



Government of **Western Australia**  
**Mental Health Commission**



Government of **Western Australia**  
**Department of Health**

Mental Health Commission & Department of Health – Office of Mental Health

# **Final Report on Progress of Implementing Stokes Review Recommendations**

April 2016

## *Acronyms*

ACIT – Acute Community Intervention Team

AOD – Alcohol and Other Drug

BAU – Bentley Adolescent Unit

CAHS – Child and Adolescent Health Service

CaLD – Culturally and Linguistically Diverse

CAMHS - Child and Adolescent Mental Health Service

CoMHWa – Consumers of Mental Health WA (Inc)

DAO – Drug and Alcohol Office

DoH – Department of Health

FSH – Fiona Stanley Hospital

IHPTS – Inter-Hospital Patient Transfer Scheme

MHA 2014 – Mental Health Act 2014

MHC – Mental Health Commission

MHiMA – Mental Health in Multicultural Australia

MHN – Mental Health Network

MHU – Mental Health Unit (formerly OMH)

NMHS – North Metropolitan Health Service

OCP – Office of the Chief Psychiatrist

OMH – Office of Mental Health (now MHU))

PSOLIS – Psychiatric Services Online Information System

SSCD – Statewide Standardised Clinical Documentation

SMHS – South Metropolitan Health Service

SSAMHS – Statewide Specialist Aboriginal Mental Health Service

WAAMH – WA Association of Mental Health

WACSUMH – WA Collaboration for Substance Use and Mental Health

WANADA – WA Network of Alcohol and other Drug Agencies

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## **Introduction**

In 2012, the “Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/service in Western Australia”, also known as the Stokes Review, was released. The Review was undertaken by Professor Bryant Stokes and jointly commissioned by the Mental Health Commission (MHC) and the Department of Health (DoH) following an inquiry into deaths at the Fremantle Mental Health Clinic at Alma Street. It was decided that, in addition to reviews of the Alma Street facility, a broader review should be undertaken to examine the admission and discharge practices at all specialist mental health facilities. In his report, Professor Stokes made 117 recommendations and an additional 10 sub-recommendations. All but two of the recommendations were endorsed by Government (recommendations 7.10.2 and 7.10.3).

A multi-agency Implementation Partnership Group (IPG) was established to oversee the implementation of the endorsed recommendations with the MHC and DoH – Office of Mental Health (OMH) allocated lead responsibility for implementation of specific recommendations. The IPG includes representation from key Government agencies, peak body Non-Government Organisations (NGOs) in the mental health sector and carer and consumer representatives. The first meeting of the IPG was in March 2013 and the group has met 12 times in the last three years.

The OMH and the MHC have made good progress and implemented as many of the Stokes Review recommendations as possible over the last three years within existing resources; however, as outlined in the Government response to the Stokes Review, implementation of a number of the recommendations of the Stokes Review requires additional funding.

This report summarises progress made by the MHC and the OMH, in partnership with key stakeholders, in implementing the recommendations of the Stokes Review, highlights important achievements and outlines the next steps for implementation of the outstanding recommendations.

As the IPG Terms of Reference indicates that it will cease three years after commencement, a future governance structure has been put in place to oversee the ongoing implementation of key Stokes Review recommendations. These governance arrangements will come into effect at the close of the IPG in April 2016.

## **Key Reforms in Mental Health**

The implementation of the Stokes Review recommendations was impacted by a number of other critical reforms in the mental health sector. Where possible, the recommendations of the Stokes Review were embedded in the delivery of these reforms to ensure more consistency across the mental health sector; inconsistency was a major finding of the Stokes Review.

Major pieces of work and reform that impacted the implementation of the Stokes Review included the development of the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives (Plan), the development and implementation of the new *Mental Health Act 2014* (MHA 2014), the amalgamation of the MHC and the Drug and Alcohol Office (DAO) and the review of the inquiry into the deaths at the Fremantle Mental Health Clinic at Alma Street.

*Western Australian Mental Health, Alcohol and Other Drug Services  
Plan 2015-2025: Better Choices. Better Lives.*

The development of a clinical services plan that included analysis of clinical care, rehabilitation, living accommodation, geographical location and infrastructure was the primary recommendation of the Stokes Review.

The draft Plan was released for public consultation on 3 December 2014 and consultation concluded on 30 March 2015. There were 250 online feedback surveys completed during the consultation period, as well as 64 formal written submissions from a range of stakeholders. In addition, 19 consultation forums were held across the State. The feedback from all of this consultation was considered and where possible, incorporated into the final Plan.

The Plan was released by Government on 7 December 2015 and provides a blueprint for the investment required in mental health, alcohol and other drug services to meet the needs of Western Australians across the State by the end of 2025. The Plan will guide the development of an integrated mental health, alcohol and other drug service system that focuses on prevention, early intervention and encompasses principles to support people across the whole of life.

The actions in the Plan address a number of Stokes Review recommendations including in totality;  
Recommendations 5.1; 5.2; 5.3; 5.4 and 5.5 [Theme: Beds and clinical service plan]

Recommendations 7.6; 7.8; 7.9; 7.10.12; and 7.10.13 [Theme: Acute issues and suicide intervention]

Recommendations 8.2; 8.3; 8.5; 8.6; 8.6.1; 8.6.2; 8.6.3; 8.8; 8.9; 8.10; 8.10.1; 8.10.2; 8.10.5; 8.10.6; 8.10.7 and 8.10.11 [Theme: Children and youth]

Recommendations 9.1; 9.1.1; 9.1.2; 9.1.3 and 9.1.4 [Theme: Judicial and criminal justice system]

And partially;

Recommendations 1.1.7, 1.1.9, 1.5, 1.6, 2.3, 3.3, 3.5, 4.1, 4.8, 4.11, 4.12, 7.7, 7.10.6, 8.1, 8.6.5, 8.10.10 and 8.10.12

Attachment 1 outlines the actions related to the above Stokes Review recommendations.

The actions in the Plan will be delivered over the course of the next ten years subject to Government's fiscal capacity and budgetary processes.

### *Mental Health Act 2014*

The Mental Health Bill 2013 was passed by Parliament on 16 October 2014. It received Royal Assent on 3 November 2014 and is now known as the MHA 2014. The MHA 2014 commenced on 30 November 2015.

The passage of the MHA 2014 through Parliament has been a significant achievement in the implementation of reform in the mental health sector. The MHA 2014 itself addresses a variety of Stokes Review recommendations, including establishing processes that will ensure that families and carers have opportunities to provide input into treatment, care and support for their loved one; enhancing access to advocacy support through the new Mental health Advocacy Service (MHAS); and enhancing the availability for recourse through the new Mental Health Tribunal (MHT).

The MHA 2014 has significantly enhanced safeguards for consumers, both voluntary and involuntary. Further, the MHA 2014 recognises the important role of families and carers. Information to be provided to families and carers includes the rights of the patient and the family member or carer, the patient diagnosis, proposed treatment and care, the patient's progress, and services available to meet the patient's needs.

As part of the commencement of the MHA 2014, and relevant to the implementation of the Stokes Review recommendation 3.3, the MHC has delivered a comprehensive eLearning package for mental health clinicians throughout Western Australia, to ensure that clinicians are aware of their obligations under the MHA 2014.

Further, the MHC has published a range of resources for consumers, families and carers, to ensure that they are aware of their rights under the MHA 2014, how they can be exercised, and what recourse is available if they don't feel that their rights are being upheld. These resources include eight brochures (which have been translated into 15 languages), a dedicated eLearning module, information sheets and targeted consumer, family and carer handbooks. Consumers, families and carers have been responsible for developing the content of the handbooks, being a 70 page consumer handbook and a 60 page family and carer handbook. The handbooks relate to voluntary and involuntary patients and feature lists of suggested questions a consumer, family member or carer may like to ask throughout the patient's journey.

All of these resources are available on the MHC website.

In addition, every involuntary patient will have access to the MHAS, with a requirement that an advocate visit or make contact within seven days for adults and 24 hours for children. Advocates can assist involuntary patients and some other patients in a range of matters, including

explaining their rights, seeking a MHT hearing and resolving complaints which relates to Stokes Review recommendation 2.3.

The core role of the MHT is to review the legal status of involuntary patients regularly. The MHT has further functions intended to help patients, families and carers uphold their rights; for example, the MHT can issue a compliance notice to a service that does not provide a patient or their support persons with certain information. In relation to Stokes Review recommendation 3.4, unlike the previous Mental Health Review Board, the MHT is required to make all reasonable efforts to notify all personal support persons of:

- The patient's application for a hearing; and
- The patient's upcoming hearing (whether automatic or upon request).

The MHT must give personal support persons who attend reviews the opportunity to express their views, and must have regard to their views.

As related to Stokes Review recommendation 6, the MHA 2014 establishes the Office of the Chief Psychiatrist (OCP) as an independent office. Prior to the commencement of the MHA 2014, the OCP reported to the Director General of the DoH. This new independence is important given that the role of the Chief Psychiatrist includes oversight of treatment and care provided in services that are within the remit of the Department of Health. Corresponding safeguards are:

- the Minister for Mental Health, following consultation with the Chief Psychiatrist, may issue binding directions as to general policy to be followed;
- the Chief Psychiatrist must report to the Minister upon request; and
- the Director General of the Department of Health may request a report from the Chief Psychiatrist as to treatment and care of patients within its remit, and the Chief Psychiatrist must comply with the request unless he or she has reasonable grounds for not doing so.

Other Stokes Review recommendations affected by the MHA 2014 can be found in Attachment 2.

### *Amalgamation of MHC and DAO*

The *Alcohol and Drug Authority Amendment Bill 2014* (the Bill) was passed by the Legislative Council on 18 February 2015 and received Royal Assent on 25 February 2015.

The Bill enabled the amalgamation of the DAO and the MHC to take place to form a new entity called the 'Mental Health Commission' and for the new MHC to be the employing authority for all DAO staff.



The DAO and the MHC amalgamated on 1 July 2015.

The amalgamated MHC will relocate to new premises at Workzone, 1 Nash Street East Perth, early 2016. The new office location will support MHC service delivery by providing one location for MHC stakeholders, while creating a working environment for staff that promotes mental health and wellbeing. Also relocating to Workzone is the OCP, WA Association of Mental Health (WAAMH), WA Network of Alcohol and other Drug Agencies (WANADA) and the Local Drug Action Group (LDAG Inc.). All entities will remain independent and this will be clearly defined by signage on the interior and exterior of the building.

It is anticipated that this amalgamation will result in better integration of mental health and alcohol and other drugs at both a policy and service delivery level. Stokes Review recommendations 1.6, 4.11 and 7.7 will be supported through the amalgamation.

## **Key Themes and Recommendations of the Stokes Review**

The Stokes Review recommendations were grouped into nine themes:

- Governance
- Patients
- Carers and families
- Clinicians and professional development
- Beds and clinical services plan
- Office of the Chief Psychiatrist
- Acute issues and suicide prevention – including recommendations from the Deputy State Coroner and the Office of the Chief Psychiatrist
- Children and youth – including recommendations from the Commissioner for Children and Young People
- Judicial and criminal justice system

The following section provides progress of specific important recommendations.

### *Actively Pursuing Workforce Development, Service Growth and Service Provision*

A Mental Health Leadership Program was established in 2014 to support staff across the mental health system to develop their leadership potential and progress a range of service improvement initiatives. Over two years, a total of 46 initiatives relating to implementation of the Stokes Review

and the MHA 2014 have been led by 54 senior clinical and service mental health staff. These Leaders have been supported by more than 100 additional staff and consumer and carer representatives.

The program content is designed to promote cross-service collaboration, reform and culture change. The program has provided an opportunity for the DoH Mental Health Services and bodies such as the OMH, the OCP and the MHC to come together to tackle significant issues impacting the sector.

Many initiatives associated with the program have made an impact by improving care for mental health consumers; for example, a 2014 program initiative relating to the establishment of the first Older Adult Hospital in the Home Service in Western Australia was awarded a 2015 Mental Health Commission Good Outcomes Award for improving mental health outcomes in seniors. With many of the individual initiatives producing noteworthy outcomes, the impact of the program as a whole has been significant. Based only on initiative outcomes with a quantifiable cost saving, the 2015 program saved more than \$342,000 over the span of five months, in addition to time released and numerous other outcomes relating to improved patient care.

An external review of the 2014 program and ongoing participant feedback have indicated that the program is an important means of driving system-wide mental health reform and increasing workforce leadership and service improvement capability. The program is continuing in 2016, with participants commencing in March and May, and sustainability planning is underway to ensure continuation of similar opportunities in the future.

### *Statewide Standardised Clinical Documentation*

A suite of Statewide Standardised Clinical Documentation (SSCD) has been endorsed by the previous Acting Director General, Chief Medical Officer, and the Chief Psychiatrist for implementation across all WA public adult Mental Health Services. Six SSCD Forms have been endorsed for implementation within the Child and Adolescent Health Service (CAHS) and seven Forms have been endorsed for adults, including:

- Triage
- Risk Assessment and Management Plan (Currently on PSOLIS as Brief Risk Assessment)
- Assessment (Adult)/Initial Assessment (Child and Adolescent)
- Physical Examination
- Physical Appearance (not applicable for CAHS)
- Treatment, Support and Discharge Plan (Currently on PSOLIS as Management Plan)
- Care Transfer Summary.

The OMH and Health Applications hosted three large workshops in early 2014 to consult and engage clinicians and data experts on the requirements of implementing SSCD into the Psychiatric Services Online Information System (PSOLIS). In March 2014, the OMH established an SSCD Working Group to progress work on the implementation of SSCD across the Health Services and assist with gathering the requirements for implementing SSCD onto PSOLIS. The OMH issued an Operational Directive on 4 June 2014 mandating all public Mental Health Services use the SSCD suite in the mental health setting. DoH staff continue to use current modules on PSOLIS until all PSOLIS modules are updated with the SSCD suite. Maintaining the use of current modules is essential to retaining information and visibility across Health Services. DoH staff use writable PDFs or a paper based system for those documents that are not on PSOLIS.

Between November 2014 and February 2015, the OMH and Health Applications hosted a number of smaller focus group sessions to gather the requirements for implementing the SSCD Triage, Adult and Child and Adolescent Mental Health Service (CAMHS) Risk Assessment and Management Plan (RAMP) into PSOLIS. The A/Director General (A/DG) approved the full Triage and RAMP Information and Communications Technology (ICT) Functional Requirement documents in April 2015.

On 4 June 2015, the PSOLIS Governance Committee (PGC) prioritised the MHA 2014 requirements, which impacted on the delivery of the Triage module, and the Adult and CAMHS RAMP. The main features of the Triage module were updated as part of the 30 November 2015 PSOLIS Release Schedule. The OMH launched an electronic learning (eLearning) module for Triage as well as marketing material to increase DoH staff knowledge and understanding of the SSCD requirements. The PSOLIS modules will continue to be updated with the remaining ICT requirements for Triage and RAMP (Adult and CAMHS) as part of the PSOLIS priorities and PSOLIS release schedules. The PGC will oversee and establish the PSOLIS priorities and release schedule based on a three-tiered hierarchical structure of what is legislatively required, then what is contractually required and finally what is operationally required. ICT requirements for the remaining SSCD documents will be gathered according to PGC's guidance.

### *Chief Psychiatrist's Standards*

The Chief Psychiatrist has accepted the National Standards for Mental Health Services 2010 as the overarching standards relevant for the MHA 2014. The Chief Psychiatrist's Standards and Guidelines Working Group, including clinicians, service providers, consumers and carers, developed eight jurisdictional standards that have been embedded in the *Clinicians' Practice Guide to the Mental Health Act 2014 (November 2015)* and also released as a separate document, the *Chief Psychiatrist's Standards for Clinical Care (November 2015)*, with both available on the Chief Psychiatrist's website. The Standards are a reference point seeking to consistently leverage safe

and quality care for the benefit of consumers and carers.  
The eight standards are:

- Aboriginal Practice
- Assessment
- Care Planning
- Consumer and Carer Involvement in Individual Care
- Physical Health Care of Mental Health Consumers
- Risk Assessment and Management
- Seclusion and Bodily Restraint Reduction
- Transfer of Care.

### *Inter-Hospital Patient Transport*

Under the *Mental Health Act 1996*, WA Police were the only people authorised to perform patient transfers for people subject to Transport Orders. This situation was identified as a concern by many stakeholders but the requirements of the 1996 Act prevented other options.

Recommendation 1.3 from the Stokes Review was to develop a mental health transport system that will safely transfer patients between hospitals across the metropolitan area. In response to this recommendation, the Western Australian State Government committed funds to develop a transport service initiative that will be delivered under the new MHA 2014.

The MHC funded a 2-year pilot metropolitan inter-hospital mental health transport program in 2014. The Pilot Inter-Hospital Patient Transfer Scheme (IHPTS) was provided by North Metropolitan Health Service (NMHS).

The IHPTS began in March 2014. Regarding the operation of the IHPTS, the following is noted:

- The evaluation report on the first full year of operation of the pilot service (March 2014 - March 2015) found that it produced benefits for individuals, families, carers and the system as a whole.
- Transfers occurred in a more timely manner, with 89% of all transfers taking place with a wait time of less than 4 hours, due to the close availability of the pickup crew and the reduced need to wait for Police.
- By using special constables instead of WA Police, the pilot service reduced WA Police involvement in transports – for example Police involvement in inter hospital transfers between SCGH and Graylands reduced from 67% to 6% over the 12 month period.

The DoH has developed contractual arrangements with 3 patient transport providers to deliver mental health transport services in the metropolitan area for individuals subject to transport orders under the MHA 2014. The new service commenced on 29 February 2016. The service will provide transports between hospitals and from community to hospital.

### *Care Planning*

The use of a suite of standardised clinical documentation is mandatory across all public mental health services. A treatment, support and discharge plan is currently required to be completed in PSOLIS, and is currently on PSOLIS as the Management Plan. The Management Plan includes a field for the consumer's signature and the SSCD guidelines require that a copy of the signed document be provided to the consumer and, with the consumer's permission, their carer.

The Chief Psychiatrist's Standards for Clinical Care under the MHA 2014, which address this recommendation, are the Care Planning Standard and Consumer and Carer Involvement in Individual Care Standard. The Standards came into effect on 30 November 2015. The Standards will ensure that all consumers have a written care plan and that the consumer is a partner in the care planning process. The Standards stipulate that carer involvement must also be facilitated.

Care Planning across the Health Services is also supported by local policies. For example, South Metropolitan Health Service (SMHS) has adopted the Care Coordination Framework and Policy. NMHS Mental Health has a Case Management Policy and Model, with case managers having responsibility for developing individualised care plans in partnership with consumers and carers. CAMHS emphasises choice and collaboration with consumers and carers in relation to care coordination, such as the Choice and Partnership Approach at Community CAMHS. Western Australian Country Health Service (WACHS) policies have been reviewed to ensure alignment with the MHA 2014 and the Charter of Mental Health Care Principles. In addition, training has also been provided to mental health clinicians in areas such as patient-centred care, recovery oriented care, collaborative care planning and trauma informed care.

Health Service compliance with care planning requirements will be monitored and reported.

### *Subacute Services*

The MHC seeks to build a Western Australian mental health, alcohol and other drug service system that enables everyone to work together to encourage and support people who experience mental health, alcohol and other drug problems to stay in the community, out of hospital and live satisfying, meaningful and contributing lives.

Community based subacute (step-up, step-down) services provide short term supported residential care for people recovering from mental health problems to receive an appropriate level of treatment where hospital care is not required. These community-based services offer flexible,

home-like care for local people closer to where they live in a more appropriate therapeutic care setting.

Since opening in May 2013, there have been 625 admissions at the 22 bed Joondalup step-up, step-down community subacute service (as of 29 February 2016). Of the clients, over 95% were successfully transitioned into the community without requiring hospital admission or re-admission.

Construction at the Rockingham site commenced in April 2015. It is anticipated the 10 bed service will be ready to receive clients in late-2016.

Planning for the delivery of the 6 bed Broome service has commenced. The design is expected to be finalised shortly, and consultation with the local authority is ongoing to ensure the service meets planning and development requirements. Subject to formal development approval, funding and licensing requirements, the service is anticipated to become operational by the mid of 2018.

Potential land options have been identified in Karratha (6 beds) and Bunbury (10 beds). These services would be anticipated to become operational by the end of 2018. Community consultation forums are planned for Karratha and Bunbury in the near future.

The Karratha and Bunbury projects have been announced as funded through Royalties for Regions, with \$27.9 million in funding earmarked for establishment and delivery of these services.

### *Statewide Specialist Aboriginal Mental Health Service*

The Statewide Specialist Aboriginal Mental Health Service (SSAMHS) was originally funded by the State Government as an initiative contributing to the National Partnership Agreement (NPA) on 'Closing the Gap' in Indigenous Health Outcomes. This NPA expired in June 2013. In July 2013, the Aboriginal Affairs Cabinet Subcommittee approved a further 12 months of funding for SSAMHS and requested that all of the Closing the Gap programs be reviewed to clarify objectives and outcomes, identify gaps and reduce duplication of funding and services. In the 2014/15 Budget Process, an additional \$29.1 million was allocated to the SSAMHS for the period 2014-2017, of which \$19 million will be spent on the delivery of the service in regional and remote areas. It is estimated that approximately \$6.4 million of that funding will be spent in the Kimberley region. A comprehensive evaluation of the SSAMHS program is currently underway which is due to be completed by September 2016. The evaluation will inform the next business case with the view of securing funding beyond 30 June 2017.

## *Children and youth*

### **General overview**

Children and families are involved in their care via signed care plans, provide feedback on services, and have access to the online CAMHS website that includes a medication safety toolbox, mental health information and links to advocacy services. Competency-based training and credentialing of staff, policies, multidisciplinary decision making, discharge and transfer of care information and processes, use of standardised forms, availability of emergency response services and clear entry criteria all support holistic care. A focus on physical health has seen implementation of a suite of policy documents and tools, use of examinations, monitoring and observations and partnerships with medical practitioners, within the hospital setting as well as in the community.

### **Recommendation 8.5 - Recovery programs for children are established**

A recovery-oriented culture is embedded across CAMHS as legislated in the Charter of Mental Health Care Principles, MHA 2014. CAMHS-specific competency-based clinical training using a recovery framework has been implemented. A developmentally appropriate template titled 'My Action Recovery Plan', designed as a CAMHS version of the Adult SSCD Treatment Support and Discharge Plan, is at an advanced trialling stage.

Touchstone, a specialist recovery day program for young people presenting with persistent deliberate self-harm and suicidality, and infants with identified significant mental health disorders, has been delivering services from August 2015, with preliminary data suggesting a trend towards a reduction in the number of inpatient admissions. Staff across CAMHS have been trained in Adolescent Mentalisation - Based Integrative Therapy, an evidence-based integrative framework to support cross agency treatment delivery for this target group.

### **Recommendation 8.7 - Treatment teams involve all the child's services and communicate with one another in a timely and respectful manner**

CAMHS teams have established an Acute/Community Protocol, are attending each other's discharge and regular clinical meetings when required, and have implemented streamlined referral pathways to improve connections between teams. The implementation of an updated discharge and transfer policy and the CAMHS Shared Care Guideline support clinical care. Memorandum of Understanding (MOU) and service level agreements with external services/agencies further support care, for example, CAMHS and headspace local MOUs. CAHS, CAMHS and WACHS CAMHS have established regular collaborative meetings that have resulted in joint training opportunities and sharing of policy documents, as well as providing a forum for discussion of current issues.

**Recommendation 8.10.4 - The Statewide Specialist Aboriginal Mental Health Service and Infant, Child Adolescent and Youth Mental Health Service establish a close working relationship and seamless referral process to ensure the best possible outcomes for Aboriginal children and young people**

A service agreement between CAHS and the MHC regarding the provision of services to Aboriginal children and adolescents is in place, articulating funding arrangements, key performance indicators and reporting framework. Embedding of five Aboriginal staff members in metropolitan based Community CAMHS teams has led to increased access by Aboriginal children and families as evidenced by increased occasions of service and an increased number of Aboriginal children with care plans.

**Recommendation 8.10.8 - The new Acute Response Emergency Team and specialist mental health services establish a close working relationship and seamless referral processes to ensure rapid access to treatment**

The Acute Response Team (ART) began delivering services on 5 November 2012 in the metropolitan area for children and young people up to the age of 18. It provides access and patient flow coordination for all CAMHS beds i.e. Princess Margaret Hospital (PMH) Ward 4H and Bentley Adolescent Unit; telephone consultation for crisis management and advice to all of WA, via a central 1800 telephone number available 24 hours a day/seven days a week; in reach to PMH and all Perth metropolitan emergency departments; and community visits in the metropolitan area. ART and the Acute Community Intervention Team together provide interventions and follow-up (up to eight weeks) until the child or adolescent is referred to appropriate services.

*Police Co-Response*

The WA Police, the MHC and the DoH have developed a 2 year trial 'Mental Health Co-Response' service to provide coordinated and prompt response for people experiencing a mental health crisis in the community. The service model is based on similar successful co-response models operating in Victoria and New South Wales, and includes the joint attendance by police and mental health professionals to mental health crisis incidents, in order to provide prompt mental health assessment and onward referral to appropriate services.

The service commenced in January 2016 and includes a Coordination Unit, two mobile units (located in Cannington and Mirrabooka), and dedicated mental health staff operating out of the Police Operations Centre and the Perth Watch-House.



## *Court Diversion*

The MHC's strategic policy, Mental Health 2020, recognises that people who experience mental illness are overrepresented in the justice system and that many do not receive the care and support they need to address their offending and assist their recovery.

The pilot Mental Health Court Diversion and Support Program helps to address this issue by offering a tailored response for individuals whose offending is linked to mental illness.

Program participants are supervised by a Court while they receive holistic support that addresses the underlying causes of their offending behaviour. This approach aims to enhance participants' health and wellbeing, improve community safety and, where appropriate, provide an alternative to imprisonment.

The pilot comprises an adult program, the Start Court, and a children's program, Links. Specific information on each component of the program can be found below.

The pilot program was established in 2013 with initial funding of \$6.7 million for 20 months. Pilot funding was extended through the 2014/15 and 2015/16 State Budgets, bringing total investment to date to \$16 million. Ongoing funding will be sought through the 2016/17 State Budget process.

The pilot program is a partnership between the MHC and the Department of the Attorney General. The other agencies that contribute to the pilot program are:

- The Department of Health
- The Department of Corrective Services
- WA Police
- Legal Aid WA
- Outcare Inc. (a Non-Government service provider).

The pilot program was independently evaluated in 2014. The evaluation made a number of positive findings, including that the Program is operating in accordance with good practice and is highly valued by participants, their families and carers, and stakeholders within the justice system.

### **Adult Program – Start Court**

The Start Court is a Magistrates Court that specialises in dealing with offenders who have mental health issues. Participants are offered a program that combines access to mental health supports and services with regular appearances before the Start Court Magistrate. The Start Court operates within the Central Law Courts in Perth.

Between its commencement in March 2013 and 30 September 2015, the Start Court received 788 referrals, of which 412 resulted in the referred person receiving support from the Start Court's dedicated clinical team under the supervision of the Start Court Magistrate. A total of 191 individuals entered a formal program of ongoing support, of whom 99 completed the program and 43 were current participants as of 30 September 2015.

The 2014 evaluation found that the Start Court:

- Was established quickly and effectively and is aligned with good practice.
- Has operated to capacity since being initiated.
- Motivates participants to change their behaviour.
- Is delivering valued outcomes to individuals and their families/carers.

A cost analysis undertaken as part of the 2014 evaluation found that the daily cost of undertaking the Start Court program is significantly less than the daily cost of keeping a person in custody, but more than the daily cost of managing offenders in the community under community corrections supervision. However, it should be noted that the cost of community supervision does not include the cost of any mental health services the person may require.

### **Children's Program**

Links offers mental health assessment and support to young people who appear before the Children's Court. It comprises a clinical mental health team that is based within the Perth Children's Court, and a team of community support coordinators who assist participants to address non-clinical issues (such as issues relating to school engagement, transport and relationships).

Between its commencement in April 2013 and 30 September 2015, Links received 655 referrals relating to 431 young people. 84.6% of referrals resulted in a formal mental health assessment. 72.6% of young people referred had no prior history with public mental health services and 94.2% were not currently receiving support from a mental health service.

As with the Start Court, the 2014 cost analysis found that the daily cost of participation in the Links program is significantly less than the daily cost of keeping a person in juvenile detention, but more than the cost of community supervision. It should again be noted that the cost of community supervision does not include the cost of any mental health services the person may require.

The 2014 evaluation found that Links:

- Fills a gap by providing an essential clinical mental health capacity at Perth Children's Court.
- Is highly regarded by judicial officers and other stakeholders.

- Has been able to build the trust of young people who have previously been disengaged from treatment and educational services.
- Has established a cohesive multidisciplinary approach.

## **Outstanding Stokes Review Recommendations**

In addition to actions in the Plan that contribute to the outcomes associated with many Stokes Review recommendations, there are 12 recommendations that have outstanding components and an additional recommendation that is on-going in nature.

Some of the relevant recommendations and key aspects for implementation are detailed below. For a full list of outstanding recommendations, responsible agency and estimated completion date please see Attachment 3.

### *Compliance Reporting*

The measurement, ongoing monitoring and reporting for compliance of key recommendations is an essential element in ensuring the compliance and improvement in admission, referral, transfer, and discharge practices in Western Australia, in addition to adherence to new statutory requirements of the MHA 2014.

A suite of outcome focussed Performance Indicators (PIs) has been identified by the OMH, following consultation with key stakeholders, such as the OCP, the MHC, the MHAS (formerly the Council of Official Visitors), the Health Services and consumer and carer representatives. Final consultation is currently being undertaken with key DoH governance groups and following this, DoH approval for the suite of PIs will be sought.

The majority of PIs will include existing Health Service PIs used for accreditation and standards monitoring purposes, sourced from annual clinical documentation audits. Other PIs will initially require periodic audits of available documentation and processes, pending implementation of electronic data recording and reporting systems. These PIs will be embedded into existing reporting mechanisms as part of normal business practice.

### *Improving the Oral Health of Mental Health Consumers*

Since mid-2014, the OMH has been collaborating with the Oral Health Improvement Unit, Dental Health Services, the Clinical Research Centre, NMHS Mental Health, SMHS Mental Health, and University of Western Australia (UWA)-based research, education and statistical analysis

teams to develop a state-wide approach to oral health screening, promotion and access to public dental services for mental health consumers.

A qualitative research project into barriers and enablers for mental health consumer access to public dental services funded by the OMH was completed in February 2016. The research investigated perspectives of dental health professionals, mental health professionals and mental health consumers, family members and carers. The findings from the research have to date resulted in two conference presentations and three journal articles submitted for peer review. Further recruitment of consumers, family members and carers is being pursued by the research team.

In August 2015, Dr Elizabeth Moore and Brett Heslop from SMHS along with a consumer guest presenter delivered a mental health education session for UWA dental students. An additional session for Dental Health Service staff also took place in August. Similar guest lectures are planned to continue in the second half of 2016.

The substantial work on this recommendation has informed the development of a pilot addressing barriers to appropriate oral health care in mental health settings. This pilot will commence in March 2016 and involves strengthening linkages between Bentley Mental Health and Liddell Dental Health Clinic and providing support for mental health staff to screen for oral health issues.

In partnership with student volunteers from the UWA School of Dentistry, oral health promotional materials appropriate for consumers and carers/non-dental health care workers are being developed for use in mental health settings. The resources will be reviewed by consumers and carers and distributed as part of the pilot. Quantitative data linkage and cleaning is also underway to determine the current use of publically funded dental services by consumers with severe and persistent mental illness. A preliminary data analysis will be available by late 2016.

### *System Navigation*

The MHC is currently in the process of planning the development of a 'one stop shop' that will provide system navigation for people and families in crisis as well as providing assistance to those seeking information and advice on mental health and drug and alcohol issues. A consultation event was held by the MHC in March 2016 to discuss the model for system navigation in association with the 'one stop shop' with further consultation as required.

The WHO Mental Health Gap Action Program, has highlighted the need for a comprehensive and systematic description of all the mental health resources available and the utilisation of these resources, stating that it is important to know not only how many services are there in every health area, but also what are they doing and where they are located.

In Australia, the National Mental Health Commission review released in 2015 drew attention to the relevance of a bottom-up approach to understanding service availability (or gaps) at the local level, and the need for local planning of care and responsiveness to the diverse needs of different communities across Australia.

The Western Australian mental health and alcohol and other drug (AOD) atlases will provide a new decision making tool for commissioning, monitoring, reviewing and improving mental health and AOD systems of care in local areas. It will comprise a standardised inventory of all the services providing care for people experiencing mental ill-health and/or AOD issues in local areas as well as a spatial analysis (geographical maps). Over time additional data can be added to the Atlas to analyse types of service utilisation, types of interventions, efficiency, and health outcomes. This all contributes to evidence-informed policy and decision making and ultimately better mental health care for the community.

An additional system navigation tool being developed is the online service directory. The home page of the MHC's new website will be dedicated to providing concise and easy to follow information where people can locate and contact the services they are looking for. The opening page will contain a list of crisis and support contacts as well as an online service directory. The service directory will improve access and information available to the public, relating to public, private and non-government mental health, alcohol and other drug treatment services and supports. The service directory will link to the mental health and alcohol and other drug (AOD) atlases. Information pertaining to Western Australian is currently being reviewed and updated by the MHC. The home page has already been road tested by a variety of stakeholders at various points in its development, and feedback from these consultations has shaped the latest version.

These aspects of system navigation will also be supported by the implementation of actions in the Plan associated with Stokes Review recommendation 3.5 as indicated in Attachment 1.

### *Mental Health Emergency Response Line*

The Mental Health Emergency Response Line (MHERL) currently provides a 24 hour/seven day a week specialist mental health telephone triage service, advice and information to the community, and an on-call consultant psychiatrist is available after-hours every day of the year and overnight.

A Project Control Group, chaired by the NMHS, has provided oversight of the implementation of Stokes Review recommendations relevant to the operations of MHERL and linked services.

As a result of this project, NMHS and SMHS now have similar models for their Assessment and Treatment Teams (ATTs). The NMHS's four ATTs provide community mental health intervention between 8.30am and 10pm and prioritise emergencies, with an on-call service between 10pm and 8.30am. The SMHS now has ATTs in all its health districts, providing an acute service between 8am and 10pm. After 10pm, those requiring a mental health emergency service

can contact MHERL, contact or present to an Emergency Department (Royal Perth, Armadale, Fiona Stanley and Rockingham), and contact or present to Triage at Bentley Health Service and the Alma Street Centre.

A two year trial of Mental Health and WA Police Co-Response Teams began in January 2016, involving the NMHS and SMHS. A MHERL triage clinician is based at the WA Police Operations Centre, Midland, while another mental health clinician is based at the Perth Watch House to provide onsite mental health assessments. In the north metropolitan area, the team operates from the Stirling Catchment Monday to Saturday, from 2pm to 10pm, providing community mental health home visits that are triaged by the WA Police Operations Centre. The south metropolitan area involves the Bentley Mental Health Service during the afternoon shift, six days a week.

The CAMHS ART provides a crisis response service with a 24 hour 1800 number. Where a child or adolescent is identified as being at risk, they are assessed by a Senior Registered Mental Health Nurse and Senior Social Worker, and dependant on the level of risk and complexity, the on-call Registrar. The on-call Registrar or the on-call Consultant Child and Adolescent Psychiatrist approve the care plan and discharge from the ward or Emergency Department (ED). CAMHS ART also provides in-reach to adult EDs.

WACHS is currently implementing the Emergency Telemental Health Service Improvement Project, developed to improve response to emergency and acute mental health presentations and implement requirements of the MHA 2014. RuralLink is available in regional areas, providing a specialist after-hours mental health telephone service.

Decisions about mental health emergencies are supported by the SSCD Triage document on PSOLIS that includes a standardised decision support tool i.e. the Urgency of Response tool.

As detailed above, a substantial range of initiatives that address recommendation 7.1.2 have been completed and formal sign off is being sought. It is anticipated that the monitoring of progress on initiatives that are currently underway (e.g. Mental Health/Police Co-response and WACHS Telemental Health) will continue under local Health Service and other governance structures.

### *Psychiatric hostels*

The OMH has liaised with the MHC, psychiatric hostel licensee holders (Managers), Licensing and Accreditation Regulatory Authority (LARU) and Community Mental Health Service (CMHS) teams to review current service provision to residents within psychiatric hostels. It has been identified that a number of agreements have been formalised as a MOU or Service Level Agreement (SLA) since the Stokes Review recommendations were released in 2012. The OMH has been supporting further agreements to be formalised between the parties that do not currently have a signed document in existence. The agreements will help to promote ongoing communication between

CMHS teams and psychiatric hostel managers, improve understanding of roles and responsibilities, and provide consumers and carers with information to reference.

During consultation with the MHC, the OMH was advised to focus on service provision for the traditional 'for-profit' psychiatric hostels within the Perth Inner City, Bentley and Swan catchments as service level agreements had not been documented with a number of these hostels.

The OMH set up meetings with each of the CMHS teams (Perth Inner City, Midland (formerly Swan) and Bentley), and with the assistance of the MHC, met with licensee holders within each catchment at selected hostels that did not have a formalised SLA in place. The OMH also sourced data to support the services currently being provided to residents at the psychiatric hostels, such as when care plans have been created and updated along with consultations between clinicians and residents.

The Perth Inner City CMHS has established service level agreements with each of the psychiatric hostels within its catchment area; several have been established since the Stokes Review recommendations were published, including one with a traditional 'for profit' hostel.

During late October and early November 2015, the Midland CMHS team and clinic relocated from Swan Districts Hospital to a Midland site. A number of service level agreements are already in place with psychiatric hostels, and the CMHS is planning to establish similar agreements with the remaining three 'for profit' hostels within their catchment area. The MHC has provided the relevant hostel licensee holders with an example SLA and has promoted the benefits of formalising agreements.

The Bentley CMHS has undergone a redesign and in January 2016 implemented a Supported Accommodation Clinical Treatment Team to improve clinical care, efficiency, clinical governance and delivery of evidence based psychopharmacological and psychosocial treatments. Advanced metabolic screening is currently being completed jointly with GPs. The forward plan is to include mammograms, prostate checks and preventative medical reviews. Bentley representatives attend meetings with local GPs to enhance collaborative working, clinical care and treatment of residents who live in the hostels. An oral health care pilot for mental health consumers has commenced within the catchment area. The Bentley Co-Directors have visited hostels to discuss information sharing, processes, referral pathways and policies/procedures. The intention is to enhance collaboration between both parties to highlight the service that can be provided and how best to suit the individual accommodation facility.

## **Future Governance of Stokes Review Implementation**

As the term of the IPG comes to a close, it is important for a new governance process to be established to oversee the implementation of outcomes of the Stokes Review and ensure that recommendations are embedded in the standard operation of the DoH and MHC.

The following outlines future governance processes for the implementation of key outstanding recommendations, associated actions in the Plan and monitoring of outcomes associated with the recommendations of the Stokes Review.

### *Office of Mental Health On-going Monitoring and Compliance Related to the Stokes Review Recommendations*

The DoH is the lead agency for implementing 78 of the 127 Stokes Review recommendations and sub-recommendations. Note that two of these recommendations, 7.10.2 and 7.10.3, were not endorsed by the DoH. The OMH has completed or has established processes for 66 (87 per cent) of the above Stokes Review recommendations, with the remaining 10 (13 per cent) making good progress.

Many of the Stokes Review recommendations are ongoing (not time-limited) and the Mental Health Unit (MHU), formerly the Office of Mental Health, will continue to work in partnership with the Health Services to support their continuing delivery. In addition, many recommendations have been embedded or will be embedded as part of normal business practice in the Health Services.

The oversight of these recommendations will be through existing Health Service, the MHU or DoH governance groups, depending on the recommendation and/or initiative/project. The existing governance groups include the Mental Health Executive Directors' Forum, Mental Health Network Executive Advisory Group, Clinical Reference Group, Mental Health System-wide Clinical Policy Group, PSOLIS Working Group and PSOLIS Governance Committee, Mental Health Data Management Group and Coroner's Recommendations Working Group. Some of these groups were established as a result of the Stokes Review, to improve governance and co-ordination across the mental health system.

The MHU will also work in partnership with the Health Services to ensure that strategies implemented by Health Services to address the Stokes Review recommendations are monitored for compliance. A suite of outcome focused PIs has been identified by the MHU, and pending further consultation and approval, will be embedded into existing reporting mechanisms as part of normal business practice.



## *Stokes Review Recommendations Related to the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives.*

Many of the recommendations of the Stokes Review are anticipated to be implemented by the actions of the Plan.

The reporting on the Stokes Review to date indicated that the recommendations related to the Plan would be considered complete when the Plan was finalised and endorsed by Government and that full implementation of the actions of the Plan, and consequently the related Stokes Review recommendations, would be contingent upon budgetary processes and Government's fiscal capacity.

Although this has now occurred, the Mental Health Commissioner (the Commissioner) has agreed that a comprehensive, long term view should be held for these recommendations to ensure that outcomes are achieved. To this end, the remaining recommendations related to the Plan have not been reported as complete and are detailed with associated Plan actions in Appendix 1.

As outlined in Appendix C of the Plan, the governance of the Plan will include a representative oversight committee that will report directly to the Commissioner. This committee will monitor annual progress and the implementation of all proposals and review the Plan as required. Therefore, this committee or supporting working groups established to assist in the monitoring of the implementation of the Plan will be responsible for monitoring actions in relation to the Stokes Review recommendations and providing information to the Commissioner, DoH and the Minister for Mental Health where appropriate.

Reporting on progress will occur through the Plan reporting process at meetings with the Minister for Mental Health, partnership meetings with the DoH, peak bodies and non-government agencies and at Mental Health Advisory Council, and Alcohol and Other Drug Advisory Board meetings. Where appropriate, information can be included in the MHC's annual reporting.

This approach will ensure that the outcomes associated with the Stokes Review recommendations are embedded in the future work of the MHC and the DoH through the implementation of the Plan.

### *Outstanding Stokes Review Recommendations and Associated Governance*

Outstanding recommendations of the Stokes Review have been detailed in Appendix 2 and elsewhere in this report. Progress on all of the listed recommendations will be reported by the respective lead agencies to the Director General (DG) of the DoH and the Commissioner. The DG and Commissioner will report to the Minister for Mental Health at regular meetings. Information will be shared between agencies at regular partnership meetings.

## *Office of the Chief Psychiatrist – Chief Psychiatrist’s Monitoring Program*

The Chief Psychiatrist’s Monitoring Program gathers information around the system of mental health care service delivery. The aim of the program is to provide feedback to the system, with an expectation that services will take action on recommendations for continuous quality improvement, with one aim – to improve health outcomes for people with a mental illness.

The Program adds value to mental health service provision because it has capacity to examine and reflect upon clinical care in detail as required, which augments broader service review processes such as undertaken during accreditations.

Routine monitoring, evaluation, and reporting of the standards of psychiatric care will be benchmarked against the Chief Psychiatrist’s Standards of Clinical Care and will provide mental health services with evidence of their strengths, weaknesses, and gaps thereby providing opportunities for improvement of service delivery.

The routine monitoring will be supplemented by ad hoc targeted reviews of specific topics which may include areas such as physical health examination and care around restrictive practices.

The skills of the staff implementing this Program fall into the distinct areas of clinical experience and expertise, monitoring and evaluation, and high order data management and analysis.

The Chief Psychiatrist has determined that certain focal recommendations from the Stokes Review that pertain to his statutory role and function will be subject to routine monitoring, evaluation and reporting by his Office.

He acknowledges that primary responsibility for monitoring compliance for all recommendations from the Stokes Review is jointly shared between the DoH and the MHC.

## ATTACHMENT 1

The table below outlines the Stokes Review recommendations impacted, either partially or in full, by the actions in the Plan and lists their associated Plan actions.

Stokes Review Recommendation	Associated Actions in the Plan
1.1.7 - Developing the mental health workforce and mandating systems of supervision, continuing professional development, and credentialing of a service as well as personnel, to provide the required mental health care of that service.	Actions 32, 35, 60, 66, 88, 89 and 91(a) from the Plan by the end of 2017 Actions 138 and 139 from the Plan by the end of 2020 Action 160 from the Plan by the end of 2025
1.1.9 - Ensuring the development of a robust information system (including electronic) with flexibility for ease of use by all mental health practitioners including those who practice in areas of public mental health managed by a private provider.	Action 91 from the Plan by the end of 2017 Action 140 in the Plan by the end of 2020 Action 161 in the Plan by the end of 2025
1.5 - The new Executive Director of Mental Health Services of the Department of Health needs to ensure there are bridge programs that associate mental health with disability and culturally and linguistically diverse services.	Actions 55(d,e,f), 56(c), 57 and 79 in the Plan by the end of 2017 Action 134 by the end of 2020
1.6 - The new Executive Director of Mental Health Services develops policy with the Drug and Alcohol Office to enable mutual cooperative working with complex cases.	Actions 34, 80, 83 and 88 in the Plan by the end of 2017 Action 127 in the Plan by the end of 2020
2.3 - Every patient has access to individual advocacy services to assist with the navigation through the system and development of a care plan.	Actions 23, 84 and 85 by the end of 2017 Actions 131 and 136 in the Plan by the end of 2020
3.3 - The carers of patients need education, training, and information about the 'patient's conditions' as well as what are the signs of relapse and that may cause relapse triggers.	Actions 73 and 80(b,c) in the Plan by the end of 2017
3.5 - The governance of the system should provide to carers, patients, and GPs an appropriate way to navigate the mental health system in seeking advice and support, particularly in crises.	Actions 32, 80(a,b,c) and 84 in the Plan by the end of 2017 Actions 135 and 136 in the Plan by the end of 2020
4.1 - Clinicians need to work actively with the Executive Director of Mental Health	Actions 83 and 88 in the Plan by the end of 2017

Services of the Department of Health to assist in workforce planning and service development.	Actions 138 and 139 in the Plan by the end of 2020 Action 160 in the Plan by the end of 2025
4.8 - Residents of psychiatric hostels and other mental health facilities should have equal access to mental health services as other members of the community.	Actions 21, 22 and 24 in the Plan by the end of 2017 Actions 99 and 101 in the Plan by the end of 2020 Actions 145 and 146 in the Plan by the end of 2025
4.11 - Since mental health and substance-use disorders, including drug and alcohol issues, co-occur with high frequency in mental illness, it is imperative that clinicians are trained in the recognition and treatment of comorbid disorders of this type.	Actions 32, 35, 60, 67, 88 and 89 in the Plan by the end of 2017 Actions 138 and 139 in the Plan by the end of 2020 Action 160 in the Plan by the end of 2025
4.12 - Education and training should be provided to all staff to ensure ongoing quality of patient care and management. This should also be specifically available to workers of NGOs to ensure a high quality of care.	Actions 22, 32, 35, 60, 67, 88 and 89 in the Plan by the end of 2017 Actions 128, 138, and 139 in the Plan by the end of 2020 Action 160 in the Plan by the end of 2025
5.1 - The current acute bed configuration can only be adjusted when there are appropriate step-down rehabilitation and supported accommodation beds established. Any attempt to close acute beds before these systems are in place will be further detrimental to the system.	Actions 3 and 9 in the Plan are existing commitments Actions 24 and 38 in the Plan by the end of 2017 Actions 99 and 107 in the Plan by the end of 2020 Actions 146 and 151 in the Plan by the end of 2025
5.2 - Adolescent beds need to be increased to take into account the increasing population of youths. Beds must also be provided for child forensic and eating disorder patients. These are urgent requirements.	Action 10(d) of the Plan is an existing commitment Actions 28, 46, 54(a) and 65 in the Plan by the end of 2017 Action 120(a) in the Plan by the end of 2020 Actions 156(a) and 157 in the Plan by the end of 2025
5.3 - Rural, child, adolescent, and youth beds should be considered a priority in forward planning and attended to immediately.	Action 9(b,c,d,e) of the Plan are existing commitments Actions 39 and 47 in the Plan by the end of 2017 Actions 112 and 113 in the Plan by the end of 2020 Action 151 in the Plan by the end of 2025
5.4 - Close working between the Department of Health as the provider and the Mental Health Commission as the funder need to occur so that a robust Clinical Services Plan is developed that provides step-down facilities as an early and	Action 9 of the Plan is an existing commitment - as part of the Government's 2013 Election Commitment, the MHC is currently progressing the establishment of the following step-up/step-down

<p>pressing need.</p>	<p>community bed facilities: Rockingham (Peel – 10 beds); Broome (Kimberley – 6 beds); Karratha (Pilbara – 6 beds); and Bunbury (South West – 10 beds).</p> <p>Actions 38 and 39 in the Plan by the end of 2017  Action 107 in the Plan by the end of 2020  Action 151 in the Plan by the end of 2025</p>
<p>5.5 - The full range of beds needs to be provided in each geographical area. This is crucial to ensure continuity of care across the spectrum of accommodation.</p>	<p>The Matrix (located on page 105 of the Plan) outlines the number of beds required by the end of 2025 in each of the following regions: State-wide, Graylands, North Metropolitan, South Metropolitan, Kimberley, Pilbara, Midwest, Great Southern, Southwest, Wheatbelt</p> <p>In the metropolitan matrix (page 106 of the Plan) shows the number of beds required by the end of 2025 in each of the following catchment areas: State-wide, Graylands, North Metropolitan, South Metropolitan, City, Joondalup-Wanneroo, Lower West, Stirling-Osborne Park, Swan and Hills, Armadale, Bentley, Fremantle, Peel and Rockingham/Kwinana</p>
<p>7.6 - Continue to resource the currently COAG Closing the Gap funded Specialist Aboriginal Mental Health Service (SAMHS) to assist Aboriginal people to access culturally secure mental health services, particularly those in custody or on parole and those with comorbid conditions such as substance abuse disorders.</p>	<p>Action 5 of the Plan is an existing commitment  Actions 42, 65 and 78 in the Plan by the end of 2017  Action 133 in the Plan by the end of 2020  Action 157 in the Plan by the end of 2025</p>
<p>7.7 - Encourage training and education of mental health workers in the management of comorbid conditions of drug and alcohol misuse.</p>	<p>See recommendation 4.11</p>
<p>7.8 - Continue to resource the current COAG Closing the Gap funded SAMHS suicide intervention teams, including the support of Aboriginal Elders Specialist Mental Health Services and government and non-government agencies.</p>	<p>See recommendation 7.6</p>

<p>7.9 - Develop respite services and increase rehabilitation services.</p>	<p>One of the key strategies in the Community Support section of the Plan is: Expand family and carer information, support and flexible respite services. Respite services are included in the modelled “hours of Support” for community support services. The Plan identifies the need for community bed based services of up to 628 beds across the State by the end of 2025. The Plan further identifies the need to expand community support and community treatment services that provide recovery focused ‘rehabilitation’ for people to achieve their recovery goals.</p> <p>Action 21 in the Plan by the end of 2017  Action 101 in the Plan by the end of 2020  Action 145 in the Plan by the end of 2025</p>
<p>7.10.6 - Ultimately all community health services should be funded to respond holistically to crises. Families, as well as patients, need support, especially on discharge of patient back into their care. Carers need to know the people involved with the care of their patient.</p>	<p>Actions 31, 32, 80(b) and 81 in the Plan by the end of 2017</p>
<p>7.10.12 - There is a very real need for day hospital facilities/transition units/wellbeing centres—whatever one chooses to call them as outlined by Professor Silburn in more locations throughout the metropolitan region and the rest of the State, as outlined by Professor Silburn. Such centres will accommodate the difficult transition from admission to the community following discharge and as a community support for those dealing with mental health issues.</p>	<p>Action 9 of the Plan is an existing commitment - as part of the Government’s 2013 Election Commitment, the MHC is currently progressing the establishment of the following step-up/step-down community bed facilities: Rockingham (Peel – 10 beds); Broome (Kimberley – 6 beds); Karratha (Pilbara – 6 beds); and Bunbury (South West – 10 beds).</p> <p>Actions 21, 22 and 39 in the Plan by the end of 2017  Actions 101 and 107 in the Plan by the end of 2020  Actions 145 and 151 in the Plan by the end of 2025</p>

<p>7.10.13 - There needs to be relevant facilities out of the metropolitan area for short term care of patients in crisis to avoid dislocation as an added stress. I don't know if the secure facility at Bunbury Regional Hospital is now adequate but there is nothing in the north of the State. I note the reference to a plan for a facility for Broome. This needs to become a reality.</p>	<p>Actions 39 and 47 in the Plan by the end of 2017  Actions 107, 112 and 113 in the Plan by the end of 2020  Action 151 in the Plan by the end of 2025    See also recommendations 5.5 and 7.10.12</p>
<p>8.1 - A central referring position is established to receive referrals for children and youth services, which will then direct the referral to the correct services in the patient's locality.</p>	<p>Actions 32 and 80(a,b,c) in the Plan by the end of 2017</p>
<p>8.2 - After-hours services are established for children and adolescent and youth services in rural and remote communities, where possible.</p>	<p>Actions 21, 22, 27, 28, 32 and 52 in the Plan by the end of 2017  Actions 101 and 102 in the Plan by the end of 2020  Actions 145 and 148(b) in the Plan by the end of 2025</p>
<p>8.3 - Emergency response services, including the Acute Community Intervention Team and the King Edward Hospital Unit for Mother and Baby, are supported.</p>	<p>Actions 10(d) and 12 are existing commitments in the Plan  Actions 31, 32 and 55(b) in the Plan by the end of 2017  Action 120(b) in the Plan by the end of 2020  Action 156(b) in the Plan by the end of 2025</p>
<p>8.5 - Recovery programs for children are established.</p>	<p>Actions 21, 22, 27 and 68 in the Plan by the end of 2017  Action 101, 128 and 129 in the Plan by the end of 2020  Action 145 in the Plan by the end of 2025</p>
<p>8.6 - Special provisions are made for the clinical governance of the mental health needs of youth (16–25 years of age). The State would benefit from the advent of a comprehensive youth stream with a range of services that do not have barriers to access.</p>	<p>A dedicated youth stream will be established across the whole continuum of care, to address the specific challenges that face youth who experience mental illness.  Action 10(d) is an existing commitment in the Plan  Actions 18, 21, 28, 46, 57, 62 and 65 in the Plan by the end of 2017  Actions 94, and 121 of the Plan by the end of 2020  Action 157 in the Plan by the end of 2025</p>

<p>8.6.1 - Children should be treated in separate areas from adults, and young children should be separated from youth. Establish a youth inpatient unit with the capacity to manage comorbidities and alcohol and drug withdrawal.</p>	<p>The modelling shows that dedicated youth, and infant, child and adolescent beds are required. As detailed in the Plan matrix by the end of 2025, the following inpatient beds are required:</p> <p>Total for the State:</p> <ul style="list-style-type: none"> <li>• 27 acute beds for Infant, Child and Adolescent</li> <li>• 83 acute beds for Youth</li> <li>• 18 subacute bed for Youth</li> <li>• 98 AOD high/complex medical withdrawal beds (some of which would be for youth)</li> </ul> <p>Action 10(a,d) are existing commitments in the Plan Action 46 in the Plan by the end of 2017</p>
<p>8.6.2 - Respite and rehabilitation services are developed for youth.</p>	<p>See recommendations 7.9, 8.5 and 8.6</p>
<p>8.6.3 - A service is established for youths with gender and sexual identity problems. Such a service requires expertise in psychiatric morbidity, suicidal behaviour, endocrinology and hormone treatments and close links with surgical and legal services.</p>	<p>Action 56(a) in the Plan by the end of 2017</p>
<p>8.6.5 - Workforce planning must be made to address the shortage of Child Psychiatrists.</p>	<p>Action 88 in the Plan by the end of 2017 Actions 138 and 139 in the Plan by the end of 2020 Action 160 in the Plan by the end of 2025</p>
<p>8.8 - A more equitable distribution of community resources is provided.</p>	<p>The Plan models service requirements based on population projections to the end of 2025, thereby ensuring that services are planned for each region, based on the population need and growth. In order to ensure the equitable distribution of community based services for people living in regional and remote areas, specific weightings were applied in the modelling process to take account of the additional cost and difficulties in</p>



	providing services. The modelling includes all elements of the service continuum for mental health, alcohol and other drug services, allowing limited resources to be targeted to expand service elements with the biggest gap between current services and demand.
8.9 - Early childhood assessment and intervention programs are established for those children who show signs of the development of possible mental illness.	Actions 18, 27 and 35 in the Plan by the end of 2017 Action 105 in the Plan by the end of 2020
8.10.1 - A strategic and comprehensive plan for the mental health and wellbeing of children and young people across WA be developed by the MHC [Mental Health Commission]. This plan should provide for the implementation and funding of promotion, prevention, early intervention, treatment and programs.	See Recommendation 8.6
8.10.2 - Funding to the State's Infant, Child Adolescent and Youth Mental Health Service be increased so it is able to provide comprehensive early intervention and treatment services for children and young people across WA, including meeting the needs of those with mild, moderate and severe mental illness.	Action 27 and 28 in the Plan by the end of 2017
8.10.5 - Priority is given by the mental health service to the assessment, referral, admission, and continuity of treatment of children and young people in out-of-home care or leaving care.	The Plan proposes the development of a specialised service for children in care. The multidisciplinary team will support children and adolescents with mental health disorders in the care of the Chief Executive Officer of the Department of Child Protection and Family Services. Action 56(b) in the Plan by the end of 2017
8.10.6 - A dedicated forensic mental health unit for children and young people be established.	Actions 59, 62 and 65 in the Plan by the end of 2017 Actions 121 and 122 in the Plan by the end of 2020 Actions 157 and 159 in the Plan by the end of 2025
8.10.7 - Children and young people appearing before the Children's Court of Western Australia have access to appropriate, comprehensive mental health assessment, referral and treatment services.	Actions 13 and 14 in the Plan are existing commitments Action 123 in the Plan by the end of 2020

<p>8.10.10 - Transition strategies for young people moving from child and adolescent services to youth mental health services and from youth services into adult services be developed and implemented to ensure the individual is supported and continuity of care is maintained at both transition points.</p>	<p>The new dedicated youth community treatment services will establish formalised protocols and procedures for transition between Child and Adolescent and Youth and between Youth and Adult mental health services that are consistently applied across the state.</p> <p>Actions 80(a,b,c) in the Plan by the end of 2017</p>
<p>8.10.11 - The Disability Services Commission work with the Mental Health Commission to identify the services required to address the unique needs and risk factors for children and young people with disabilities in a coordinated and seamless manner.</p>	<p>Action 55(e) in the Plan by the end of 2017.</p>
<p>8.10.12 - All children and young people admitted to the mental health system have a treatment, support and discharge plan and that policies, processes and procedure that ensure care and discharge planning occurs to the level that ensures continuity of services and includes planning for education, accommodation and other support services as needed.</p>	<p>Actions 80(b,c) and 83 in the Plan by the end of 2017</p> <p>Action 135 in the Plan by the end of 2020</p>
<p>9.1 - As a matter of urgency, the Department of Health, the Mental Health Commission and the Department of Corrective Services (and other relevant stakeholders) undertake a collaborative planning process to develop a 10-year plan for forensic mental health in WA. (This plan will form the forensic mental health component of the State Mental Health Clinical Services Plan). Important elements to that plan include: As early as possible in the planning process, a business case for expansion of the currently inadequate number and location of secure forensic mental health inpatient beds needs to be developed for urgent government consideration.</p>	<p>The Department of Health, the Mental Health Commission and the Department of Corrective services have inputted into the Plan. A business case is currently being prepared for consideration.</p> <p>Actions 58, 59, 61, 62, 63, 64, 65 and 66 in the Plan by the end of 2017</p> <p>Actions 121, 122, 123, 124, 125, 126 and 127 in the Plan by the end of 2020</p> <p>Actions 157, 158 and 159 in the Plan by the end of 2025</p>
<p>9.1.1 - To divert early and minor offenders from the formal justice system and further offending behaviour in appropriate model, business case and funding for a police diversion service in WA are established.</p>	<p>Actions 58 and 59 in the Plan by the end of 2017</p>
<p>9.1.2 - The rapid and timely establishment of the recently funded Court Diversion</p>	<p>See Recommendation 8.10.7</p>

<p>and Support Program for adult courts is supported. The approved program for the Children's Court is also supported and it is recognised it will need early expansion to a complete service as in the adult courts.</p>	
<p>9.1.3 - The planning, business cases and funding for provision of a full range of mental health services in WA prisons and detention centres. This will involve dedicated units and services in prison for mentally ill women, youth, Aboriginal and people with acquired brain injury/intellectual disability.</p>	<p>Actions 61, 62, 63 and 65 in the Plan by the end of 2017  Action 121 in the Plan by the end of 2020  Action 157 in the Plan by the end of 2025</p>
<p>9.1.4 - Community services are expanded to facilitate transition from prison, to assertively follow up people who are seriously mentally ill and present a serious risk of harm to themselves and others, and to closely follow up and monitor mentally impaired accused patients on custody orders in the community. Also, there is a need to assess and care for particular groups of individuals with particular care needs such as sex offenders, stalkers and arsonists.</p>	<p>Action 59 in the Plan by the end of 2017  Actions 122, 125 and 126 in the Plan by the end of 2020  Action 159 in the Plan by the end of 2025</p>

**Note:** Recommendation 8.10 is not included as it does not have specific actions in the Plan and relates to recommendations 8.10.1 – 8.10.12 being implemented.

## ATTACHMENT 2

The table below includes Stokes Review recommendations associated with the implementation of the MHA 2014.

Recommendation Number	Recommendation
1.1.2	Policy setting, including those of standards and those of best practice.
1.1.5	Working closely with the Office of the Chief Psychiatrist to ensure compliance with regulations from that Office.
1.2	Works closely with other service providers such as GPs, private hospitals, and NGOs to ensure the system has solid links between the inpatient and community health clinics so there is a seamless flow of patients between them and establishes and monitors those links.
2.1	The new Executive Director of Mental Health Services <sup>1</sup> mandates the policy development of patient focussed service and insists that every patient is involved in care and discharge planning.
2.2	Every patient must have a care plan and be given a copy of it. Prior to discharge, the care plan must be discussed in a way that the patient understands and be signed off by the patient. With the discharge plan the carer is also involved as appropriate.
2.7	All mental health clinicians must ensure that the physical wellbeing (including dental) of all patients under their care is regularly assessed and treated by appropriate specialist clinicians (e.g. podiatrist, diabetes educator). This is a key performance indicator that requires monitoring for compliance.
2.9	Where a patient has indicated the possibility of performing self-harm, that patient must always be comprehensively assessed by a mental health practitioner and their care plan be approved by a psychiatrist or psychiatric registrar and not discharged until that approval occurs.
2.10	No patient is to be discharged from an ED or another facility without an adequate care plan. Where there is a carer clearly involved, the carer should be included in the discussion of the care plan and discharge plan. Carer involvement is essential, especially in life-threatening situations, and is to be fostered at every opportunity. The

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<sup>1</sup> The Executive Director of Mental Health Services (EDMHS) role existed in the structure of the OMH. The OMH no longer exists and the MHU is now in place. The EDMHS role is not mentioned in the MHA 2014.

	sanctity of patients' confidentiality should not be used as a reason for not communicating with carers in these situations.
2.11	Patients must be made clearly aware of their voluntary and involuntary status.
3.1	Whilst the patient is the primary focus of care, the views of the carer must also be considered.
3.2	Carers must be involved in care planning and most significantly in a patient's discharge plan, including the place, day, and time of discharge.
3.3	The carers of patients need education, training, and information about the 'patient's conditions' as well as what are the signs of relapse and that may cause relapse triggers.
3.4	The carers of patients need to be informed in a timely fashion when the patient is to be reviewed by the Mental Health Review Board and supported to attend.
3.6	A carer should have equal status with the patient in reporting triggers that might indicate deterioration in the patient's condition.
3.7	Carer communication by mental health clinicians is mandatory for the system to be robust and provide patient best practice.
3.8	Patients may demand confidentiality of care and treatment but mental health clinicians in this situation need to understand and take into account the requirements and vulnerability of carers. Mental Health practitioners must be aware of the rights and safety of carers.
4.2	Clinicians must ensure the service in which they are working does not deviate from the standards and protocols set.
4.7	Links between community mental health services and inpatient facilities must be maintained and maximised to ensure continuity of care and continuation of treatment plans.
7.1	Patients presenting anywhere in the public health system with suicidal intent must undergo a best practice risk-screening process and, where required, a comprehensive assessment by a mental health professional. A care plan must be formulated and all decisions to discharge require medical oversight and approval.
7.1.1	It is important that no decisions are made in isolation or by isolated practitioners.
7.3	The care plan must accompany the patient between community and other treatment

	settings and be communicated to new clinicians at the time of transition. This ensures the care passport maintains treatment continuity.
7.4	Every patient must have an identified case manager.
7.5	The assessment, care plan, and decision to refer a patient from one public mental health service to another should be seamless. The patient should not experience further assessments as barriers to entry. There should be no requirement to repeat triage.
7.11.1a	All patients, regardless of how well known they are to the MHS (Mental Health Service) should receive as comprehensive a psychiatric assessment as is possible on entry to the MHS for each specific episode of care including patients transferred from other facilities.
7.11.1c	The MHS, with the patient's informed consent, includes carers, other service providers, and others nominated by the consumer in assessment.
7.11.2c	Risk management plans are updated or revised with any new information relevant to that individual patient.
7.11.3a	There is a current individual multi-disciplinary treatment, care, and recovery plan, which is developed in consultation with, and regularly reviewed with, the patient and, with the patient's informed consent, their carer(s). The treatment, care and recovery plan is available to both of them.
7.11.3b	The treatment and support provided by the MHS is developed and evaluated collaboratively with the patient and their carer(s). This is documented in the current individual treatment, care and recovery plan.
7.11.4a	The patient and their carer(s) and other service providers are involved in developing the exit (discharge) plan. Copies of the exit plan are made available to the patient and, with the patient's informed consent, their carer(s).

## ATTACHMENT 3

Although many Stokes Review recommendations have been implemented or are part of a larger structure to ensure outcomes are implemented, there are a small number that will require some further work to complete. This is due to the complex nature of the projects associated with these recommendations. In many case s, some components of the recommendation have already been achieved.

The table below lists the recommendations that currently have an outstanding component and includes the lead agency responsible for implementation and estimated completion date.

Stokes Review Recommendation	Lead Agency	Estimated Completion
1.1.4	DoH	June 2016
1.1.5	DoH	June 2016
2.7	DoH	August 2016
3.5	MHC	Awaiting confirmation from Minister for Mental Health
4.1	MHC	Approximately August 2016
4.2	DoH	June 2016
4.5	DoH	June 2016
4.8	DoH	June 2016
	The component of this recommendation linked to the actions of the Plan will be monitored by the MHC.	
4.9	DoH	June 2016
4.10	DoH	June 2016
4.12	MHC	On-going
6	MHC	May 2016
7.1.2	DoH	June 2016