to total beds as at November 2018 of 795. As per the Plan Matrix, sub-totals of mental health hospital beds are not inclusive of private bed numbers.

Changes to optimal levels of mental health beds reflect changes to the estimated population profile of Western Australia by 2025 where overall growth has decreased by 7% while the estimated proportion of the population over 65 years has increased.

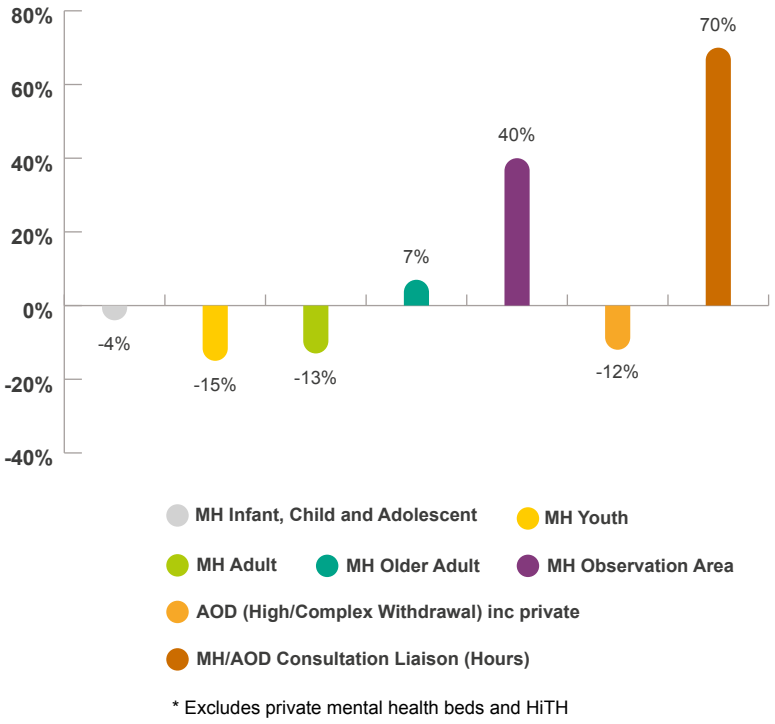
Compared with 2015 modelling, notable changes to optimal levels of hospital-based beds, excluding HiTH, are outlined below:

- The optimal number for infant, child and adolescent dedicated beds required by the end of 2025 has decreased marginally from 27 to 26 beds;
- The optimal number of youth beds required by the end of 2025 has decreased by 15% (from 101 to 86 beds);
- The optimal number of adult beds required by the end of 2025 has decreased by 13% (from 496 to 435 beds);
- The optimal number of older adult beds required by the end of 2025 has increased by 7% (from 192 to 206 beds);
- The optimal number of MHOA places required by the end of 2025 has increased by 40% from 40 to 56 beds; and
- The optimal level of mental health/ AOD consultation liaison service hours by the end of 2025 has increased by 70% from 309,000 hours to 525,000 hours.

A breakdown of beds by age cohort for HiTH was not available for the Plan but is now provided in the Plan Update 2018. The total number of HiTH beds across all age cohorts has decreased by 6% from 195 beds to a total of 183 beds.

A decrease in the optimal number of subacute/non-acute beds by the end of 2025 reflects changes to the rate of population growth by age cohort.

Figure 27: Hospital-based – Percentage change in 2025 optimal levels, compared with original optimal levels in the Plan*



* Excludes private mental health beds and HiTH

In addition, the estimated need for mental health youth beds now reflects the reconfiguration of the Bentley Adolescent Unit (BAU) to create a 12 bed youth inpatient service rather than a subacute service, as originally identified in the Plan. This change was designed to ensure appropriate levels of access to acute services for youth older than 16 years were maintained following the opening of PCH.

The Plan acknowledged that further work was required to further explore the requirement for MHOAs, particularly in regional areas where there are inpatient mental health beds. As such, the need for additional MHOA services has been determined by identifying the need for MHOAs based on the number of mental health bed days provided by hospitals, and the capability of hospitals to provide support services to the MHOAs. This assessment has resulted in a 40% increase to the optimal level of MHOA places by the end of 2025.

The 2015 modelling for consultation liaison services reflected requirements for people with a primary mental health related diagnosis, including those with co-occurring AOD service needs. The required level of consultation liaison services has increased significantly as the modelling in the Plan Update 2018 has now been refined to also include estimates for people whose primary concern is AOD related.

Alcohol and Other Drugs

The modelling from the Plan indicated a requirement for AOD high/complex withdrawal beds to grow to 117 beds by the end of 2025.

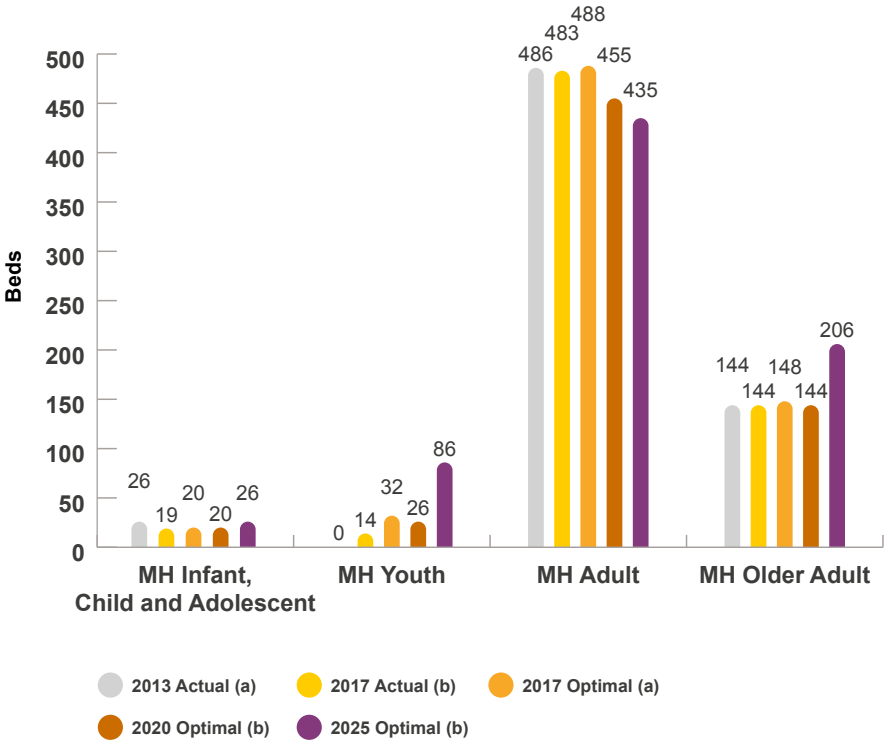
Revised modelling for the Plan Update 2018 indicates that the optimal number of AOD high/complex withdrawal beds has decreased by 12% (14 beds) to 103 beds (see **Figure 27**) in line with changes to the rate of population growth (7% decrease) and weightings for remote and regional (3-25% increase) and Aboriginal population groups (16% decrease).

Current services compared with 2025 estimates

Updated modelling has identified the need for current mental health hospital-based beds to increase by 27% (268 beds) from 722 in 2017, to 990 by the end of 2025 (see **Figures 28 and 29**).

Updated optimal service levels at 2025 for all types of hospital-based mental health beds are provided in Table 5. Current levels of hospital-based services compared with updated optimal levels by the end of 2025 are outlined in **Figures 28, 29 and 30.**

Figure 28: Mental health – Hospital-based – Optimal and actual levels of service



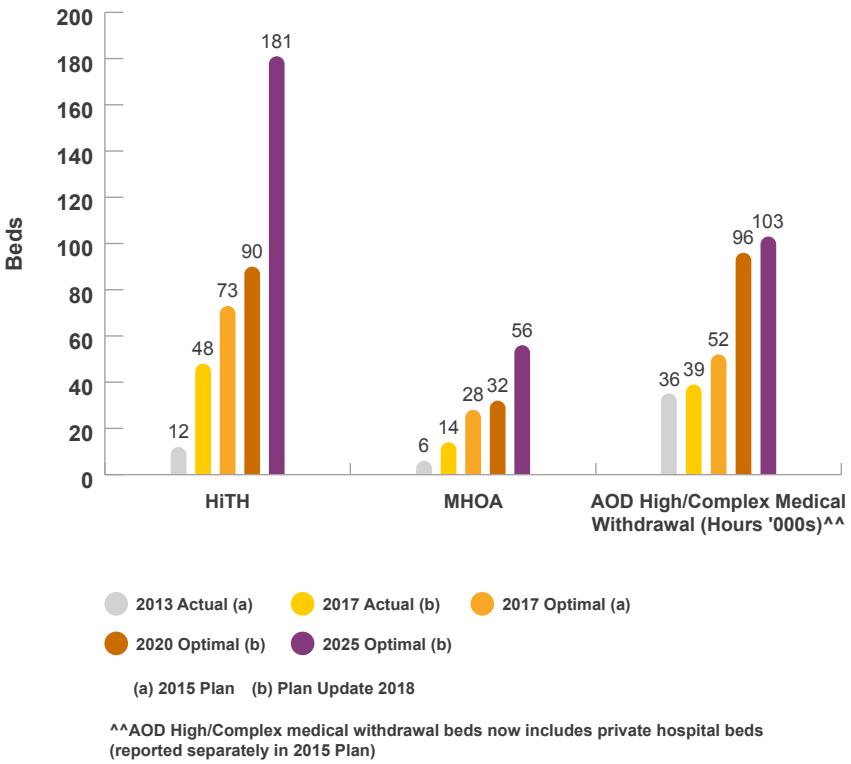
* Excludes private mental health beds and HiTH

Mental Health

The following outlines the 2017 actuals compared to the 2025 modelled demand for mental health hospital-based services:

- The number of infant, child and adolescent beds is required to grow by seven beds from 2017 to reach an estimated optimal level of 26 beds by the end of 2025;
- The total number of acute, subacute/non-acute and HiTH youth beds is required to increase by almost fivefold to meet the 107 youth beds required by the end of 2025;
- The total number of acute, subacute/non-acute and HiTH adult beds is required to increase by 5% (28 beds) to meet an estimated optimal level of 543 by the end of 2025;
- The total number of older adult acute, subacute/non-acute and HiTH beds is required to increase by 70% (106 beds) to reach optimal levels of 258 by the end of 2025;
- The optimal number of MHOA places is required to increase three fold (42 beds) to reach optimal levels of 56 beds by the end of 2025; and
- Mental health/AOD consultation services require a 98% increase (260,000 hours) to meet required optimal levels of 525,000 hours by the end of 2025.

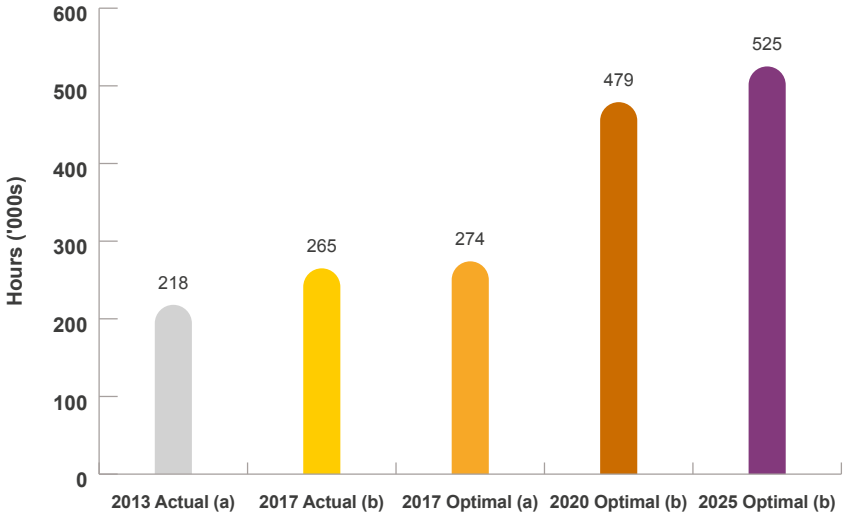
Figure 29: Mental Health – Hospital-based – Optimal and actual levels of service



(a) 2015 Plan (b) Plan Update 2018

^^AOD High/Complex medical withdrawal beds now includes private hospital beds (reported separately in 2015 Plan)

Figure 30: Hospital-based – MH/AOD consultation liaison – Optimal and actual levels of service



(a) 2015 Plan (b) Plan Update 2018

It is noted that in 2014, the Plaistowe Ward at Graylands Health Campus was closed and 16 HiTH beds were opened.

The modelling shows that relative to current bed capacity, significant growth is required for youth and older adult services, with minor increases in beds required for adults and infant, child and adolescents. A dedicated youth stream has not yet been fully developed in Western Australia, therefore many of the current adult inpatient services are actually providing services for adults aged 18-64 years (which includes youth aged 18-24 years). Over time, as the dedicated youth stream is expanded, current adult services may be able to be transitioned into providing services for youth.

There remains a shortfall in supply in community-based services and, in the absence of suitable alternatives, hospital services are currently experiencing higher demand. Hospital-based services will not experience excessive demand if all elements of the mental health and AOD service system are in balance and at reasonable levels relative to the optimal levels. While expanding services that focus on prevention and community-based care will ultimately reduce the use of higher cost hospital-based services, responding to the increased demand remains a challenge within the context of a fiscally constrained environment. Reducing hospital-based services to reallocate funding to community services is not feasible in the current circumstance where demand already exceeds supply of hospital-based services. As more community-based services are established, demand will even out across services, and hospital services will not experience excess demand.

Changes to levels of service from 30 June 2017 to 30 September 2018

As of 30 June 2017, there were 22 youth beds operational. This comprised of 8 beds from the Youth HiTH program and 14 beds from Fiona Stanley Hospital Youth Unit. With the East Metropolitan Youth Unit (EMyU) being fully operational in August 2018, 12 beds were added to the total number of youth beds available, resulting in a total of 34 beds (including youth HiTH beds), relative to the 2020 and 2025 optimal levels of 36 and 107 respectively.

As of 30 June 2017, there were 19 infant, child and adolescent beds operational at BAU. In May 2018, PCH opened, adding 20 infant, child and adolescent beds. However, the BAU was closed in June 2018. Consequently, as of July 2018, there are a total number of 20 beds for infants, children and adolescents (an increase of one bed). PCH accepts children and young people up to 15 years old, and 16 year olds where clinically appropriate.

Alcohol and Other Drugs

Public and private AOD hospital bed numbers were originally presented separately in the Plan Matrix. However, as the services provided are similar, in the Plan Update 2018 these bed services are combined. The Plan Update also addresses the misclassification of five private beds as high/complex medical withdrawal (instead of low medical withdrawal) and a revised count in 2017 identifying the actual number of public and private high/complex medical withdrawal beds in 2013 is 36.

Compared with actual bed numbers at 2017 of 39, a growth in AOD high/complex medical withdrawal beds of 164% (64 beds) is required to meet optimal level of 103 beds by the end of 2025 (see **Figure 29**).

Achievements – Hospital-Based Services

Strategic priorities identified for hospital-based services has included a realignment of the type and location of hospital beds and continued expansion of the HiTH program.

Continuing to monitor readmission rates and diagnostic groups accessing mental health services (for example, people with a personality disorder) and to ensure the provision of a transport service for people requiring transfer under the Act were also identified as ongoing priorities. In addition, the Commission will pursue a balanced mix of beds within each Health Service Provider catchment.

Key achievements in hospital-based services are outlined below.

Mental Health

- HiTH places have increased from 5.5% to 6.2% of the total inpatient bed count from December 2015 to June 2017;
- Commencement of the Youth HiTH service for young people aged 16 to 24 years experiencing an acute phase of mental illness;
- Opening of new and replacement mental health hospital places including:
    - 30-bed acute mental health unit at Fiona Stanley Hospital including:
        - » eight perinatal (mother and baby) beds;
        - » 14 youth beds;
        - » eight short-stay mental health assessment beds; and
    - 56 inpatient beds at the new St John of God Midland Public Hospital including 16 older adult and 40 adult beds;
- Commenced planning with DOH and Health Service Providers for the divestment of infrastructure, and decommissioning and reinvestment of services at the Graylands Health Campus (including Selby Older Adult Mental Health Service). Contemporary and community-based replacement services will be established prior to the decommissioning of any existing services, and may include inpatient beds, HiTH beds, community bed-based and community support services (accommodation); and
- Planning for expansion of the Joondalup Health Campus has commenced, including the opening of 25 to 30 additional mental health beds.

Additional Achievements to 30 September 2018

- Establishment of a new 10 bed MHOA at Joondalup Health Campus in February 2018, as a public private partnership with Ramsay Health Care and DOH, with a total of $7.1 million in project funding;
- Planning and securing funding for a MHOA Plus[11] service at Royal Perth Hospital by December 2019. The MHOA Plus will provide a comprehensive suite of psychiatric services to better meet the mental health needs of the large inner city population. Complementing the MHOA Plus, an Urgent Care Clinic (Toxicology)[12] was established at Royal Perth Hospital on 22 May 2018, aimed at reducing pressure on the emergency department and reducing waitlists. The Urgent Care Clinic (Toxicology) is located adjacent to the emergency department and provides specialised services for people with behavioural disturbances, usually caused by drugs and alcohol; and
- Commenced planning for the redevelopment of the Geraldton Health Campus which will provide a new acute psychiatric unit and mental health short stay unit to safely manage demand for emergency and critical care and mental health services, and align with contemporary models of care.

[11] The MHOA Plus will consist of an 8 bed unit to treat less acute patients and a separate authorised 12 bed unit for patients requiring higher acuity therapy and potentially longer term care. Under the current proposal, Ward 2K will be closed and replaced by the MHOA and associated Mental Health Inpatient Unit. The inclusion of the Secure Unit will include the transformation of RPH into an authorised hospital.

[12] The UCC comprises of 6 treatment spaces including 5 beds and 1 chair.

Alcohol and Other Drugs

Key achievements impacting AOD hospital-based services are outlined below.

- Provision of specialist in-reach support provided by Next Step to the Joondalup Health Campus Emergency Department. This service provides information, support and referral options to individuals, family members and hospital staff for people affected by substance use including methamphetamine;
- Expansion of specialist in-reach services by Next Step to Fremantle, Sir Charles Gairdner and Royal Perth Hospitals. These services have enabled the delivery of seamless care that provides more opportunity to deliver wrap around support services and shared care arrangements with community AOD services; and
- Endorsement of a new AOD Withdrawal Management Policy with Health Service Providers in August 2017 that supports services to provide access to a range of inpatient, outpatient and community-based AOD withdrawal services closer to home to meet the needs of their communities including for those with co-occurring mental health and AOD issues.

Current Strategic Context – Hospital-Based Services

Implementation of the Plan for all hospital-based services has progressed well and a significant number of initiatives have been successfully completed for both mental health and AOD services.

Election Commitments

In its 2017 election commitments, the State Government identified the requirement for an additional 25 to 30 mental health beds at the Joondalup Health Campus and an additional 20 beds based on need, a 10 bed MHOA at Royal Perth Hospital, and additional mental health beds as part of the Geraldton Hospital redevelopment.

Youth Services

Progress of the Plan's reform agenda for hospital-based youth services has been impacted by the closure of eight beds at Princess Margaret Hospital in advance of the opening of PCH. Additional beds for youth 16-24 years of age were opened at the BAU (increasing capa city to 19 beds) and Fiona Stanley Hospital youth unit (14 beds) to further assist with the treatment of 16 and 17 year olds.

With the opening of PCH, the ongoing availability of inpatient services for 16 and 17 year olds will be shared across Health Service Providers as the 20 acute beds at PCH become available for young people up to 15 years of age, including 16 year olds where clinically appropriate.

In view of the need to maintain appropriate levels of access to acute services for youth older than 16 years, the BAU has been converted into a 12 bed youth inpatient service by the East Metropolitan Health Services (known as the EMyU) rather than a statewide 14 bed subacute inpatient service as described in the Plan. Further to this, eight youth HiTH beds have become operational in the North Metropolitan Health Service.

Graylands Hospital and Selby Older Adult Mental Health Service

The Commission continues to work with the North Metropolitan Health Service and DOH for the divestment of infrastructure and the decommissioning and reinvestment of services at Graylands Hospital and Selby Older Adult Mental Health Service, and its replacement with an appropriate continuum of contemporary services.

Work is progressing on business cases to ensure that appropriate mechanisms are in place to support the recommissioning of contemporary infrastructure and services to replace those previously available at the Graylands Hospital and Selby Older Adult Mental Health Service sites, including the development of a balance of services by region as supported by the Plan modelling.

To improve current services across Western Australia and the number of individuals receiving adequate treatment in a timely manner, recommissioning of inpatient beds from Graylands Hospital into areas of projected need will enable appropriate support to be provided closer to home. This will further increase continuity of care for individuals who have accessed inpatient units, and are reintegrating into the community, providing them with linkages to community-based supports and timely onward referral to appropriate internal and external services in parallel including community mental health services. The development of new services is integral to ensure there is no delay in transfer due to unavailability of beds, and to ensure continuity of care, and that clinical and security risks are managed appropriately.

Health Services Act 2016

The implementation of the *Health Services Act 2016* and the creation of the East Metropolitan Health Service required Health Services Providers to restructure the allocation of resources, establish new processes that reflect changes to areas of responsibility and build new relationships. During this period of structural change, the focus has remained on the continuity of services and further reform of mental health services. This is strongly supported by the transparent and accountable contracting arrangements the Commission has with Health Service Providers.

Health Service Providers and DOH have been supported to increase specialist support services to people affected by methamphetamine use; however the prioritisation of these requirements has impacted on the capacity of Health Service Providers to expand inpatient AOD withdrawal services.

Assertive Patient Flow

Progress in relation to assertive patient flow is managed through the Mental Health Patient Flow Working group, established in December 2017. The group is tasked with identifying and making recommendations for the reform of the current assertive patient flow process. Phase one, the design of a new model including high level principles that will form the foundation of the future patient flow model has been completed. The project is currently in phase two, with work progressing on defining operating workflows, policies and procedures that will underpin implementation. The new Mental Health Patient Flow model will be rolled out in March 2019.

Future Directions – Hospital-Based Services

Although the updated modelling for optimal levels of youth acute, subacute and HiTH hospital-based services by the end of 2025 has decreased from the Plan, 85 additional youth beds are still required by the end of 2025.

The opening of a 20 bed mental health unit at PCH for children up to the age of 15 years old (and 16 years old where clinically appropriate) has resulted in one additional bed for this age cohort. Increasing current levels of youth dedicated beds to meet estimated demand, including for youth aged 16 and 17 years old, remains a priority.

In 2017-18, there were 57,047 presentations to emergency departments for mental health-related issues, with an average waiting time of 113 minutes to be admitted to a bed. However, patient flow reports indicate a small number of mental health patients waiting an extended period of time for a specialised mental health bed when presenting at hospital emergency departments.

Long wait times are not acceptable and do not represent the most appropriate clinical care setting for these vulnerable patients. The Commission will continue to work with the Mental Health Patient Flow Working Group to implement the assertive patient flow process, to ensure wait times in emergency departments are kept to a minimum.

Continuing to enhance the range of inpatient AOD withdrawal services across the State including for those with co-occurring mental illness remains an ongoing priority.

Future priority initiatives in the mental health and AOD sectors include:

- Progress decommissioning of services from the Graylands Hospital and Selby Older Adult Mental Health Service sites, and their replacement with contemporary acute inpatient and community-based infrastructure and services including the development of services by region as supported by the Plan modelling;

- Continue planning for the expansion of Joondalup Health Campus, with the addition of 25 to 30 new mental health beds;
- Further development of flexible service models for the MHOA at Royal Perth Hospital and consideration of expansion of MHOAs at other sites across the State. This includes consideration of Emergency Stabilisation and Referral Areas (ESARAs) within emergency departments to increase access to AOD low medical withdrawal and stabilisation services. ESARAs would also facilitate transition into ongoing treatment services that include assertive engagement with individuals and their families;
- Allocation of $73.3 million for DOH as part of the redevelopment of the Geraldton Health Campus from 2019-20, which includes the delivery of a four bed mental health short stay unit, a 12 bed (four secure and eight open) acute psychiatric unit, four HiTH places supported by a comprehensive community-based service, in addition to a $7.7 million allocation for a community mental health step up/step down service located off campus;
- Continued resourcing of Health Service Providers to expand the use of telehealth links in regional areas (including tele-psychiatry and specialised services) and support for use by outer metropolitan services;
- Further planning and modelling for older adult mental health beds with consideration to national reforms. Expand the capacity of hospitals, including country hospitals, to provide a range of inpatient, outpatient and community-based services consistent with the statewide AOD withdrawal management policy;
- Increase access to specialist clinical hospital in-reach services for individuals with co-occurring mental health and AOD problems with a focus on methamphetamine use; and
- Work with DoH, Health Service Providers and community services to improve flow through between hospitals beds, Emergency Departments, community treatment, community bed-based services and supported accommodation.

Table 5: Summary of Plan Matrix, Hospital-Based Services

Service Type		State Total				
		2013 Actual (a)	2017 Actual (b)	2017 Optimal (a)	2020 Optimal (b)	2025 Optimal (b)
Hospital Based Services	Beds (total)	710	761	822	863	1,094
	Hours ('000) (total)	218	265	274	479	525
MH Infant, Child and Adolescent	Beds	26	19	20	20	26
MH Youth Acute	Beds	-	14	18	26	74
MH Youth Subacute/Non-acute	Beds	-	-	14	-	12
MH Youth HiTH***	Beds	-	8	n/a	10	21
MH Adult Acute	Beds	384	404	386	396	358
MH Adult Subacute/Non-acute	Beds	102	79	102	59	76
MH Adult HiTH***	Beds	12	32	n/a	61	109
MH Older Adult Acute	Beds	144	144	93	144	84
MH Older Adult Subacute/Non-acute	Beds	-	-	55	-	122
MH Older Adult HiTH***	Beds	-	8	n/a	19	52
Total HiTH	Beds	12	48	73	90	181
Mental Health Observation Area (MHOA)	Beds	6	14	28	32	56
MH Private ^	Beds	231	269	231	269	269
AOD (High/Complex Medical Withdrawal) incl private ^^	Beds	36	39	52	96	103
MH/AOD Consultation Liaison	Hours ('000)	218	265	274	479	525

(a) 2015 Plan and (b) Plan Update 2018

*** HITH beds are a substitution for both acute and Subacute/Non-acute hospital beds. HITH beds by age cohort was not available in 2015 but are provided in Plan Update 2018.
^ Current MH private beds, unknown whether they will grow and are not reflected in Hospital Bed-Based Services sub-total.
^^ AOD private beds were separately calculated in 2015. As services provided in the private sector are similar, they are treated as the same service. AOD private beds are included in total Hospital Based Bed Total.

Specialised Statewide Services

Specialised statewide services offer an additional level of expertise or service response for people with particular clinical conditions or complex and high level needs. Services can include targeted interventions, shared care, comprehensive care and rehabilitation for extended periods, and support to general services.

Key Achievements since the release of the Plan

Commissioning of a specialised statewide perinatal (mother and baby) inpatient service.

Development of the Western Australian Eating Disorders Outreach and Consultation Service.

$850,000 annual funding to commence a Statewide Gender Diversity Service.

The service elements of the specialised statewide services stream featured in the Plan include:

- Specialised statewide inpatient services for:
  - Eating disorders;
  - Perinatal; and
  - Neuropsychiatry and Neurosciences.
- Community-based specialised statewide services including:
  - Eating disorder services;
  - Perinatal services;
  - Long term rehabilitation services;
  - Neuropsychiatry and Neurosciences; Attention Deficit Hyperactivity Disorder (ADHD);
  - Co-occurring mental illness and intellectual, cognitive or developmental disability (including autism) service;
  - Sexuality, Sex and Gender Diversity service;
  - Children in Care program;
  - Transcultural services;
  - Hearing and vision impaired; and
  - Homelessness program

Modelling Update – Specialised Statewide Services

Changes to 2025 estimates

For specialised statewide services, the inpatient beds component for eating disorders and perinatal beds are modelled separately. More work is required regarding the modelling for the specialised neuropsychiatry and neurosciences inpatient beds within the capacity of total hospital bed numbers.

The community-based specialised statewide services have been included within the total modelled community treatment hours of service (see community treatment services).

Figure 31 outlines changes in modelled optimal levels of eating disorder and perinatal inpatient bed numbers, by the end of 2025 compared with the original optimal levels in the Plan.

The Plan updated modelling shown in **Figure 31** indicates that:

- The revised optimal level of inpatient beds for eating disorders has reduced by 15% from 47 to 40 beds required by the end of 2025; and
- The optimal number of perinatal beds has reduced by 11% from 28 to 25 beds by the end of 2025.

Changes to population growth rates, and a correction to the overestimation of readmission rates for specialised statewide hospital beds, have reduced the estimated demand for eating disorder and perinatal beds by the end of 2025 compared with the original optimal levels in the Plan.

Figure 31: Mental health – Specialised Statewide – Percentage change in 2025 optimal levels, compared with optimal levels in the Plan

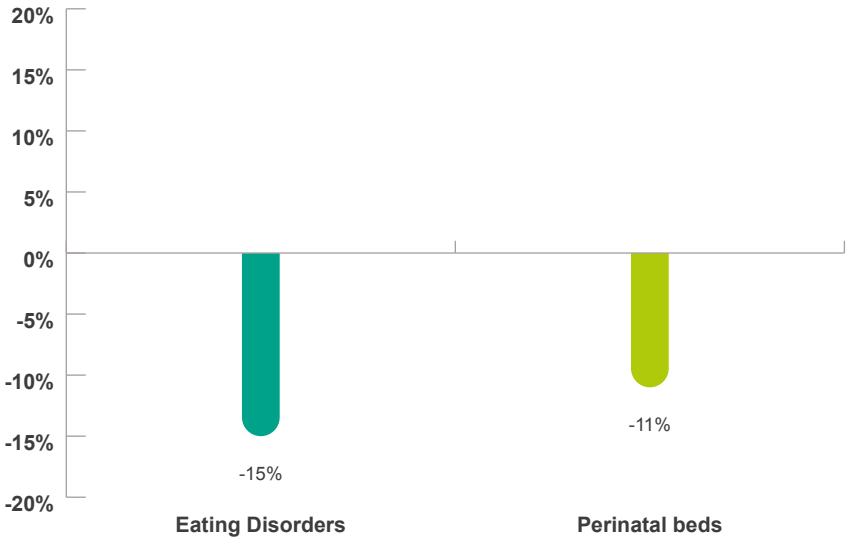
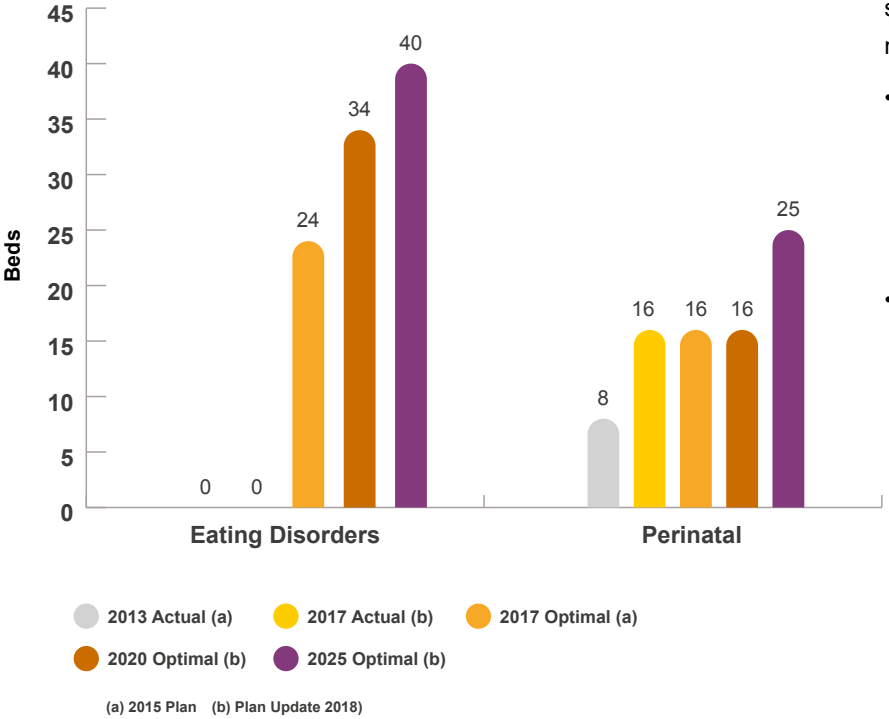


Figure 32: Mental health – Specialised Statewide – Optimal and actual levels of service



Current services compared with 2025 estimates

Figure 32 shows that at present there are no dedicated inpatient beds for eating disorders, with the introduction of 40 beds required by the end of 2025 to reach optimal levels. While the 2020 requirement for 16 perinatal beds has been met, a growth of 56% (nine beds) is required to reach optimal levels of 25 beds by the end of 2025.

Achievements – Specialised Statewide Services

Strategic achievements aimed at expanding the availability of a range of high quality, effective and efficient specialised statewide services to meet demand include:

- Commissioning of a specialised statewide perinatal (mother and baby) inpatient service at Fiona Stanley Hospital with eight beds, operational from June 2015;
- Commencement of a Statewide Gender Diversity Service by CAHS with $850,000 in annual funding from 2015-16;

- Development of the Western Australian Eating Disorders Outreach and Consultation Service with $800,000 in annual funding from 2015-16;
- Commenced collaborative adaptation of the Core Capability Framework for working with people with an intellectual disability and/or autism and co-occurring mental health issues (developed by the Western Australian Council of Social Services with Commission funding), for use as a required training resource by Health Service Providers;
- The Personality Disorders MHN Sub Network commenced development of guidelines for the best practice support for individuals with a personality disorder presenting at Emergency Departments and other health settings; and
- Collaborative development of overarching principles by the MHN to support integrated governance structures, quality assurance and comprehensive coverage of the State's population when a service is available in multiple regions but is not statewide (trans-regional) and accepts referrals outside their geographical catchment areas.

Additional Achievements to 30 September 2018

- Development of 'A Model for an effective and sustainable statewide Transcultural Mental Health Service for Western Australia Project Proposal', by the MHN's Multicultural Sub Network; and
- Discussions with DoH and early planning including Statewide modelling for children, adolescent and adult eating disorder services.

Current Strategic Context - Specialised Statewide Services

Substantial progress has been made in expanding access to inpatient perinatal services. The First Thousand Days: an Evidence Paper examines the influences on the development of children from conception to age two. The Evidence Paper builds on previous literature reviews and provides a comprehensive summary of current evidence for the significance of the first 1,000 days. The Commission will consider the recommendations in the Evidence Paper as part of the review of current procurement and planning process for future procurements.

Challenges remain in implementing dedicated inpatient beds for eating disorders and expanding existing and establishing new community-based specialised statewide services. The treatment of eating disorders is most appropriately delivered in dedicated general health beds, with specialist in-reach mental health services. The Commission is working closely with DoH on this issue.

The development of new specialised clinical services in the area of co-occurring and multiple complex needs, including intellectual, cognitive or developmental disability, has been influenced by the roll out of NDIS in Western Australia.

As eligible Western Australians with psychosocial and other support needs transition to the NDIS, the Commission will continue to pursue opportunities to provide integrated specialised clinical care to those with severe mental illness and multiple complex needs.

For those with psychosocial and other support needs who are not eligible for the NDIS the Commission is providing a wide range of services delivered through various non-government organisations including, but not limited to; community mental health step up/ step down services; respite services; accommodation support services and family and carer supports. These services contribute to the National Psychosocial Support Measure (NPS). An overarching objective of the NPS measure is to support people with severe mental illness and associated psychosocial functional impairment, who are not more appropriately supported through the NDIS.

Opportunities to prioritise investment for developing new specialised statewide services and reconfiguring existing services in the public mental health sector, including those related to neurosciences and neuropsychiatry, and hearing and vision impaired, have not arisen since the release of the Plan but remain as priority areas for the further development of specialised statewide services.

Future Directions – Specialised Statewide Services

Areas of priority for further progress in implementing specialised statewide services as described in the Plan include:

- Establish specialised inpatient services for eating disorders and neuropsychiatry and neurosciences;
- Establish community-based specialised statewide services including for:
    - children in care;
    - neuropsychiatry; and neurosciences disorders;
- Expand community-based specialised statewide services including for:
    - eating disorder services; and
    - perinatal services, including considering recommendations from the First Thousand Days: An Evidence Paper;
- Enhance workforce capabilities to manage personality disorders as well as co-occurring mental illness and a range of complex disorders such as AOD, intellectual, cognitive or developmental disability (including autism spectrum disorder), ADHD, hearing and vision impaired, and homelessness; and
- The MHN's Multicultural Sub Network has developed a project proposal for a transcultural mental health service for Western Australia. The Commission and WAPHA are working together with a view to developing a final model that is effective and sustainable statewide that aims to increase access to culturally appropriate care in the community.

Table 6: Summary of Plan Matrix, Specialised Statewide Services

Service Type		State Total				
		2013 Actual (a)	2017 Actual (b)	2017 Optimal (a)	2020 Optimal (b)	2025 Optimal (b)
Specialised Statewide Services (inpatient) ****	Beds (total)	8	16	40	50	65
Eating Disorders	Beds	0	0	24	34	40
Perinatal beds	Beds	8	16	16	16	25

(a) 2015 Plan (b) Plan Update 2018

**** Specialised Statewide Services refer to those services that are accessible to the entire State's population, but may be located in one specific location (e.g. the metropolitan area).

Forensic Services

Forensic services aim to prevent people with severe mental health and AOD problems becoming involved in the criminal justice system or reoffending. Forensic services also provide treatment and support for people through all stages of the criminal justice system (equivalent services to those available to the general community).

Key Achievements since the release of the Plan

Establishment of the Police Mental Health Co-Response program.

Commenced provision of prison in-reach transition services.

Establishment of a 77-bed women's AOD Rehabilitation Prison at Wandoo. In addition, planning has commenced for a male AOD rehabilitation facility at Casuarina Prison.

The following service elements relate to forensic services:

- Early intervention, including prevention and general community services;
- Pre-arrest police liaison/support, including police and mental health co-response;
- Arrest/police lock-up, including Police Drug Diversion and mental health and AOD in-reach into police lock-ups;
- Court Liaison and Support, including Court Diversion Programs;
- Prison and Detention, including in-prison community treatment, in-prison subacute beds
- Specialised forensic mental health inpatient services;
- Specialised forensic mental health and AOD community treatment services; and
- Community linked services, including accommodation and community beds.

Modelling Update – Forensic Services

The national modelling tools used to develop the Plan do not include the provision for modelling forensic services. To account for this, forensic services required for Western Australia, as identified in the Plan, were developed jointly by the Commission, the former Drug and Alcohol Office, DOH and the former Department of Corrective Services. This planning occurred in extensive consultation with the Forensic Mental Health Planning Group, the former Drug and Alcohol Office Treatment and Support Expert Group, and engagement with consumers, carers and support persons.

As modelling for forensic services does not form part of the national modelling tools, the estimated levels of service required have not been revised since the release of the Plan in 2015.

The Commission will continue to work with the Department of Justice, DoH and relevant stakeholders to further develop the modelling of forensic services required.

Current services compared with 2025 estimates

Figure 33 and **Figure 34** outline the estimated optimal service levels required by the end of 2025 and the current services provided at 30 June 2017.

As at 30 June 2017, the number of forensic inpatient beds provided had decreased from 38 to 37, due to the relocation of ward areas at Graylands Hospital. As at 30 September 2018, this had further decreased to 35 beds as a result of the closure of the Hutchison Ward, at Graylands Hospital due to health and safety concerns.

At 30 June 2017, there were no mental health/AOD in-prison beds in Western Australia. With the opening of Wandoo Rehabilitation Prison for women in mid-2018 by the Department of Justice, there are now 77 AOD rehabilitation places available for women in prison. In addition, an AOD rehabilitation prison for men is currently under development and is expected to commence operation in mid-2020. However, there are currently no in-prison subacute mental health beds, and the Plan estimates that by the end of 2025, the optimal level is 70 mental health/AOD beds.

Figure 33: Forensic – Bed-based – Optimal and actual levels of service

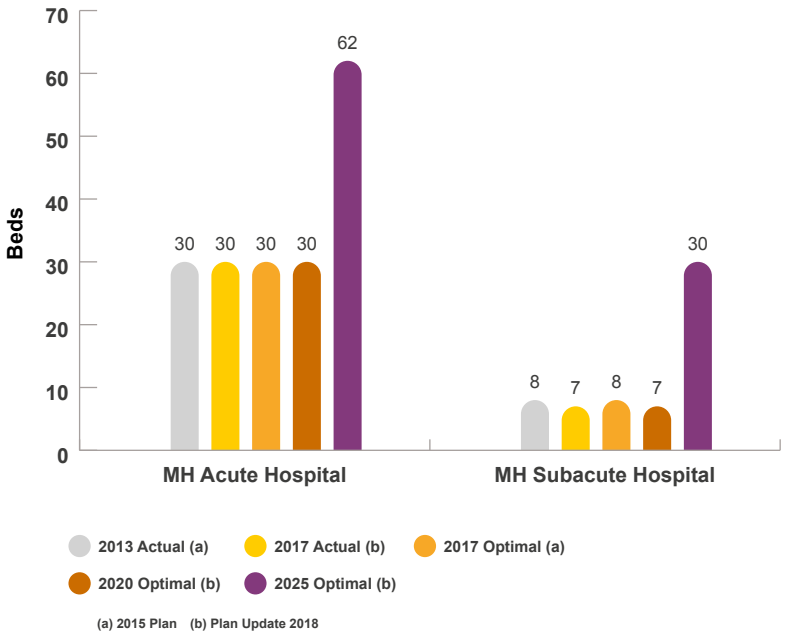
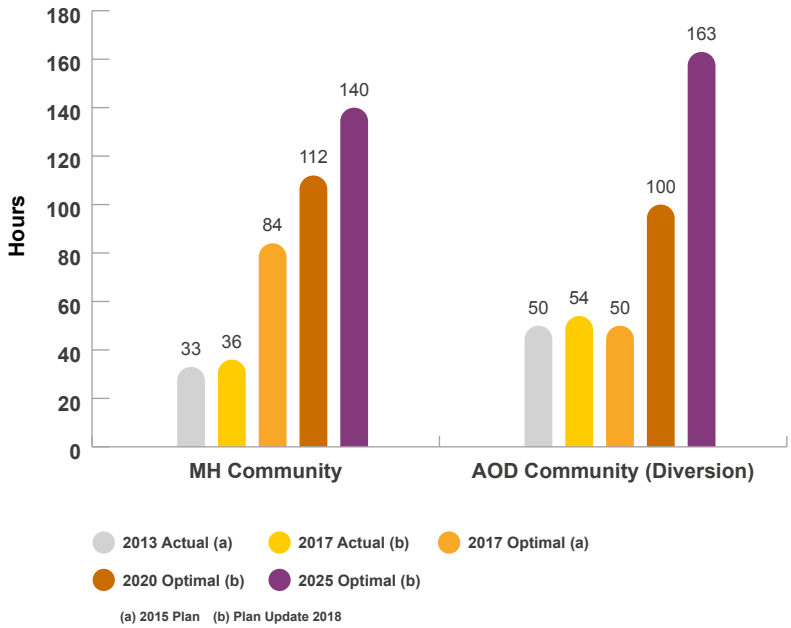


Figure 34: Forensic – Community-based – Optimal and actual levels of service



The Plan indicates that there is a requirement for a total of 55 additional secure forensic mental health acute and subacute inpatient beds, including dedicated or separable places for men, women, young people and Aboriginal people by the end of 2025.

In relation to forensic community treatment hours of service, mental health is required to grow from 2017 by 289% (104,000 hours) and AOD is required to grow by 202% (109,000 hours) by the end of 2025, in order to reach optimal levels of service.

Changes to levels of service since 30 June 2017 to 30 September 2018

In mid-2018, the Hutchison Ward, a seven bed forensic mental health subacute unit at Graylands Health Campus, was closed due to health and safety concerns. Patients that resided in Hutchison Ward were transferred to Graylands subacute beds. This reduced the total number of forensic subacute beds from seven to five. The Commission will seek opportunities to purchase subacute forensic beds elsewhere in the system.

In addition, in July 2018, Wandoo AOD Rehabilitation Prison for women commenced operation, with capacity for up to 77 beds. While it is noted that there is still a requirement for in-prison mental health beds, the establishment of the AOD rehabilitation prison for women has increased the number of in-prison AOD beds (mental health/ AOD beds in Matrix page 33) from 0 to 77.

Achievements – Forensic Services

Achievements since the release of the Plan to 30 June 2017, aimed at preventing people with severe mental health and AOD problems becoming involved in the criminal justice system, and the provision of treatment and support at all stages through the criminal justice system include:

- Continuation of the multi-agency Court Diversion Program with $13.1 million continued funding over three years from 2016-17 to 2018-19 to divert adults (Start Court) and young people who appear before the Children's Court (Links Program) with mental illness, away from the criminal justice system and into treatment to reduce the risk of reoffending;
- A dedicated stream for individuals with co-occurring mental health and AOD problems was introduced, to enable individuals to be assessed and referred from the Start Court to specialist AOD drug treatment providers. In addition, two additional consumer and carer representatives were recruited to the Start Court Operational Committee;
- Collaboration with the Department of Justice and the North Metropolitan Health Service to develop and establish a new forensic mental health prison in-reach transition service. In response to identified unmet need, the service commenced in February 2017 across several metropolitan prisons. This service assists prisoners who experience severe and enduring mental illness with complex co-morbidity, in preparing for release. The service facilitates transition between prison and community mental health services;
- Collaboration with the former Department of Corrective Services to develop a new online training package for prison officers and other Department of Corrective Services staff, designed to raise awareness about mental health and AOD issues in a corrections setting, including the general prison population, Aboriginal prisoners, women and young people;
- Implementation and continued provision of a Mental Health Police Co-Response program in partnership with the WA Police Force and DoH. The service aims to intervene early and divert people with mental illness away from the criminal justice system and to the treatment and support networks they need. In addition, the service aims to reduce the risk of injury for the responders during mental health crisis; improve situational awareness, confidence and decision-making of WA Police Force during a response; and improve collaboration between Police, mental health services and other agencies involved in the management of mental health crisis;
- Implementation of the recommendations from the review of the *Criminal Law (Mentally Impaired Accused) Act 1996* (CLMIA Act) tabled in Parliament in April 2016 by the former Attorney General to ensure the fair and just treatment of mentally impaired accused; and
- Collaboration with DoH and the Department of Justice on the Justice Health Project, to examine issues and consider options for the optimal management and commissioning of prison (custodial) health services, including mental health and AOD services.

Additional Achievements to 30 September 2018

- Completion of the Mental Health Police Co Response Trial Evaluation by Edith Cowan University; and
- Establishment of a women's AOD rehabilitation prison at Wandoo in July 2018 by the Department of Justice, with the commencement of planning for a male AOD rehabilitation prison at Casuarina Prison.

Current Strategic Context – Forensic Services

There are a number of factors that may influence the development and delivery of forensic service provision in Western Australia over the coming years.

The amalgamation of the Department of Corrective Services with the Department of the Attorney General to form the Department of Justice facilitates a more coordinated approach for services across the continuum of the justice system.

As part of the Methamphetamine Action Plan, the State Government committed to the implementation of two AOD rehabilitation services in prisons. Wandoo AOD rehabilitation unit for women commenced operation in mid-2018, with planning for the men's AOD rehabilitation prison at Casuarina Prison being led by the Department of Justice.

Currently, inpatient forensic beds are located on the Graylands Health Campus. However, there are currently no dedicated forensic beds in Western Australia for people under the age of 18 years. This means that if a child becomes so unwell that they require secure acute mental health treatment, the only option is to place them in the Frankland Centre at Graylands Hospital, although this is an option of last resort. Due to the lack of forensic mental health beds for youth, children who are severely mentally unwell who are in detention and who are not transferred to the Frankland Centre must be cared for at Banksia Hill Detention Centre in the Crisis Care Unit. This unit is also used for management and protection, and is not configured to provide mental health treatment.

Detailed planning for the continuum of forensic services including dedicated forensic inpatient beds is required. The Commonwealth Government has commenced the development of a national modelling tool for forensic services as part of the NMHSPF. It is expected that the modelling tool will be completed in 2019.

The configuration of future forensic inpatient beds is being considered within the context of the decommissioning and reconfiguration of Graylands Health Campus.

In addition, the State Government has committed to reform Western Australia's mentally impaired accused laws as a matter of priority through a review of the CLMIA Act. The reforms will seek to ensure a balance between the rights and rehabilitation of the mentally impaired accused and the safety of the community.

Future Directions – Forensic Services

Areas of priority for further progress in implementing Forensic Services as described in the Plan, and in line with the State Governments election commitments, include:

- The Department of Justice to continue the development of a male AOD rehabilitation unit at Casuarina Prison;
- The North Metropolitan Health Service, DoH and the Commission, in partnership with key stakeholders, to undertake planning for the delivery of a continuum of forensic services including consideration of additional forensic inpatient beds, particularly for women and youth;
- Consideration of mental health subacute services in prisons;
- Assist with the development of the NMHSPF forensic services national modelling tool, and work with the Department of Justice, DoH, Health Service Providers and other key stakeholders to model optimal levels of service for forensic mental health and AOD services in Western Australia; and
- The Department of Justice to progress reform of the CLMIA Act so that it better supports the rights and rehabilitation of mentally impaired accused persons.

Table 7: Summary of Plan Matrix, Forensic Services

Service Type		State Total				
		2013 Actual (a)	2017 Actual (b)	2017 Optimal (a)	2020 Optimal (b)	2025 Optimal (b)
Forensic Services	Beds (total)	38	37	38	37	92
	Hours ('000) (total)	83	90	134	212	302
MH Acute Hospital	Beds	30	30	30	30	62
MH Subacute Hospital	Beds	8	7	8	7	30
MH Community	Hours ('000)	33	36	84	112	140
AOD Community (Diversion)	Hours ('000)	50	54	50	100	163
Forensic Services (in-prison)	Beds (total)	0	0	70	70	70
In-prison MH/AOD beds	Beds	0	0	70	70	70

(a) 2015 Plan (b) Plan Update 2018

System-Wide Reform

System-wide reform refers to system improvements and new initiatives to support the achievement of the Plan's vision and implementation.

Key Achievements since the release of the Plan

Establishment of the Mental Health Network and Sub Networks.

Ongoing implementation of the *Mental Health Act 2014*, including completion of the PIR, which aims to improve the rights of consumers and ensure the best possible treatment and care.

Co-designed the Statewide Consumer, Family and Carer Engagement Framework and the model of service for Recovery Colleges.

The Plan identified a range of system-wide reform priority areas that are being progressed alongside the implementation of the other Plan actions within each of the service streams. System-wide reform initiatives are essential in order to support the transformation of the mental health and AOD service system. Areas of work focus on:

- Recovery-oriented practice[13];
- Co-production[14] and co-design[15] with consumers, families and carers;
- Advocacy;
- Individualised funding;
- Aboriginal people;
- Cultural and social diversity;
- System integration and navigation;
- Organisational effectiveness and efficiency;
- Research and evaluation;
- Monthly performance reporting to Health Service Providers;
- Workforce;
- Information and communication technology; and
- Capital infrastructure.

Achievements – System-Wide Reform

Key achievements to 30 June 2017 in the area of system-wide reform include, but are not limited to:

- Co-design and implementation of the Commission's Consumer, Family, Carer and Community Paid Partnership Policy;
- The development of the co-designed Engagement Framework and Toolkit to assist government, NGOs (including private enterprise), and the community in effectively engaging and working together to achieve better outcomes in the mental health and AOD sectors;
- Co-design of a model of service for Recovery Colleges;
- Continued funding of:
    - Consumers of Mental Health WA to represent and advocate for people with lived experience of mental health issues;
    - Western Australian Association for Mental Health as the peak body

[13] In the Plan the term "recovery" is based on the National Framework for Recovery-oriented Mental Health Service's definition, which is "being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues". The philosophy of recovery as this definition implies, is also applicable to the AOD sector, and in in relation to AOD it may or may not involve personal goals of abstinence.
[14] Co-Production: Implementing, delivering and evaluating supports, systems and services, where consumers, carers and professionals work in an equal and reciprocal relationship, with shared power and responsibilities, to achieve positive change and improved outcomes.
[15] Co-Design: Identifying and creating an entirely new plan, initiative or service, that is successful, sustainable and cost-effective, and reflects the needs, expectations and requirements of all those who participated in, and will be affected by the plan.

representing community-based mental health service providers; and
    - Western Australian Network of Alcohol and other Drug Agencies as the peak body in the AOD sector;
- Drafting the Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025 to guide the growth and development of an appropriately qualified and skilled workforce that will provide individualised, high quality mental health and AOD services and programs for the Western Australian community;
- Continued support for the growth and development of the peer workforce including through Overdose Prevention and Management which trains peer educators to provide harm-reduction information to opioid users; Naloxone Peer Education which trains peers to recognise and respond to opioid overdose including using naloxone; and Methamphetamine Peer Education which trains peer educators to provide harm-reduction information to methamphetamine users;
- Established a partnership with the Curtin University Centre for Transformative Work Design to support the development of a comprehensive set of mental health support resources for Western Australian workplaces, including for those working fly in/fly out;
- Implementation of improvements to commissioning practices, including development and implementation of a procurement schedule to expand and enhance levels and mix of community support via co-design and co-production;
- The evaluation of NGOs within the context of the National Standards for Mental Health Services and the Commission's Mental Health Outcomes Statement has led to continued improvement in the quality of recovery-based community support services;
- Commencement of the *Mental Health Act 2014* on 30 November 2015 that has seen increased access to advocacy and support services for consumers including establishing the right to access Aboriginal Elders as required;
- Completion of a Core Capability Framework for co-occurring mental illness and intellectual, cognitive or developmental disability (including autism spectrum) service;
- Finalisation of Collaborative Care Framework 2016 that provides an agreed guide to help services to improve and respond to the needs of people with co-occurring mental health and AOD problems;
- Establishment of the MHN and Sub Networks (in the areas of youth, eating disorders, forensic, perinatal and infant, multicultural, neuropsychiatry and developmental disability, older adult, personality disorders, Joondalup/Wanneroo region, and Peel and Rockingham/Kwinana region) to support the development of care pathways, models of care, clinical guidelines, and other service improvements in these key areas;
- Expansion of AOD frontline workforce training and development to better support those who help others affected by methamphetamine related harm; and
- Commencement of the development of a draft Online Services Directory that will provide a central point for information on Western Australian mental health and AOD services.

Additional Achievements to 30 September 2018

- Completion of the PIR of the *Mental Health Act 2014*;
- Establishment of the AOD Consumer and Community Coalition (AODCCC), the first AOD consumer peak body of its kind in Western Australia. The consumer led formation of the AODCCC is a step toward stronger consumer advocacy, engagement and representation in Western Australia; and
- Continued partnership with Curtin University on the ‘Looking Forward, Moving Forward’ Systems Change Project (2017 2021) to grow the capacity of organisations to be flexible, confident and competent in supporting Aboriginal families and improve access for Aboriginal

people to mental health and AOD services. This Project expands on the work of the 'Looking Forward' Project which resulted in the development of the *Minditj Kaart-Moorditj Kaart* Framework, and is moving to an implementation and evaluation phase.

Current Strategic Context – System-Wide Reform

Many of the system-wide reforms described in the Plan require sustained effort to effect real change; therefore it is important to continue to focus on the system-wide reforms over time.

Key areas of service reform across the mental health and AOD systems are being progressed when strategic opportunities arise including through the implementation of the *Health Services Act 2016* and when new and innovative service requirements are commissioned such as with the Rockingham step up/step down service.

Implementation and Review of the Mental Health Act 2014

The ongoing implementation of the *Mental Health Act 2014* continues to support hospital and community-based care reforms by ensuring that people experiencing mental illness are provided with the best possible treatment and care, their rights are respected and the roles and rights of people acting as personal support for consumers are recognised. The subsequent recommendations from the PIR will aid in the Statutory Review of the *Mental Health Act 2014* and assist in identifying any required amendments. The Commission will work collaboratively with relevant stakeholders such as the Office of the Chief Psychiatrist, DOH and Health Service Providers on such amendments, particularly as they are incorporated into the delivery and monitoring of standardised models of service.

Development of Key Strategic Documents

The Commission is currently in the process of the development, finalisation and/or implementation of key strategic documents, including the Prevention Plan, Workforce Strategic Framework, Statewide Engagement Framework and the Accommodation and Support Strategy. These documents will provide a necessary foundation for government, non-government and the community in planning for future activities, and to facilitate integrated services. In addition, these strategies will provide a guide for investment in prevention and promotion activities, workforce development and accommodation and support services.

Developing an Integrated System

The mental health, AOD system includes a variety of treatment rehabilitation, care and support services as a result of the divergent needs of people with mental health and AOD issues. The resulting system may therefore appear complex. Responding to and addressing the divergent needs of individuals, including through enabling choice, co-design and co-production, can be very complex.

An effective and integrated system is essential to ensure individuals do not fall through the gaps across the service continuum and when transitioning between services, and that each individual receives the appropriate level of care and support to meet their needs.

It is essential that mental health and AOD services work together across primary care, community and hospital-based services and across health and human service sectors in an integrated, coordinated way, to ensure service delivery is comprehensive, cohesive, accessible, responsive, and optimises the use of limited resources.

In developing an integrated system, it is important to recognise and build upon existing services and programs and identify where new services and programs may be required or where linkages to services and organisations need to be forged or strengthened.

Services for Co-occurring Mental Health and AOD

Mental health and AOD problems, more often than not, occur together and with other health and/or social issues (e.g. trauma, cognitive impairment, physical health and housing problems).

Commissioning and service delivery requires collaborative and, where appropriate, integrated provision of treatment for mental health and AOD problems. This involves the establishment of more consistent approaches to collaboration, joint protocols, clearly defined treatment and support protocols and care pathways.

Culturally Secure Services

Strategies to improve the health and wellbeing of Aboriginal people need to be developed by and with Aboriginal people, communities and Elders, taking into account Aboriginal definitions of health and wellbeing.

All Commission funded services are required to deliver culturally secure services for Aboriginal people as part of the contract service requirements. In addition, Aboriginal people are identified as a priority target group for service provision. Under the quality standards outlined in the contract, all Commission funded service providers are required to acknowledge and respect the history, cultural rights, values, beliefs and diversity of Aboriginal peoples and work towards embedding the principle of cultural security into the delivery of services. The service provider must develop, refine and deliver AOD services under the guidance of 'Strong Spirit Strong Mind Aboriginal Drug and Alcohol Framework for Western Australia 2011-2015, the 'WA Aboriginal Health and Wellbeing Framework 2015-2030', and the 'Cultural Respect Framework 2016-2026'.

Commission's Procurement Schedule 2018-2025

Implementation of the Commission's Procurement Schedule 2017-2025 for non-government community-based services will also affect further system wide changes by embedding service providers' contractual requirements to deliver quality assured, recovery focussed, individualised care and supports. This includes requirements for service providers to demonstrate their capabilities to meaningfully engage in co-production with consumers, families and carers, provide trauma informed care, be culturally competent in the design and delivering of services and be able to provide services that are accessible and sensitive to the needs of people with co-occurring issues, Aboriginal people, people from culturally and linguistically diverse backgrounds and LGBTI+ communities.

Primary Care

The Commission works closely with WAPHA to improve integrated service delivery through planned and coordinated commissioning, structured system change and a commitment to better health outcomes for Western Australians.

The Commission and WAPHA have been working in partnership to facilitate better transitions and care linkages between non-acute and acute care and to reduce barriers to treatment.

Balance of Services

In rebalancing the system across the continuum of community-based care through to hospital-based care, services need to be reconfigured so that beds and community services are distributed geographically in accordance with population need and balanced across Health Service Provider catchments.

Election Commitments

Commitments from the 2017 election have prioritised investment in the capital infrastructure required to increase the number of acute mental health beds by 50 in metropolitan and regional hospitals including expansions at Joondalup Health Campus and Geraldton Hospital, and the allocation of 20 step up/step down services in line with need.

NDIS

The implementation of the NDIS and the inclusion of individuals with ongoing needs for psychosocial supports has created some uncertainty in Western Australia, as it has across the rest of Australia. The Commission will continue to monitor its implementation in order to minimise any issues relating to service access and quality for people with mental health issues.

Progression of system-wide reform priorities is currently, and will continue to be, impacted by the current fiscal environment. Advancement of system-wide reform actions are progressing within existing resources and where possible budget submissions are presented to seek additional funding. The limitations of budget cycles, where funding is not readily available for longer term investments, impacts on the ability to effect long term change.

These constraints have impacted on the development of a 10 year mental health and AOD service Information and Communication Technology Plan that will further enhance the management of information across the system and support the delivery of treatment and support services as originally described in the Plan.

Future Directions – System-Wide Reform

Progress has been made on a number of system-wide reform areas, however increased focus on system reform over the coming years remains essential. This will occur alongside the implementation of other actions within the Plan.

Key priorities for system-wide reform include:

- Further progress integration of mental health and AOD services including a requirement for commissioned services to develop coordination and communication strategies to ensure relevant services are integrated and people are supported to transition effectively between services, programs and geographical regions;
- Continue to support the improvement of consumer, carer and family experience and engagement through:
    - Implementation of the Engagement Framework and Toolkit;
    - Continuing to support consumer and advocacy peak bodies;

    - Providing training, support and remuneration for consumer, carer and family representatives;
    - Continuing to support the growth and development of the peer workforce;
    - Statewide implementation of consumer satisfaction indicators by Health Service Providers (following completion of a pilot trial of the YES Survey), including transparent and timely publication of outcomes; and
    - Ensuring effective complaints mechanisms are in place, which lead to continual service improvements;
- Develop comprehensive models of service for all major service streams (including mechanisms for monitoring and reviewing) and commence commissioning of services based on agreed models of service;
- Investigate international best practice culture change programs such as the World Health Organisation's Quality Rights Initiative, to improve the quality of care provided by mental health services; and subsequently progress initiatives to ensure all services are provided using contemporary holistic, person-centred, recovery approaches;
- Standardise, establish, monitor and publish KPIs;
- Expand access to a range of funding programs across the service system for individuals who are not eligible for NDIS funding;
- Finalise and commence implementation of the Workforce Strategic Framework;
- Finalise and commence implementation of the Accommodation and Support Strategy;
- Continue to implement processes and practices to improve the cultural security of services and programs. This includes the incorporation of culturally secure and respectful, non-discriminatory principles in the design of service models and associated practices, procedures, protocols, and commissioning practices;
- Continued funding support from the Department of Communities via national housing and homelessness programs for the Mobile Clinical Outreach Team as a proactive multidisciplinary mental health outreach service that works with people who are homeless or at risk of homelessness, having a serious and/or persistent mental illness;
- Continue to build upon programs to improve the physical health of consumers including partnering with existing healthy lifestyle and injury prevention health promotion programs, including the WA Health Promotion Strategic Framework 2017-2021;
- Implement and monitor the recommendations of the PIR of the *Mental Health Act 2014*, progress relevant amendments, and prepare for the Statutory Review; and
- Implement a planned and coordinated approach to improve information and technology, clinical information systems, eHealth, telehealth and information sharing.

Summary and Conclusion

9.

Summary and Conclusion

This Plan Update 2018 is the first scheduled remodelling of the optimal level and mix of services for the Western Australian mental health and AOD service system since the Plan was released in 2015. Updated population forecasts, and Aboriginal, regional and remoteness weightings have been applied to the two nationally agreed planning tools: the NMHSPF and the NDASPM, to provide an updated overview of estimated requirements by the end of 2025. In addition, optimal levels for metropolitan Health Service Providers have been revised to reflect the introduction of the East Metropolitan Health Service since the release of the Plan.

While revised modelling outlines slightly reduced levels of optimal service provision for mental health and AOD services by the end of 2025, there is a need to continue to rebalance the system to ensure an increase in community-based services, which will in turn reduce excessive demand for hospital-based services.

The Plan Update 2018 highlights key achievements to date primarily from the perspective of the Commission, as well as the ongoing need to continue with a strategic, balanced and targeted approach to increasing investment and expenditure in Western Australia's mental health and AOD systems.

The support and genuine engagement of consumers, carers and their families in the co-design and co-production of programs and services is critical to achieving long term, sustainable system reform. Further investment and expenditure will also support the reconfiguration of services so that beds and community services are distributed in response to the needs of the population as demonstrated in the modelling and from other types of evidence indicative of community need.

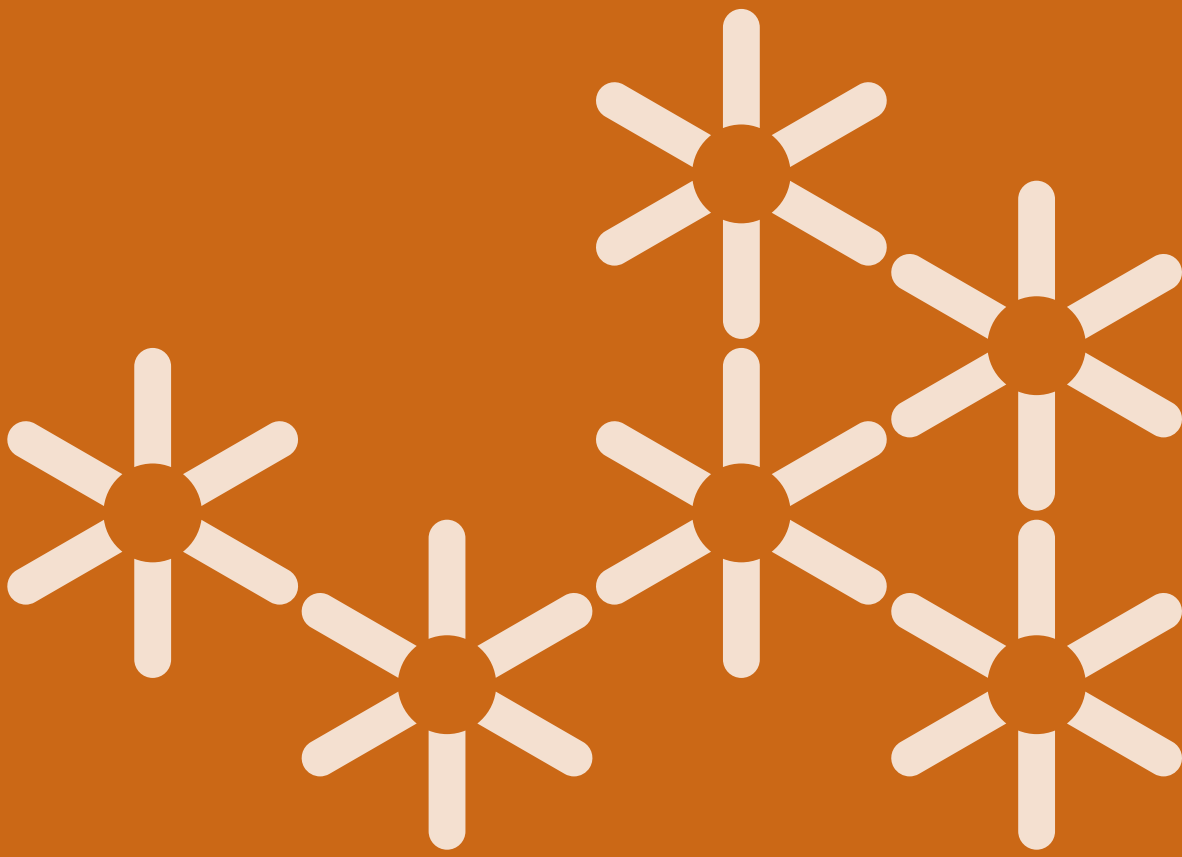
There remains a shortfall in supply in community-based services, and in the absence of suitable alternatives, hospital services are currently experiencing higher demand. Hospital based services will not experience excessive demand if all elements of the mental health and AOD system are in balance and at reasonable levels relative to the optimal levels. While expanding services that focus on prevention and community-based care will ultimately reduce the use of higher cost hospital-based services, responding to the increased demand remains a challenge within the context of a fiscally constrained environment. Reducing hospital-based services to re-allocate funding to community services is not feasible in the current circumstance where demand already exceeds supply of hospital-based services. As more community-based services are established, demand will even out across services, and hospital services will not experience excess demand.

As we enter the second phase of implementing the Plan to the next time horizon (by the end of 2020), enhancing the quantity and quality of community support services, as well as increasing the amount invested and spent, will continue as a key strategic focus. Refocussing hospital based services towards the provision of more person-centred care, and strengthening integration with community-based services, will continue in the context of improved contracting and accountability requirements between the Commission and Health Service Providers. All Government services will be further guided by the outcomes from the Sustainable Health Review and recommendations of the Methamphetamine Action Plan Taskforce Report.

The Plan Update 2018 is an important first review of progress towards implementing the Plan and assists in laying the groundwork for the development of the mid-term review scheduled to commence in 2020. The mid-term review will include a comprehensive review of the modelling for all service streams and will seek to determine whether system reforms have led to better outcomes for consumers. In addition, the mid-term review will identify priority actions for implementation through to 2025.

Appendices

10.



Appendix 1:
Summary of Strategic Reference Sources

Western Australian Alcohol and Drug Interagency Strategy 2018-2022

The Western Australian Alcohol and Drug Interagency Strategy 2018-2022 (WAADIS) is Western Australia's key policy document that outlines strategies to prevent and reduce the adverse impacts of AOD in Western Australia. WAADIS will operate under the national framework of supply, demand and harm-reduction and is underpinned by two core elements: first and foremost a focus on prevention and early intervention; and secondly, on providing support for those who need it.

The key strategic areas of the WAADIS are:

- focusing on prevention;
- intervening before problems become entrenched;
- effective law enforcement approaches;
- effective treatment and support services; and
- strategic coordination and capacity building.

WAADIS applies to all Western Australians, however evidence suggests that some population groups experience greater impacts from AOD use than others and therefore require additional support. These priority target groups include Aboriginal people and communities, children and young people, people with co-occurring mental health and AOD problems, people in rural and remote areas, including fly in/fly out and drive in/drive out workers, families, including AOD using parents, and those interacting with the Justice and corrections systems.

The priority drugs of concern listed in the WAADIS include alcohol, cannabis, methamphetamines, heroin and other opioids.

The implementation of the WAADIS is supported by the Drug and Alcohol Strategic Senior Officer's Group, which consists of senior representatives from the main human and social service State Government departments including the: Department of Justice; Department of Local Government, Sport and Cultural Industries; DoH; Department of Education; Department of Communities; and WA Police Force.

First Interim State Public Health Plan for Western Australia

The First Interim State Public Health Plan has been developed by DOH to assist the development of local public health plans by local governments and as a guide and support for NGOs, State Government departments, industry and the general public. Stakeholder feedback was sought on the First Interim Plan in 2017 and consideration will be given to the release of a Second Interim State Public Health Plan at a later stage.

The First Interim State Public Health Plan highlights that while Western Australia has a high standard of health compared with other countries, there is evidence that health status varies considerably across different population groups. The health status report for Western Australians presents a range of information about the health status of the Western Australian population, examines trends over time and identifies inequalities in health for Aboriginal people and other high risk and vulnerable communities and population groups.

Of particular relevance to the Commission's Plan is that alcohol use was reported as the second leading risk factor causing disease burden in Western Australia in 2011 (5.1%). Alcohol use was also responsible for 21% of the burden from suicide and self-inflicted injuries and 27% of the burden from motor vehicle road traffic injuries in Western Australia.

Priority areas for public health programs identified include:

- Empowering and enabling people to make healthy lifestyle choices;
- Providing health protection for the community; and
- Improving Aboriginal health.

Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025

The development of a system-wide multi-agency accommodation and support strategy to address the needs of individuals with mental health and/or AOD problems is identified as a priority area within the Plan.

The Accommodation and Support Strategy is the first of its kind in Western Australia and outlines the key features of a quality accommodation and support system to enable people with severe mental health issues and/or mild, moderate or severe AOD issues to sustain and maintain their accommodation in a community of their choice.

The Accommodation and Support Strategy is underpinned by the following principles:

- individual rights;
- personalised;
- inclusive communities;
- effective system wide partnerships; and
- continuous improvement.

The Accommodation and Support Strategy is a high level document with a multiagency approach. Government agencies, NGOs and the private sector will work together with consumers, families and carers to develop effective partnerships and develop further initiatives to provide an integrated accommodation and support system.

Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025

The Plan identifies the requirement to develop a Prevention Plan to address mental health and AOD issues in the Western Australian community. The Prevention Plan aims to provide an overview of the recommended programs, strategies and initiatives that promote optimal mental health, reduce the incidence of mental illness, suicide, and prevent and reduce drug use and harmful alcohol use in the Western Australian community.

The Prevention Plan focuses primarily on activities relating to mental health promotion and the primary prevention of mental health and AOD related issues. Promotion and prevention actions target the general population and groups at risk to promote optimal mental health and wellbeing, keep people well and to prevent and reduce AOD harm.

The Prevention Plan includes contextual background information, strategies categorised into domains across the life course, reference to priority populations, and a summary of prevention system supports that will support the implementation of the Prevention Plan.

The Prevention Plan development was led by the Commission in partnership with a range of key stakeholders, including academic experts, senior representatives from a range of government departments, key non-government

agencies and the general public, including consumers, carers and families of those with a lived experience of mental health and AOD related issues.

The Prevention Plan provides a guide for all stakeholders, including the Commission, for the development and implementation of evidence-based and evidence-informed strategies to promote mental health and prevent mental health, AOD related issues. Whilst the Commission provides high level oversight for the Prevention Plan's implementation, its implementation resides with a range of stakeholders responsible for mental health promotion and mental illness and AOD prevention.

Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025

The Plan identifies the requirement to develop a comprehensive mental health and AOD workforce planning and development strategy.

The Workforce Strategic Framework aims to guide the growth and development of an appropriately qualified and skilled workforce that will provide individualised, high quality mental health and AOD services and programs for the Western Australian community. The Workforce Strategic Framework outlines recommended strategies and actions that can be implemented by a range of organisations, including government and non-government agencies at the state and/or national level.

Development was led by the Commission in collaboration with key stakeholders including consumers, families and carers of those with a lived experience of mental health and AOD problems, senior representatives from a range of government departments, key non government agencies, peak mental health and AOD bodies, and clinicians.

The Workforce Strategic Framework provides a suite of strategies and recommended actions to inform current and future workforce planning and development decisions, development and investment. Strategic workforce investments that are aligned with the Workforce Strategic Framework can further develop workforce capacity and capability, thereby contributing to improved consumer, family and carer outcomes.

Collaboration between the Commission, DoH, peak bodies and other key agencies within the government, non-government and private sectors will be necessary in order to determine appropriate allocation of actions to address the priority areas and ensure successful implementation of the Workforce Strategic Framework. It identifies key roles and responsibilities of key agencies and organisations to assist in its implementation.

Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025

The Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018 2025 (Engagement Framework) and Toolkit aim to assist government, NGOs (including private enterprise), and the community in effectively engaging and working together to achieve better outcomes in the mental health and AOD sectors.

The co-designed Engagement Framework explains what engagement is at individual, service, sector and system levels and describes different types of approaches. Furthermore, the Engagement Framework explains the benefits of meaningful and genuine engagement and what works and what does not work, particularly in the mental health and AOD sectors.

The goal of the Engagement Framework is to support a vibrant community to work together to achieve better outcomes in the mental health and AOD sectors. The Engagement Framework outlines a set of interrelated principles and strategies to enable best practice engagement. The five principles include safety, authenticity, humanity, diversity and equity.

The accompanying Toolkit provides a step by step process to planning, developing, actioning and reviewing engagement strategies and practices in line with the five guiding principles outlined in the Engagement Framework. The Toolkit also includes specific strategies for engaging with diverse groups and showcases 10 practical examples of how government and non-government groups and organisations have actioned the five guiding principles across a variety of Western Australian projects and programs.

The Engagement Framework and Toolkit are designed to be used at individual, service, sector and system levels and are intended to be accessible and easy to use for all people, including those receiving services, those providing services, and those developing policies and strategies in the mental health and AOD sectors. While the Engagement Framework and Toolkit were developed for these sectors, the principles and their application are considered universal and transferrable across other sectors.

National Drug Strategy 2017-2026

The National Drug Strategy 2017-2026 (National Drug Strategy) provides a national framework which identifies national priorities relating to alcohol, tobacco and other drugs, guides action by governments in partnership with service providers and the community, and outlines a national commitment to harm minimisation through balanced adoption of effective demand, supply and harm-reduction strategies.

The National Drug Strategy was informed by a national consultation process throughout 2015, which included key informant interviews, online survey feedback and stakeholder forums. The consultation process was invaluable in shaping the direction and priorities for the National Drug Strategy, as well as confirming strong support for Australia continuing its commitment to harm minimisation underpinning its national drug policy approach.

The National Drug Strategy uses a balanced harm minimisation approach addressing demand reduction, supply reduction and harm-reduction, and is underpinned by the following strategic principles:

- partnerships;
- coordination and collaboration;
- national direction, jurisdictional implementation; and
- evidence-informed responses.

Fifth National Mental Health and Suicide Prevention Plan 2017-2022

Federal, State and Territory Health Ministers endorsed the Fifth Plan and its Implementation Plan at the Council of Australian Governments Health Council meeting in Brisbane on 4 August 2017.

The Fifth Plan articulates a cross jurisdictional framework for implementing national action over the next five years, building on the foundation established by previous national mental health plans and reform efforts.

Development of the Fifth Plan was led by the Mental Health Principal Committee (MHPC) (formerly the Mental Health, Drug and Alcohol Principal Advisory Committee) of which the Mental Health Commissioner is a member.

The Fifth Plan is focused on improvements across eight targeted priority areas:

- achieving integrated regional planning and service delivery;
- effective suicide prevention;
- coordinated treatment and supports for people with severe and complex mental illness;
- improving Aboriginal and Torres Strait Islander mental health and suicide prevention;
- improving the physical health of people living with mental illness and reducing early mortality;
- reducing stigma and discrimination;
- making safety and quality central to mental health service delivery; and
- ensuring that the enablers of effective system performance and system improvement are in place.

These key areas of focus correlate with reform directions currently underway through the Plan and the Western Australian Suicide Prevention Strategy 2020.

The Fifth Plan also responds to calls for a national approach to address suicide prevention and will be used to guide other sectors and to support health agencies to interact with other portfolios to drive action in this priority area.

The Commission was involved in the preparation and refinement of the Fifth Plan throughout the drafting process, including contributions through the MHPC.

Ongoing collaboration and engagement across the sector and with consumers and carers is required to successfully implement the Fifth Plan and achieve meaningful reform to improve the lives of people living with mental illness including the needs of children and young people.

Appendix 2: Implementation Status of Plan Actions due by end of 2017 as at 30 June 2017

Completed Actions:

Prevention
Actions: 1, 2 and 19.

Community Support Services
Actions: 3, 4 and 44.

Community Treatment Services
Actions: 6, 7, 8 and 31.

Community Bed-Based Services
Action: 9a.

Hospital-Based Services
Actions: 10b, 10c, 10d, 11, 46 and 53.

Specialised Statewide Services
Actions: 12, and 56a.

Forensic Services
Actions: 13, 14 and 64.

System Reform
Actions: 68, 69, 71, 87 and 89.

Additional Actions Completed as at 30 September 2018

Actions: 5, 10a, 15, 16, 20, 29, 40, 41, 55b, 61, 65, 66, 67 70, 72, 81 and 85.

Actions in Progress:

Prevention
Actions: 16, 17, 18 and 20.

Community Support Services
Actions: 21, 22, 24, 25, 26 and 57.

Community Treatment Services
Actions: 5, 27, 28, 29, 30, 32, 33, 34, 35, and 37.

Community Bed-Based Services
Actions: 9b, 9c, 9d, 9e, 38, 39, 40, 41, 42 and 43.

Hospital-Based Services
Actions: 10a, 45, 47, 48, 49, 50, 51 and 52.

Specialised Statewide Services
Actions: 54.1, 54.2, 55a, 55b, 55c, 55d, 55e, 56b and 56c.

Forensic Services
Actions: 58, 59, 60, 61, 62, 63, 65 and 66.

System Reform
Actions: 15, 67, 70, 72, 73, 74, 75, 76, 77, 78, 79, 80a, 80b, 81, 82, 83, 84, 85, 86 and 88.

Pending Actions

Community Support Services
Action: 23.

Community Treatment Services
Action: 36.

Specialised Statewide Services
Actions: 55f and 56d.

System Reform
Actions: 80c, 90, 91a, 91b, 91c and 91d.

Appendix 3: Technical Notes

This appendix broadly outlines the national frameworks, population based planning support tools and the Western Australian Framework that have been used in the development of the Plan Update 2018.

National Service Planning Frameworks

National Mental Health Service Planning Framework (NMHSPF)

The Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009-2014, made an explicit commitment to developing the NMHSPF. The development of the NMHSPF was led by the New South Wales Ministry of Health in partnership with Queensland Health, with input from jurisdictions including Western Australia. In October 2013, the first version of the NMHSPF and its Planning Support Tool (PST) was completed and the commitment to continue supporting the development and use of these resources on a national basis was reaffirmed by the release of the Fifth Plan in October 2017, following endorsement by the Council of Australian Governments Health Council in August 2017.

The NMHSPF is based on sound epidemiological data about the prevalence of mental illness, as well as evidence-based guidelines. It describes the mental health services required for a range of conditions. It translates this into an estimate of the need and demand for mental health services per 100,000 population and the staffing, beds and resources needed to provide those services.

Drug and Alcohol Service Planning Model (DASPM)

The Drug and Alcohol Clinical Care and Prevention Model (DA-CCP) was commissioned in early 2010 by the Ministerial Council on Drug Strategy through the Intergovernmental Committee on Drugs (IGCD). The project aimed to develop a nationally agreed, population-based planning model which could be used to estimate the need and demand for AOD services across Australia. In 2013, the DASPM, which also included a Decision Support Tool (DST) for AOD services, was released to jurisdictions for the purposes of planning and analysis.

In 2014 the DA-CCP was adjusted to develop the Western Australian Drug and Alcohol Service Planning Model (WADASPM).

Western Australian Service Planning Frameworks

The two national population-based modelling tools (NMHSPF and DASPM) were adapted to address the unique needs of the Western Australian population. However, it is important to note that the modelling tools used to form the Plan, differ to that used by the DoH for the development of the Clinical Services Framework.

The Western Australian Modelling Tools

Western Australia has adapted the NMHSPF-PST to develop the Western Australian Mental Health Planning Support Tool (WAMH-PST). The WAMH-PST takes into account the unique aspects of Western Australia's geography and population distribution. This is particularly relevant when estimating services needed for youth, Aboriginal people, and rural and remote communities in Western Australia.

Like the WAMH-PST, the WADASPM-DST estimates the number and type of services required for a comprehensive AOD treatment system. An internal Steering Group within the former Western Australian Drug and Alcohol Office, in consultation with experts and stakeholders, worked to ensure that the DASPM modelling is reflective of Western Australia's unique needs including Aboriginal and Torres Strait Islander people, and rural and remote communities in Western Australia.

The former Western Australian Drug and Alcohol Office developed the Model of Demand Index (MODI), which is an index of multiple AOD related indicators. The MODI helps to identify areas of AOD service demand in Western Australia by mapping AOD demand at a localised level. This will help to inform and prioritise where new services are required.

The Western Australian Department of Health Clinical Services Framework

The Western Australian Health Clinical Services Framework (CSF) is the principal Government endorsed clinical service planning framework for Western Australia's public health system.

The CSF is refreshed at intervals of approximately five years. The latest iteration covers the 10 year period 2014-2024 and has been developed in collaboration with the Commission and the former Drug and Alcohol Office. This approach has enabled mental health and AOD services to complement the DoH's broader planning processes and financial modelling.

The demand model used by the DoH is based on an analysis of existing service utilisation data and differs from the WAMH-PST and WADASPM-DST which are estimates of demand using population and epidemiological indicators of need. However, the Plan ensures that estimates of future need across the system are able to be converted into activity (such as weighted activity units) where relevant. This will ensure that assumptions made in the Plan can be mapped to current activity planning within the public mental health system.

Estimating Services Needed

Modelling for Severity

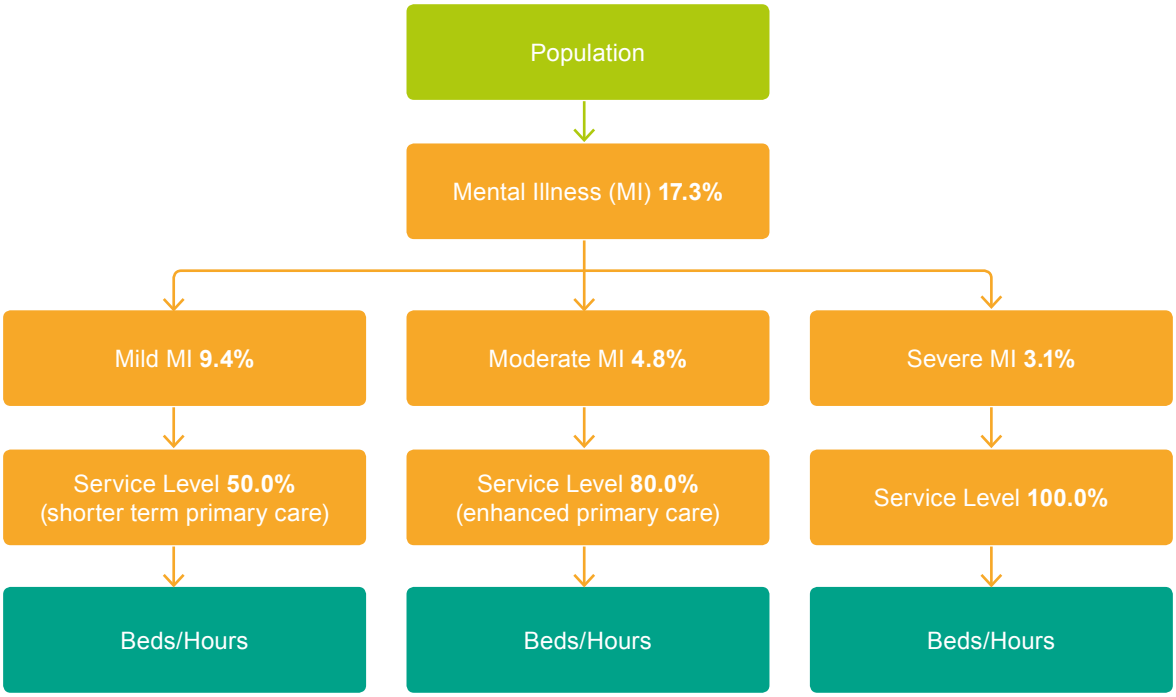
Individuals with mental health and AOD problems are categorised in the Plan as either 'mild', 'moderate' or 'severe' to aid in determining the type of services required. Definitions of severity are sourced from the National Mental Health Services Planning Framework - Technical Manual, Version 2.1, August 2016. The Commission acknowledges that these definitions take on a meaning that may not be consistent with other organisations' meanings when they use the terms 'mild', 'moderate' and 'severe'.

> **Severe** - People with diagnosed illness in a 12-month period, and severe impairment, including those where the diagnosis itself requires significant impairment (Schizophrenia, Bipolar Disorder) or other diagnoses combined with severe impairment or risk. It includes those admitted to specialist mental health units or to general hospitals or residential aged care facilities with primary mental illness diagnoses, as are those receiving care from specialised community mental health teams. This group also generates the vast majority of the demand for community support services.
>
> **Moderate** - Those with diagnosed illness and service demand in a 12-month period, where the illness is chronic and/or causes moderate disability but not falling into the severe group, whose illness can be adequately managed in enhanced primary care with some specialist support, including a small minority who also need community support services.
>
> **Mild** - Those with diagnosed illness and service demand in a 12-month period, whose illness can be adequately managed within primary care; including clinician led e-therapies.

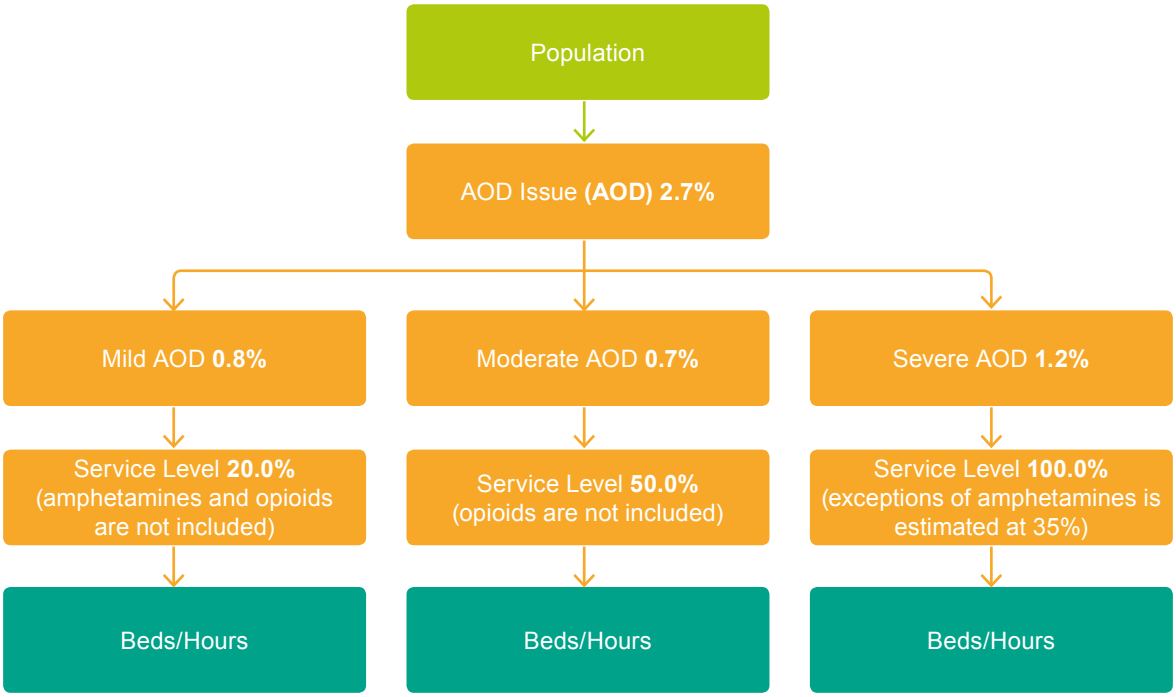
The Plan estimates services for people with a severe mental illness only. It is considered that people with a moderate or mild illness will access primary care services. The Plan also estimates services for people with mild, moderate and severe AOD problems. It is considered people with AOD problems access publicly funded services, with few seeking treatment in primary care services.

Figures 1 and 2 show the step by step modelling used in the NMHSPF-PST and the WADASPM-DST, including the severity. Light green shows the input required into the model (modifiable), orange shows the modelling assumptions (unmodifiable), and dark green indicates resource outputs.

Appendix 3, Figure 1: Mental illness prevalence and service level in NMHSPF-PST



Appendix 3, Figure 2: Alcohol and Other Drug prevalence and service level in WADASPM-DST



Modelling Process Summary

The WAMH-PST and WADASPM-DST were used to calculate the type and quantity of services needed for the projected Western Australian population. The Western Australian population projections, July 2017, were sourced from the Western Australian DPLH in October 2017. This demand modelling process involves the application of statistical methods, epidemiological data, evidence-based practice and stakeholder expertise to estimate the type and quantity of services needed based on population size and features (e.g. age groups, gender, Aboriginality, remoteness).

The modelling tools apply a stepwise modelling process to all service streams (as shown below in **Figure 3**) that can be easily explained, replicated, and updated. Assumptions applied are based on research and extensive clinical and expert consultation with key stakeholders across the State. The modelling tools are built in a flexible manner that allows complete adjustment of assumptions.

Figure 3 below provides the modelling summary used in the planning processes (WAMH PST and WADASPM-DST). Yellow shows the NMHSPF-PST and DASPM-DST resource outputs (unmodifiable), orange shows the Western Australian modelling assumptions (modifiable), and light green shows the WAMH-PST and WADASPM-DST resource outputs.

The Plan provides an estimate of the services that are required across the State and these estimates are based on the assumption that the whole system is in the “optimal” state. Therefore, a shortage in one part of the system means that other parts of the system will be unable to provide a level of service sufficient to meet demand, or a disproportionate burden will be placed on existing service elements (i.e. sub-optimal supply leading to inflated costs).

There are limitations to population based planning modelling. For example, whilst the NMHSPF modelling is attributed to a nominal age specific population of 100,000 people, the outputs of the model will in reality only approach viability for planning with total populations of all ages of at least 250,000 people. In planning for smaller regions it should therefore be noted that although the model may still assess service demand accurately, viability for planning may be a challenge with regard to modelled outputs. Creative solutions may therefore be required as to how the need is best resourced. The data provided remains a well-informed estimate influenced by underlying assumptions. Therefore, it is important to test such estimates through consultation and checking against current service configurations and benchmarks. In addition, high level estimates of resource requirements require consultation and input from people who will utilise the services, and local stakeholders to ensure appropriate “on the ground” application (taking account of resources already available and unique local circumstances).

Appendix 3 Figure 3: Western Australian planning – Inputs, Modelling and Outputs

1. NMHSPF-PST and DASPM-DST outputs

Bed/Hours estimates taken from the NMHSPF-PST and DASPM-DST, which is based on population input determined by the user. See Figures 1 & 2 above.

2. WA Age Groups

Service estimates by WA Age Groups are extrapolated from the NMHSPF-PST age groups: 0-15 years (Infant, Child & Adolescent); 16-24 years (Youth); 25-64 years (Adult); and 65+ years (Older Adult).

Service estimates by WA Age Groups from the DASPM-DST: 0-11 years (Infant & Child); 12-17 years (Youth); 18-64 years (Adult); and 65+ years (Older Adult).

3. Adjust the Readmission Rate (MH Hospital Beds only)

The NMHSPF-PST applied a 28-day re-admission rate (10%) annually.
The WAMH PST adjusts this to correct the NMHSPF-PST underestimate and to reflect re-admissions for the Western Australian context.

Age group	Annual readmission rate
Infant, Child & Adolescent (0-15 years)	10.0%
Youth (16-24 years)	30.0%
Adult (25-64 years)	30.0%
Older Adult (65+ years)	20.0%

4. Regional and Remote Loadings

Data from the Australian Bureau of Statistics is used to determine the input population by remoteness before the IHPA loadings are applied. Part of the resource need for this population is factored into the general service demand built into the care packages. IHPA loadings are conservatively applied to outer regional, remote, and very remote locations, to take into account the greater resource requirement to deliver services in the regions.

Remoteness	IHPA Loading
Regional	8%
Remote	20.0%
Very remote	25.0%

5. Aboriginal Service Utilisation Rate

The AIHW reported that the age-standardised hospitalisation rate among the Aboriginal population is higher than that of the general population, nationally. Specifically, in Western Australia the ratio in 2013-15 was 3.3 times.

Part of the resource need for the Aboriginal population is factored into the general service demand built into the care packages. The 3.3 loading is applied to the proportion of resources estimated for the Aboriginal population to take into account the greater resource requirement to deliver services for Aboriginal people.

Health Region	% of Aboriginal Population
North Metropolitan	1.1%
South Metropolitan	1.6%
East Metropolitan	2.5%
Goldfields	12.9%
Kimberley	46.1%
Pilbara	15.3%
Midwest	13.9%
Great Southern	4.9%
South West	2.5%
Wheatbelt	6.9%

6. WAMH-PST outputs and WADASPM-DST outputs

Age group	Output measure
Hospital inpatient services	Beds
Hospital consultation liaison	Hours of service
Community-bed-based services	Beds
Community treatment	Hours of service
Community support	Hours of support and Beds

Estimating Services For Out Of Scope Service Stream

Prevention and Promotion Services

While there is published evidence to guide what makes for an evidence-based approach to prevention, there is no modelling that has been comprehensively tested to guide optimal level of services for prevention activities. Although the NMHSPF includes care profiles for mental health prevention and promotion these require significant testing before they can be applied. DAPSM does not address prevention and promotion service requirements for AOD. Therefore, until validity testing has been completed 2015 modelling of services in these areas has been retained for the Plan Update 2018.

Forensic Services

The NMHSPF and DASPM do not specifically address forensic mental health and AOD services planning, neither in the service elements and care packages described, nor in the estimation of resources needed. It states explicitly that justice related or forensic mental health and AOD services were out of scope of the NMHSPF and DASPM development, particularly as the processes, services and decisions that relate to mental health services in the criminal justice system are dependent on the local judicial system. Therefore the 2015 modelling of services has been retained for the Plan Update 2018.

The key focus for forensic AOD service provision is statewide police and court diversion. The requirements and priority areas were identified and endorsed by a reference group, including major partners: the former Department of Corrective Services, Department of the Attorney General and WA Police Force. The process was informed by previous evaluations and operational experience.

Estimates in the forensic section of the Plan are for the optimal resource level required to deliver AOD court and police based diversion programs (such as Diversion Officer and Booking Service staff).

Estimated Actuals 2017

Where possible, mental health beds for 2017 were based on actual counts as at 31 December 2017 extracted through BedState. For AOD, actuals were determined through a master bed list maintained by the Commission. Hours of service for both mental health and AOD services primarily relate to full time equivalent and estimated actuals were based on 16.39% actual service cost growth in the Commission budget from 2013-14 to 2016-17, attenuated by the sum of the Wage Price Index (8.30%) increase, from the Western Australia Budget Economic and Fiscal Outlook for the same period, to derive an estimated growth figure of 8.09%.

Please note that there continues to be further work required in the analysis of the actual figures, which may result in some variance, therefore impacting on the service gap identified.

Amendments to modelling in the Plan

Where the methodology used to calculate estimated actuals or the level of services required differs from the methodology used in the Plan, these amendments are outlined below:

Community Support Services

AOD post residential rehabilitation services such as transitional housing programs were shown in the Plan as hours of service. The AOD sector consistently and more accurately describes the capacity of this service element using bed numbers and this is now reflected in the Plan Update 2018.

Community Treatment Services

A correction was made to original modelling in the Plan where mental health screening and brief intervention services provided by nursing and allied health staff were double counted as community treatment rather than prevention services.

Community Bed-based Services

A post modelling assumption applied to the original modelling in the Plan, which lowered the activity related to cannabis and benzodiazepines for residential rehabilitation and low medical withdrawal services, has been removed.

Hospital Services

The misclassification of five private AOD beds as high/complex medical withdrawal in the Plan was corrected in an actual count of public and private high/complex medical withdrawal beds undertaken in 2017.

The original modelling for hospital-based consultation liaison services included in the Plan reflected requirements only for people with a primary mental health related diagnosis (including those with co-occurring AOD service needs). Modelling in the Plan Update 2018 has now been refined to also include estimates for people whose primary concern is AOD related.

Specialised Statewide Services

The modelling presented in the Plan overestimated the re-admission rate with regards to specialised statewide hospital beds determining the number of hospital beds. This issue has been resolved in modelling for the Plan Update 2018.

Appendix 4:
2017-18 Summary of key effectiveness and efficiency indicators

The Commission reports each year on efficiency and effectiveness indicators that contribute to its agency outcomes. A summary of its performance is provided in the table below. More detailed information and analysis of its efficiency and effectiveness indicators are provided in the Key Performance Indicators section.

KEY EFFECTIVENESS INDICATOR		2017-2018 TARGET	2017-2018 ACTUAL
Outcome 1 – Improved mental health and wellbeing			
1.1	Percentage of the population with high or very high levels of psychological distress	<=9.9%	9.9%
Outcome 2 – Reduced incidence of use and harm associated with AOD use			
2.1	Percentage of the population aged 14 years and over reporting recent use of alcohol at a level placing them at risk of lifetime harm	<=21.6%	18.4%
2.2	Percentage of the population aged 14 years and over reporting recent use of illicit drugs	<=17.0%	16.8%
2.3	Rate of hospitalisation for AOD use	N/A	988.3 per 100,000 population
Outcome 3 - Accessible, high quality and appropriate mental health and AOD treatments and supports			
3.1	Re-admissions to hospital within 28 days of discharge from acute specialised mental health units (national indicator)	<=12.0%	18.1%
3.2	Percentage of contacts with community-based public mental health non-admitted services within 7 days post discharge from public mental health inpatient units (national indicator)	>=75.0%	75.7%
3.3	Percentage of closed AOD treatment episodes completed as planned	>=76.0%	72.3%
3.4	Percentage of contracted non-government mental health services that met the National Standards for Mental Health Services through independent evaluation	100.0%	80.0%
3.5	Percentage of contracted non-government AODs services that met an approved accreditation standard	90.0%	81.0%
3.6	Percentage of the population receiving public clinical mental health care (national indicator)	>=2.3%	2.4%
3.7	Percentage of the population receiving public AOD treatment	>=0.7%	0.7%

KEY EFFICIENCY INDICATOR		2017-2018 TARGET	2017-2018 ACTUAL
Service 1 - Prevention			
1.1	Cost per capita to enhance mental health and wellbeing and prevent suicide (illness prevention, promotion and protection activities)	$4.23	$3.90
1.2	Cost per capita of the population 14 years and above for initiatives that delay the uptake and reduce the harm associated with AODs and reduce the harm associated with AODs	$4.53	$4.92
1.3	Cost per person of AOD campaign target groups who are aware of, and correctly recall, the main campaign messages	$0.91	$0.99
Service 2 – Hospital-Based Services			
2.1	Average length of stay in purchased acute specialised mental health units	<15 days	15.3
2.2	Average cost per purchased bedday in acute specialised mental health units	$1,520	$1,496
2.3	Average length of stay in purchased subacute specialised mental health units	<103 days	152.6
2.4	Average cost per purchased bedday in subacute specialised mental health units	$1,467	$1,377
2.5	Average length of stay in purchased HiTH mental health units	<22 days	20.2
2.6	Average cost per purchased bedday in HiTH mental health units	$1,382	$1,455
2.7	Average length of stay in purchased forensic mental health units	<50 days	43.0
2.8	Average cost per purchased bedday in forensic mental health units	$1,383	$1,386
Service 3 – Community Bed-Based Services			
3.1	Average cost per purchased bedday for 24 hour staffed community bed-based services (national indicator)	$360	$350
3.2	Average cost per purchased bedday for non-24 hour staffed community bed-based units (national indicator)	$170	$188
3.3	Average cost per purchased bedday in step up/step down community bed-based units	$523	$535
3.4	Cost per completed treatment episode in AOD residential rehabilitation services	$10,208	$11,768
Service 4 – Community Treatment			
4.1	Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services (national indicator)	$487	$463
4.2	Average treatment days per episode of ambulatory care provided by public clinical mental health services	<5.00 days	5.04
4.3	Cost per completed treatment episode in community-based AOD services	$1,580	$1,753
Service 5 – Community Support			
5.1	Average cost per hour of community support provided to people with mental health problems	$135	$133
5.2	Average cost per episode of community support provided for AOD services	$8,783	$11,058
5.3	Average cost per package of care provided for the Individualised Community Living Strategy	$65,790	$35,317
5.4	Cost per episode of care in safe places for intoxicated people	$336	$377

Appendix 5: Abbreviations

Atlas	Integrated Atlas of Mental Health and Alcohol and Other Drugs of Western Australia - Volume I and II
The Act	Mental Health Act 2014
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
AODMPs	Alcohol and Other Drugs Management Plans
BAU	Bentley Adolescent Unit
Commission	Mental Health Commission
DoH	Department of Health
DPLH	Department of Planning, Lands and Heritage
EMyU	East Metropolitan Youth Unit
Fifth Plan	Fifth National Mental Health and Suicide Prevention Plan
GPs	General Practitioners
HiTH	Hospital in the Home
IHPA	Independent Hospital Pricing Authority
MH	Mental Health
MHN	Mental Health Network
MHOA	Mental Health Observation Area
MHPC	Mental Health Principal Committee
National Drug Strategy	National Drug Strategy 2017-2026
NDASPM	National Drug and Alcohol Service Planning Model
NMHSPF	National Mental Health Services Planning Framework
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGOs	Non-Government Organisations
PCH	Perth Children's Hospital
PIR	Post Implementation Review
The Plan	Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 2025
Plan Update 2018	Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 2025 Update 2018
WAADIS	Draft Western Australian Alcohol and Drug Interagency Strategy 2018-2022
WA Police Force	Western Australia Police Force
WAPHA	WA Primary Health Alliance

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