Government of **Western Australia**
Mental Health Commission

BETTER CHOICES. BETTER LIVES.

WESTERN AUSTRALIAN MENTAL HEALTH, ALCOHOL AND OTHER DRUG SERVICES PLAN 2015–2025

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NOTE FROM THE MINISTER

Consumers and their families in Western Australia should have access to personalised, modern and high quality services that are close to their homes.

The Government has recognised this and has made mental health, alcohol and other drug services a high priority since 2008. Over the past six years we have seen the establishment of the ministerial portfolio for mental health, the creation of the Mental Health Commission and a record 68 per cent increase in investment in the mental health, alcohol and other drug services sector. The Mental Health Commission has set up mechanisms to strengthen the voice of mental health consumers and in 2014 the Mental Health Bill passed through both houses of Parliament, which will further drive reform. In addition, we have seen the expansion of a range of evidence-based alcohol and drug services and internationally renowned prevention campaigns.

Substantial change has already taken place, but we have much more to achieve. Extensive transformation and significant investment is required to address decades of accumulated poor targeting and under-investment.

Unfortunately, individuals with mental health, alcohol and other drug problems still too often experience poor outcomes as a result of a service system that does not meet their needs. The current system is complex and difficult to navigate, therefore many consumers are left unsure how to access the help they require. Looking forward, we need to resource the system properly and progress system-wide improvement to achieve better outcomes for individuals, families and the broader community.

Despite these challenges, staff have remained committed and there are examples of great innovation. I admire, and am extremely grateful for, the unwavering dedication shown by staff who work in a system that often makes their jobs challenging.

I am therefore pleased to present the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025* (Plan), which has been developed by the Mental Health Commission, the former Drug and Alcohol Office and the Department of Health. The Department of Corrective Services was also involved in developing the forensic component of the Plan. Combining research, evidence, expert opinion, world's best practice and some of the latest planning tools, we are now able to estimate the optimal mix of services required for our growing population over the next ten years.

The reform will require all levels of government, the private and non-government sector as well as clinicians, consumers, families, and carers to work together. The Plan provides us with a clear direction, guiding our investment in capital and other resources, our policy and process development and implementation.

I believe we are all working towards the same vision and, we will continue to work together for real changes at a whole of system level and for those people with an alcohol or drug problem, mental disorder or illness and their families and carers.

Hon Helen Morton MLC
Minister for Mental Health

NOTE FROM THE COMMISSIONER

I am proud to release the final *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025* (Plan). The purpose of the Plan is to provide the State with a clear picture of the optimal mix and level of mental health, alcohol and other drug services required for the population of Western Australia.

This is a valuable document as for the first time the mental health, alcohol and other drug sector is able to quantify gaps in services and identify areas where investment and reform is required, through the use of nationally agreed, evidence-based modelling tools. I am committed to ensuring this document has bi-partisan support and trust future Governments will accept this Plan as the blueprint for the future mental health, alcohol and other drug service system.

I thank the various consumers, families, carers, clinicians and service providers who have assisted in the development of this Plan. I attended all 19 consultation forums across the State during the final consultation period, and feel fortunate to have heard firsthand not only the feedback on the draft Plan, but also the experiences and personal stories of consumers, families, carers, clinicians and service providers. Visiting towns and meeting with locals has given me a new appreciation of the challenges of delivering and accessing services in regional and remote areas as well as the difficulties faced in the metropolitan area in regards to system integration and navigation. I also heard loud and clear the need for greater access to 24-hour crisis treatment and support as well as housing and accommodation across the State.

The implementation of the Plan over the next ten years will require partnerships with all key stakeholders including all levels of Government, private and non-government, health and non-health sectors, clinicians, consumers, families and carers. The Plan tells us how we need to grow the system by articulating where and what type of services are required to be established or expanded by the end of 2025. The Plan provides a roadmap which Governments and other stakeholders can use to invest their finite resources. It would be pre-emptive for the Mental Health Commission, or any other Government department, to prescribe how the Plan should be implemented. I envisage the implementation process will be highly collaborative, evolving over time with changing trends, new evidence and experience. The years ahead will be challenging but also exciting as we work together to better meet our communities' needs.

The development of this Plan has involved numerous staff from across the Mental Health Commission, the former Drug and Alcohol Office, the Department of Health and the Department for Corrective Services and I thank all who have dedicated many hours to sharing ideas, writing and refining the Plan to ensure it is robust, evidence-based and reflects best practice.

Timothy Marney
Mental Health Commissioner

A MESSAGE FOR PEOPLE WITH MENTAL HEALTH, ALCOHOL AND OTHER DRUG PROBLEMS AND THEIR FAMILIES AND CARERS

Welcome to the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025* (Plan).

This section provides an opportunity for all those who have worked on the Plan to thank you for your willingness to share your views, opinions, personal stories and, at times, traumatic experiences.

Throughout the Plan's development consumers, families and carers have been open and often very brave in sharing their first-hand knowledge of what it is like to live with and/or be impacted by mental health, alcohol and other drug problems. Some stories have been heartbreaking, including the loss of life and breakdown of families and relationships. Consumers, families and carers have frequently expressed their frustration with a system that is complicated to navigate and does not effectively meet their needs.

Through the effective implementation of this Plan, it is expected Western Australians will be supported to stay well in the community, and that consumers who require treatment and support will have early access to high quality, effective and personalised services that help them participate fully in community life and stay connected to family and friends.

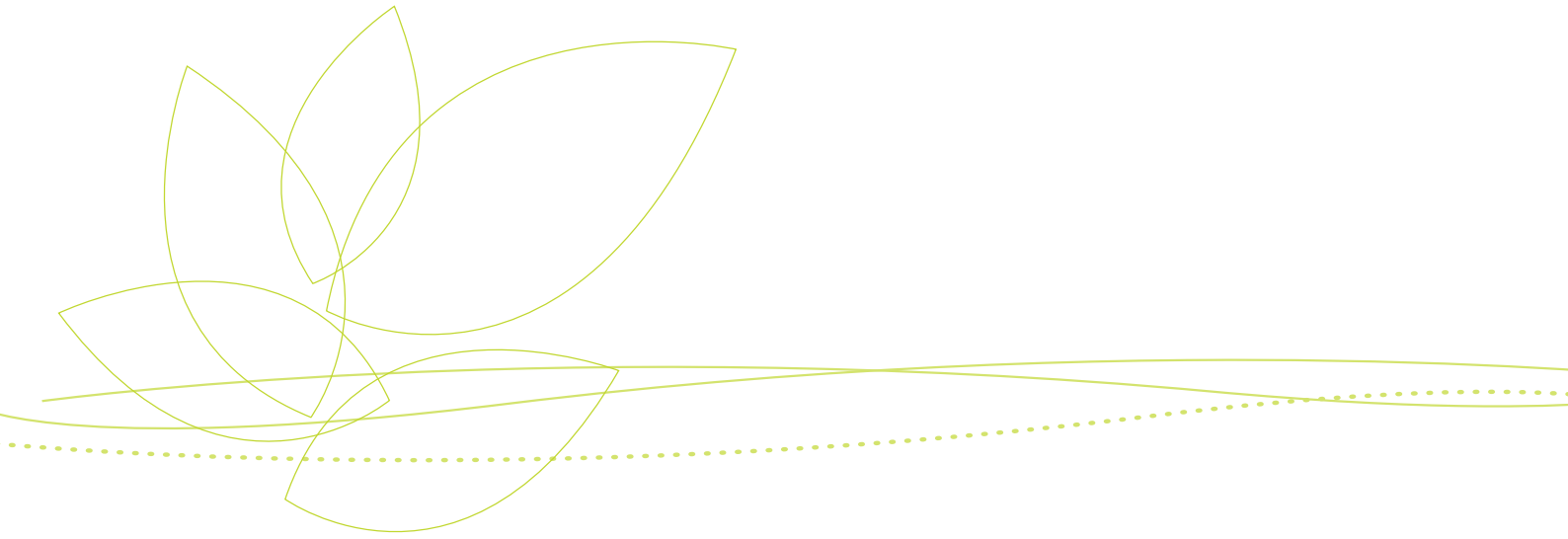
Although this Plan is primarily aimed at assisting the Government and other funding agencies to quantify the gaps in services and therefore clearly show where investment and reform is required, the need to radically improve services for consumers, families and carers is always at the centre. The stories shared and the persistence and resilience shown by consumers, carers and their families will continue to inspire those working in the mental health, alcohol and drug sector to deliver this Plan over the next ten years.

Thank you.

From all those who have worked on the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.*

IMPORTANT NOTICE

The *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025* (Plan) articulates the overall intentions regarding service development, transformation and expansion of mental health, alcohol and other drug services over the next ten years. The actions contained within this document and the subsequent investment required are dependent on Government's fiscal capacity and are subject to normal Government approval through budgetary processes. It should be noted, however, that services outlined in the Plan can also be funded by the Commonwealth Government, private and not-for-profit sectors, which are therefore subject to their own financial capacity.



OVERVIEW

Our vision

is to build a **Western Australian mental health, alcohol and other drug service system** that: prevents and reduces mental health problems, suicide and suicide attempts; prevents and reduces the adverse impacts of alcohol and other drugs; promotes positive mental health; and 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 a satisfying, hopeful and contributing life.

OVERVIEW

The *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025* (Plan) outlines the optimal mix and level of mental health, alcohol and other drug services required to meet the needs of Western Australians over the next ten years. This document provides Government and funding agencies with a 'resource calculator', clearly showing gaps in services and areas where future investment and reform should be prioritised.

At present, expenditure on mental health services is heavily reliant on costly acute services and there is an urgent need to expand the system to boost community-based services. Increasing access to community services will keep people well, out of hospital and connected to their family, friends and community. Expenditure in the alcohol and other drug sector is considered more balanced between community and hospital-based services, however is well below current demand and services need to be located closer to where people live.

WHY IS A NEW PLAN REQUIRED?

The Plan further progresses the implementation of the Mental Health Commission's Strategic Plan: *Mental Health 2020: Making it Personal and Everybody's Business* (MH2020) and the *Drug and Alcohol Interagency Strategic Framework* (ISF), which both outline the overarching strategic directions and outcomes that guide the philosophy and everyday work of the newly amalgamated Mental Health Commission. This Plan provides an estimate of the number and range of services required to achieve the strategic directions and outcomes outlined in MH2020 and the ISF.

The vision articulated in this Plan and the ISF/MH2020 are therefore closely aligned.

In 2012 the State Government commissioned Professor Bryant Stokes to undertake the *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/ services in Western Australia* (Stokes Review). This Plan was the principal recommendation of the Stokes Review. Many of the strategies and actions within the Plan address other key recommendations of the Stokes Review.

WHY IS THIS PLAN DIFFERENT?

THE PLAN USES NATIONAL MODELLING TOOLS – BASED ON THE STATE'S POPULATION

This Plan is the first of its kind in Western Australia. Never before have we had access to national modelling tools (the National Mental Health Services Planning Framework (NMHSPF) and the Drug and Alcohol Service Planning Model (DASPM) – see Appendix D for more information) that can effectively show an optimal level and mix of services and where the imbalances and underinvestment are in the current mental health, alcohol and other drug system. The national modelling tools are based on robust evidence including epidemiology, prevalence and an optimal service mix. The modelling tools have been applied to the Western Australian population, taking into account our particular characteristics such as geography and Aboriginal[i] population. Modelling will be revisited every two years to ensure the latest evidence and population demographics are taken into account.

i The use of term 'Aboriginal' within this document refers to both Aboriginal and Torres Strait Islander people.

OVERVIEW

The Western Australian models' output is expressed in hours of service, hours of support or beds. The output does not pre-determine models of service or *how* the Plan should be implemented. Implementation and the development of models of service can only be progressed in partnership with all levels of Government, private and non-government funding agencies and service providers, clinicians, and, most importantly, consumers, families and carers.

THE PLAN COVERS THE ENTIRE SERVICE CONTINUUM

The Plan includes the full range of services from prevention through to specialised statewide and forensic services. Although the Plan is structured by service streams for ease of reading, it is acknowledged the full range of services within the mental health, alcohol and other drug system need to be fully integrated and coordinated to ensure a seamless service system is provided for consumers, carers and their families. Consumers, carers and families, quite rightly, are not concerned with who is funding or providing a service, but rather they require access to an easy to navigate system where they can be provided with personalised, high quality and safe treatment and support. It is the responsibility of all levels of Government, the private and non-government sectors and clinicians to work together to provide this.

THE PLAN FOCUSES ON COLLABORATION AND REDUCING GAPS AND OVERLAPS

The Plan focuses services on improved collaboration and, where relevant, integration. Improved continuity of treatment and support for people to meet their needs holistically will be paramount in the implementation of the Plan. Collaboration, coordination and partnerships with clear accountability and protocols will result in more responsive and integrated support for people with co-occurring mental health and alcohol and other drug problems, and support effective transitions between services when required. A multi-sectoral approach with relevant service areas and sectors will also reduce fragmentation of supports such as housing, employment services and general health services. It will also contribute to reducing the number of people falling through gaps in services and decreasing overlaps and service duplication.

THE PLAN IS PHASED

The Plan provides a pathway for investment that can be progressed as enabled by the State's fiscal capacity, and the financial capacity of other service purchasers (such as the Commonwealth Government and the private sector). Actions within the Plan have been phased over three time horizons, as shown by the following figure.

OVERVIEW

THE PLAN IS PROVIDER AND FUNDER NEUTRAL

Unlike many other plans, this Plan is provider and funder neutral. This means the Plan articulates the types and level of service required across the State but does not pre-determine who should fund or provide them. Services can be funded by the State or Commonwealth Governments, private or non-government sectors and can be delivered by government, not-for-profit or private organisations. For costing purposes, the Plan assumes the current funding sources will remain approximately the same proportions as has historically been the case.

IMPLEMENTATION OF THE PLAN

The Plan outlines what mix and level of services are required but does not specify *how* the Plan should be implemented. Implementation of the Plan will be guided by the *Principles* outlined on pages 10-11 as well as by clinical and program evaluation evidence and the needs of consumers, families and carers. The Mental Health Commission will lead the implementation, working with key partners including the Commonwealth Government, private and not-for-profit sectors, clinicians, consumers, families and carers. For more information see *A Partnership Approach to Implementing Reform* on page 167.

GUIDING PRINCIPLES AND WHAT WE HOPE TO ACHIEVE

PRINCIPLES

A number of principles have guided our work during the development and finalising of the Plan. Throughout the implementation phase, these principles will continue to underpin our decisions.

- the upholding of human rights[ii] is the core responsibility of all services, which must be supported by the availability of advocacy where required
- implementation of effective prevention, mental health promotion and early intervention activity across the lifespan is essential to turn the system around
- recovery-oriented practice, including supporting people to stay connected to their community, is central to the development of mental health services
- the development of all services incorporates a holistic approach that acknowledges the impact of the social determinants of health and wellbeing such as housing, education, and employment
- consumers, families, and carers will be supported to be fully involved in co-planning, co-designing, co-delivery and co-reviewing of policies and services
- a primary focus is on rebalancing services between hospital-based and community-based: moving services to the community where clinically appropriate
- the Plan is based on robust, evidence-based national modelling tools, however it does not pre-determine service models
- services will expand in the regions and in locations where they are most required, and closer to where people live, wherever practical and feasible
- State-funded mental health services (as described in the Plan) will treat individuals with severe mental health problems only[iii] and will contribute to the funding of prevention activity. However the State should play a role in advocating for other parts of the system, including non-government organisations and primary care, to deliver the full mix of services across the severity continuum.
- alcohol and other drug services are provided to individuals across the entire severity spectrum

ii Consistent with the *Mental Health Statement of Rights and Responsibilities.*

iii The mental health services modelled in the Plan relate only to the services required for people with severe mental illness. This is recommended by the National Mental Health Services Planning Framework (NMHSPF), and is reflected in the modelling tool. However, it is understood State-funded services currently see people with moderate illness, just as some people with severe mental illness are successfully provided treatment in the primary care sector. Only through working with the Commonwealth to build the capacity and capability of primary care services will we begin to see a shift towards primary care being more able to better meet the needs of people with moderate mental illness. It is acknowledged that, inevitably, there will continue to be crossover between the sectors.

GUIDING PRINCIPLES AND WHAT WE HOPE TO ACHIEVE

- services value diversity, are culturally secure, consumer focused, family inclusive, and responsive to the needs of individuals
- services are able to meet the needs of people with co-occurring problems including co-occurring alcohol and other drug and mental health problems, as well as physical health problems, disability and trauma
- an appropriate mix of supports and services will be established that best meets the needs, goals and preferences of people with mental health, alcohol and other drug problems
- service development must consider the lifespan from the developing foetus through to older adulthood
- improved system navigation, collaboration and integration are priorities to ensure people are supported to get to the right place at the right time
- where possible services need to assist individuals to avoid coming into contact with the criminal justice system in the first instance; individuals who do come into contact with the criminal justice system have the right to receive the same access and quality of care as the general population at all stages of their involvement with the criminal justice system.

WHAT DOES RECOVERY MEAN?

Participants in the *Community Support* consultation forum were asked what recovery meant to them. A summary is provided in the graphic below. Personal recovery is defined within the *National Framework for Recovery-oriented Mental Health Services*[1] as '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'.

It is acknowledged recovery is personal and means different things to different people. In regards to alcohol and other drug use, it may or may not involve goals related to abstinence.

WHAT WE HOPE TO ACHIEVE

By implementing the strategies and actions articulated in the Plan over the next ten years, we expect to see:

- reduced rates of people developing mental health, alcohol and other drug problems, reduced attempts of suicide and a halving in the number of people who die by suicide
- reduced and delayed uptake of alcohol and other drug use, as well as decreased harms associated with alcohol and other drug use
- increased numbers of people feeling that they are treated with dignity and respect across all aspects of their lives, and their rights and choices acknowledged and respected
- a greater number of people treated and supported in community-based, recovery-oriented settings that address holistic needs including housing, education and employment
- increased numbers of people treated as close as is practical to where they live by providing services in outer metropolitan and regional locations wherever possible
- consistent and ongoing involvement of consumers, families, carers and clinicians in the planning, design and review of services
- services that are integrated, high quality, and person-centred
- improved social and economic participation for people living with mental health, alcohol and other drug problems
- greater engagement and accessing of services by Aboriginal people through the provision of culturally secure services addressing mental health, alcohol and other drug problems; and ensuring the sector workforce is culturally competent
- families and carers feeling more supported in their caring roles, and their rights and responsibilities recognised
- a diversified and modernised range of bed-based services that provide service options outside a hospital setting
- Graylands Hospital and Selby Older Adult Service will be closed and replaced by contemporary services across the State
- improved transition for people moving between services including between bed-based and community treatment and support services
- reduced demand on emergency department services and reduced avoidable inpatient admissions
- improved long-term accommodation options that deliver a safe place for vulnerable people to live and receive appropriate supports
- a more comprehensive forensic service system that offers early intervention options such as liaison and diversion, as well as services that enable recovery, rehabilitation and reduced recidivism
- a sustainable service system with increased availability of community services and initiatives to improve the efficiency and effectiveness of the system as a whole.

CONSULTATION

The consultation process to inform the development of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025* (Plan) has been comprehensive, involving more than 2,300 individuals and organisations.

Expert reference groups were formed and online surveys, consultation forums, and individual meetings have been undertaken to ensure key stakeholders have had an opportunity to contribute their experience, thoughts, opinions and ideas. The interest shown has been substantial and can be taken as an indication of the desire many people have to see real change.

A short summary of general themes from the most recent consultation process (3 December 2014 to 30 March 2015) is provided below. A more comprehensive summary is available on the Mental Health Commission's website: www.mhc.wa.gov.au

WHAT YOU SAID	OUR RESPONSE
How will the Plan be implemented?	The Plan sets out the optimal mix and level of mental health, alcohol and other drug services but does not pre-determine models of service or operational features of the system (i.e. how the Plan will be implemented). The Mental Health Commission will lead on implementation of the Plan, working with all levels of Government, private and non-government sectors, clinicians, consumers, families and carers. Adjustments to the Plan will be made every two years based on evaluation and new emerging evidence. Further information is provided in *A Partnership Approach to Implementing Reform* on page 167.
Who is going to fund the Plan?	The Plan is funder neutral. Certain aspects of the Plan may be funded by different levels of Government, the private or non-government sectors. In relation to areas for which the State Government is primarily responsible, business cases will be submitted as part of normal budgetary processes and funding will be subject to the State's fiscal capacity.
We need to invest in prevention and mental health promotion to keep people well.	Keeping people well and preventing or reducing mental health, alcohol and other drug problems is important to turn the system around. Boosting investment in prevention and mental health promotion has been flagged as a priority, see the *Prevention* section on page 28 for more detail.
Children and young people should be a priority, particularly those at high risk. **This was a particular issue raised in regional areas.**	Focusing on children and young people is recognised as vital. The needs of children and young people are recognised throughout the Plan (i.e. across most service streams) and will continue to be a high priority during the implementation of the Plan. As with all actions in the Plan, implementation will be carried out in collaboration with local communities, other relevant government agencies and coordinated across sectors.

CONSULTATION

WHAT YOU SAID	OUR RESPONSE
We want to know more detail on services planned for regional areas.	A complete section is dedicated to providing additional information on services in all regions (*Services by R*egion, see page 101). Exact locations and distribution of services are subject to consultation and an assessment of relative feasibility.
Where are we going to get the workforce to deliver the services outlined in the Plan?	Ensuring a suitably qualified and skilled workforce is available to deliver the services outlined in the Plan is the responsibility of service providers as well as State and Commonwealth Governments. Having the need identified in the Plan is a crucial first step. The Mental Health Commission will work with key partners to develop an overarching workforce strategy, which will include initiatives to boost the availability of appropriately skilled staff. It is also expected service providers, including Government, non-government and private organisations will play a role in implementing initiatives to encourage the development and recruitment of suitably skilled staff.
We need a more integrated system with improved communication and ease of navigation.	The *System-Wide Reform* section on page 139 includes details on how system integration and navigation will be improved. Improving communication and integration is also the responsibility of service providers. The 'one stop shop' service discussed on page 47 will play an integral role in facilitating service navigation.
How are we going to make sure primary care services provide an adequate level of service for people with a mild or moderate mental illness?	The Mental Health Commission will continue discussions with the Commonwealth Government and the newly established Western Australian Primary Health Networks regarding how to improve access to, and integration with, primary care services. It is acknowledged this is an area that must remain a priority in order to support the implementation of the optimal mix of services outlined in the Plan.
The needs of Aboriginal people require greater emphasis throughout the Plan.	In addition to the Statewide Specialist Aboriginal Mental Health Service, further emphasis on the needs of Aboriginal people has been included throughout the Plan (e.g. see page 147). Information on how the national modelling has been adjusted to account for increased resource requirements for mental health, alcohol and other drug services for Aboriginal people has been included in Appendix D.

CONSULTATION

WHAT YOU SAID	OUR RESPONSE
Consumers and families need access to significantly improved 24-hour crisis and emergency services.	The improvement of 24-hour crisis and emergency services has been and will continue to be a priority of the Mental Health Commission and the Department of Health. The Plan commits to delivering improved services by the end of 2017. More information can be found on page 47 – 'one stop shop'.
Greater access to housing options is needed.	Additional information on housing and accommodation has been included in the Plan, see page 37. Further to this, the Mental Health Commission is already progressing work with the Department of Housing to increase access to housing for consumers.
With our ageing population, the needs of older adults must be recognised.	The particular and unique needs of various age cohorts have been recognised in the Plan, including older adults. Dedicated services and/or programs for older adults are included in service streams where appropriate (e.g. community treatment and community bed-based services).
There is an urgent need for increased access to alcohol and other drug withdrawal management and residential rehabilitation services, particularly in regional areas.	This has been recognised in the Plan, with service establishment brought forward in the Plan phasing where possible. This is a priority for the newly amalgamated Mental Health Commission.

THE NEED FOR CHANGE

KEY FACTS

MENTAL ILLNESS

- one in five Australians will be affected by a mental health disorder each year[2]
- severe mental health disorders are experienced by approximately three per cent of the Australian population[3]
- in Western Australia, the life expectancy gap between individuals with and without a mental illness increased from 13.5 to 15.9 years for males and from 10.4 to 12.0 years for females between 1985 and 2005[4]
- internal modelling suggests that 59 per cent of the adult prison population, and 65 per cent of the juvenile prison population in Western Australia has a mental illness: almost three times the prevalence of the general population.[5]

KEY FACTS

SUICIDE

- Western Australia's suicide rate was 22 per cent higher than the national average in 2013 and has been consistently higher than the national average since 2006[6]
- the Western Australian suicide rate per 100,000 people in 2013 was eight per cent lower than the rate in 2008[7,8]
- males die by suicide at nearly three times the rate of females. In 2012, suicide accounted for 366 deaths in Western Australia, 269 males and 97 females (double the road toll)[9]
- international research estimates that, for every suicide, there are approximately 20 suicide attempts[10]
- suicide is the underlying cause of 17 per cent of deaths among persons aged 25-44 and 24 per cent of deaths among those aged 15-24[11]
- suicide rates in the Kimberley region are 2.5 times the State average and more than 3.5 times the national average.[6]

KEY FACTS

ALCOHOL AND OTHER DRUGS

- alcohol is the most prevalent drug used in Western Australia and causes the most drug-related harm (excluding tobacco) in the community[12]
- around one in five (21.6 per cent) Western Australians over 14 years of age are drinking at risk of lifetime harm and about one in five (17.0 per cent) recently used illicit drugs[13]
- around one in 10 (11.3 per cent) Western Australians have recently used cannabis and one in 25 (3.8 per cent) have recently used amphetamines/methamphetamines[13]
- in Western Australia, more than half of all domestic and more than a third of all non-domestic assaults are alcohol-related[14]
- the alcohol and drug-related hospitalisation rate per capita is 1.38 times higher in regional Western Australia than that reported in the metropolitan area (2.80 times higher in the Kimberley region)[15]
- based on various national and international studies[16,17,18] it is estimated that at least 30-50 per cent of people with an alcohol and/or other drug problem also have a co-occurring mental illness
- there is frequently an increase in alcohol and other drug use in the period before a person suicides. Western Australian Data from the Coroner's Database indicates that nearly a third of males and a quarter of females had alcohol and other drug use issues noted three months prior to their death.[19]

1 IN 5
WESTERN AUSTRALIANS OVER 14 YEARS OF AGE ARE DRINKING AT RISK OF LIFETIME HARM

OPTIMAL MIX AND OPTIMAL LEVEL OF SERVICES

The modelling tools used to develop the Plan estimate the optimal mix and optimal level of services required to meet the needs of the population over the next ten years. 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).

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 alcohol and other drug services, it includes the level of service required to meet the needs of people with mild, moderate and severe alcohol and other drug problems.

THE NEED FOR CHANGE

MENTAL HEALTH – THE OPTIMAL MIX AND LEVEL OF SERVICE

Based on the optimal mix and optimal level of service outlined in the Plan, mental health service provision in Western Australia is currently heavily concentrated on costly acute hospital-based services. Figure 1 adjacent shows the current level of services compared to the optimal level of service required to meet population demand in 2014. The graph clearly shows there is a greater disparity between current and optimal level of community services compared to hospital-based services. This results in people being unable to access community-based services, and hence have little choice but to access costly hospital-based services. There is therefore a requirement to, as a first priority, boost investment in community-based services.

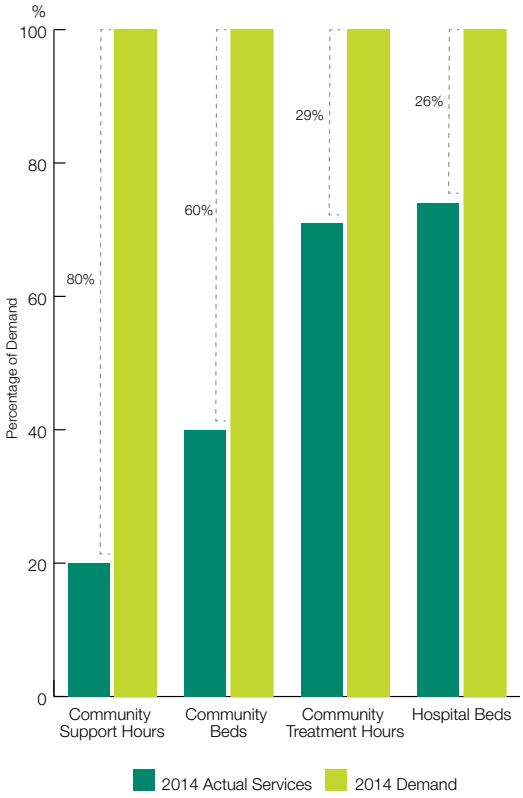


Figure 1: Current services as a proportion of 2014 demand (Mental Health only)

ALCOHOL AND DRUG TREATMENT – THE OPTIMAL MIX AND LEVEL OF SERVICE

The alcohol and other drug sector is considered more balanced across the optimal mix of services (i.e. community and hospital services) compared to the mental health sector. However, as demonstrated by Figure 2 adjacent, the 2014 current level of service is well below the optimal level required to meet population demand in 2014. There is therefore a requirement to invest in services across the optimal mix (i.e. community through to hospital-based services).

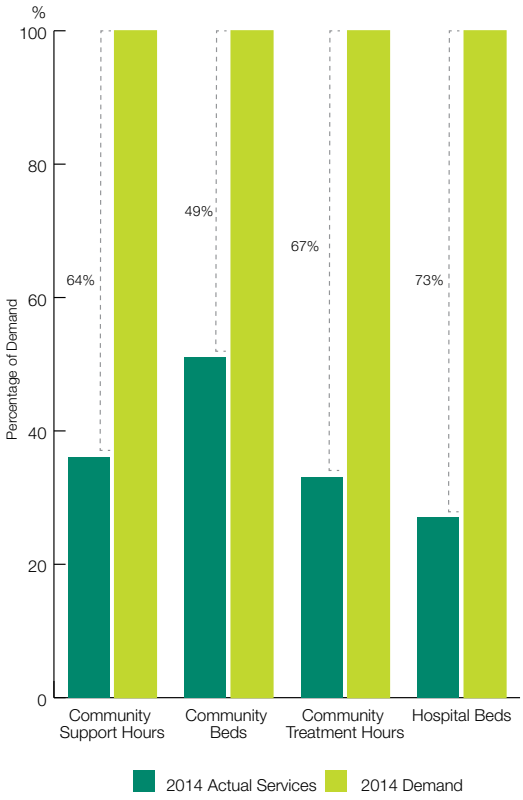
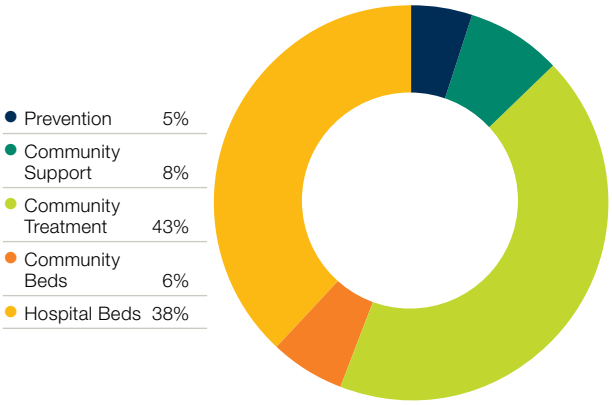


Figure 2: Current services as a proportion of 2014 demand (Alcohol and Other Drugs only)

UNBALANCED EXPENDITURE

Based on 2012-13 budget figures, expenditure on mental health, alcohol and other drug services is unbalanced. As expected from information provided on page 20, a higher *proportion* of the total budget is spent on hospital-based services than what the optimal mix and optimal level indicates is required. Figure 3 below shows the expenditure on an inefficient versus optimal mix of services in Western Australia.

Current inefficient mix of services (2012-13)



Optimal mix of services (2025)

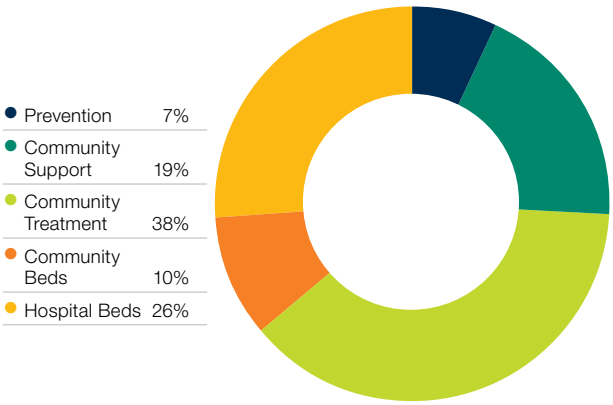


Figure 3: Expenditure on an inefficient versus optimal mix of services, Western Australia

Inadequate investment in prevention and community-based services puts pressure on other parts of the system. Lower than optimal investment in prevention services and programs limits the ability to prevent people developing mental health, alcohol and other drug problems in the first place – thereby reducing our ability to turn the system around.

Lack of access to community services leads to people having to access costly hospital-based services and makes it more difficult for inpatient services to safely discharge patients who require ongoing support but no longer need to be in hospital. This is illustrated by survey results in 2009 which indicated that more than 40 per cent of individuals occupying mental health inpatient beds at any given time could be discharged if appropriate community services were available.[20]

Recent reports indicate that in Western Australia, Commonwealth-subsidised specialised mental health services, and particularly psychiatry and primary care services, are provided at a lower rate than the national average.[21] This also puts greater pressure on State-funded services. Western Australia's recent rapid population growth further highlights the unsustainability of the current approach of managing demand for mental health services through acute inpatient services, the highest cost point on the service continuum.

There are also many barriers to people accessing treatment for alcohol and other drug problems in primary health care settings. There is strong evidence for screening and brief interventions by General Practitioners (GPs) for mild to moderate alcohol problems and for some other drugs, such as cannabis, but low uptake of GPs using these interventions.[22] Similarly, there are gaps in the recruitment of GPs authorised to prescribe opioid pharmacotherapies, particularly in regional areas.

Working with the Commonwealth to boost investment in primary health care and rebalancing investment to boost State funded community services, particularly in the mental health sector, will bring more balance to expenditure. Further focus on supporting GPs to undertake screening and brief interventions will also have positive impacts on system efficiency and consumer health outcomes.

Improved cost efficiencies to the system will also promote the best outcomes for consumers, carers and their families as treatment will be offered in the most appropriate care setting. The implications of no action will include the continued shortage of mental health services in Western Australia, which are currently treating only 65 per cent of the target population.[5]

Until now, these issues have been broadly understood but have been difficult to quantify and thus easy to avoid. The gaps in the system are now well understood; therefore this Plan provides a detailed pathway to develop and grow the system to reach the optimal mix and level of services over ten years to the end of 2025.

IF WE DO NOT CHANGE

The current system is unsustainable from a health, social, economic and financial perspective.

People with severe mental illnesses make up three per cent of the population, and as a result of the symptoms experienced, will come to the attention of, and seek mental health treatment, regardless of the availability of specialist services. If people are not able to access mental health services, those with severe mental illness can end up in the criminal justice system, on involuntary orders, and can jeopardise their housing, employment and relationships.

If we do not change the system, there will be a continuation of:

- extended lengths of stay and more frequent admissions and readmissions to inpatient units
- increases in hospital emergency department presentations due to mental illness or alcohol and drug-related harm (overcrowding and access block)
- health, social and economic costs to individuals, families and the community
- a continued difficulty in navigating and accessing the system (people falling through the gaps)
- a continued high-level of recidivism and involvement in the justice system for people with mental health, alcohol and other drug problems
- more people with mental health and/or alcohol and other drug problems amongst those who are homeless
- delays in access to treatment causing mental health, alcohol and other drug problems to worsen (leading to the need for higher cost treatment).

THE NEED FOR CHANGE

Over the life of the Plan, a minimum of $504 million can be saved if the proposed transition articulated in the Plan occurs. Over the modelled 12 years, this translates to a 7.1 per cent saving in operational expenditure. This applies to community treatment and hospital beds only.

Cumulative net impact of moving from an inefficient to an efficient system (2012-13 terms)

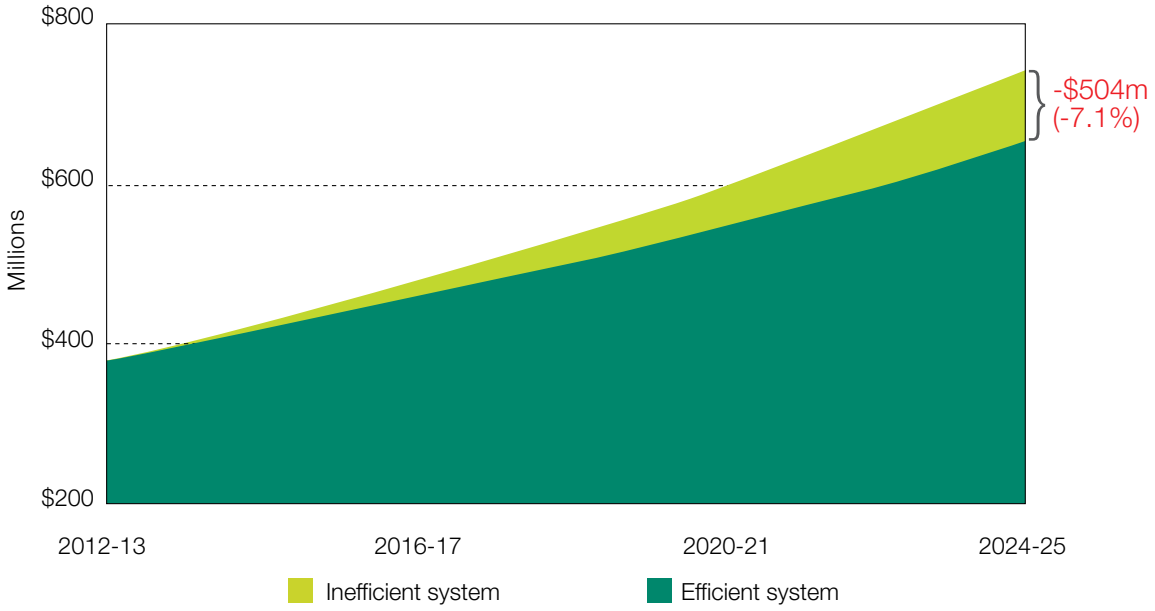


Figure 4: Operational expenditure in an inefficient and efficient system

THE PLAN

AGE APPROPRIATE SERVICES ACROSS THE SERVICE SPECTRUM

It is acknowledged age cohorts differ between mental health and alcohol and other drug services. In the early stages of the Plan implementation, further work will be undertaken to explore how age cohorts can better align and how services can work together to ensure age appropriate services are provided across the service spectrum.

INFANTS, CHILDREN AND ADOLESCENTS (ICA)

Ages 0 to 15 years (Mental Health) and ages 0 to 11 years (Alcohol and Other Drug)

Supporting the mental health and wellbeing of the ICA age group, as well as protecting them from harms associated with alcohol and other drug use is important so they are able to realise their potential, cope with stress and be involved with family and other aspects of community life.[23] The development of a range of effective, strengths-based, age appropriate mental health, alcohol and other drug services and programs to support the health of the ICA age group and their families is an early priority of the Plan.

This is particularly important for people in the ICA age cohort who are highly vulnerable (e.g. children in care, children of parents with mental health, alcohol and other drug problems). Dedicated ICA services are included in *Prevention, Community Support Services, Community Treatment Services, Hospital-Based Services* and *Specialised Statewide Services* sections. Services for children aged 10 years and over are included in the *Forensic Services* section.

AGE APPROPRIATE SERVICES ACROSS THE SERVICE SPECTRUM

YOUTH

Ages 16 to 24 years (Mental Health) and ages 12 to 17 years (Alcohol and Other Drug)

Youth experience the highest prevalence and incidence for mental illness across the lifespan. Young people with co-occurring mental health, alcohol and other drug problems are particularly at risk of poor outcomes because their age and stage of physical, neurological, psychological and social development makes them vulnerable. Increasing service capacity to meet the needs of young people, and the expansion of dedicated youth mental health, alcohol and other drug services across all service streams are urgent priorities to progress.

Currently, mental health services are generally provided in three age streams: infant, child and adolescent (0-17 years); adult (18-64 years); and older adult (65 years and above). We aim to configure the existing and new mental health services into the following new age streams: infant, child and adolescent (0-15 years); youth (16-24 years); adult (25-64 years); and older adult (65 years and above) as soon as possible, in order to introduce a new, dedicated youth stream. All services will be expected to meet the needs of young people with co-occurring mental health, alcohol and other drug problems. Youth mental health services must also have the capability to identify and treat early psychosis.

Dedicated youth services have been referred to in various parts of the Plan: *Prevention, Community Support Services, Community Treatment Services, Community Bed-Based Services, Hospital-Based Services, Specialised Statewide Services*, and *Forensic Services*.

ADULTS

Ages 25 to 64 years (Mental Health) and ages 18 to 64 years (Alcohol and Other Drug)

Mental health, alcohol and other drug services for adults are included throughout the Plan. Currently adults aged 18-64 years are seen by adult services across the service spectrum, but as suggested above, existing and new adult mental health services will change to see people aged 25-64 years, once a dedicated youth stream has been established. There are some key gaps in services for adults, particularly in the *Forensic Services* and *Specialised Statewide Services* sections.

AGE APPROPRIATE SERVICES ACROSS THE SERVICE SPECTRUM

OLDER ADULTS

65 years and over (Mental Health, and Alcohol and Other Drug)

With our growing ageing population, the provision of appropriate services for older adults across the service spectrum is essential. Supporting older people to maintain and improve mental health and wellbeing and providing programs to reduce harm from alcohol and other drug use will be priorities of the Plan. Dedicated services and/or programs for older adults are referred to in the *Prevention, Community Support Services, Community Treatment Services, Community Bed-Based Services, Hospital-Based Services* and *Specialised Statewide Services*. Services for older adults in the alcohol and other drug sector and forensic system are included within the adult service stream, due to the low number of older adults accessing these services.

With our growing ageing population, the provision of appropriate services for older adults, across the service spectrum, is essential.

TURNING THE SYSTEM AROUND

TURNING THE SYSTEM AROUND

PREVENTION

WHAT IS PREVENTION AND MENTAL HEALTH PROMOTION?

Mental health, alcohol and other drug prevention refers to the initiatives and strategies implemented on a national, statewide and local basis to reduce the incidence and prevalence of mental health problems, and delay the uptake and reduce the harmful use of alcohol and other drugs and associated harms. Mental health promotion strategies aim to boost positive mental health and resilience.[iv]

Initiatives can be targeted at the whole population or specific priority target groups. Effective strategies can include raising community awareness of mental health problems and alcohol and other drug-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, alcohol and other drug problems.

iv For ease of reference, the concepts of prevention and mental health promotion will be referred to collectively as 'prevention'.

TURNING THE SYSTEM AROUND

A major five-year study, funded by the National Health and Medical Research Council (NHMRC), found investment in prevention is highly cost-effective.[24] There is strong support across Western Australia for increased, evidence-based and coordinated prevention activity. The Plan places a high priority on the implementation of effective prevention activity across the service spectrum over the next ten years to turn the system around.

AIM

Together with key partners, establish a range of evidence-based prevention programs, strategies and initiatives that will prevent and reduce drug use and harmful alcohol use, reduce the incidence of mental health problems, suicide and suicide attempts, and promote positive mental health in the Western Australian community.

CURRENT SERVICES

In 2013-14, approximately one per cent of the Mental Health Commission budget (or $7.3 million) was spent on prevention. In the same year $10.5 million of the former Drug and Alcohol Office budget was dedicated to alcohol and other drug prevention, which represented 12.9 per cent of its annual budget.

A range of prevention programs are already implemented and/or commissioned by the Mental Health Commission (and the former Drug and Alcohol Office).[v]

Examples of prevention programs include the funding provided to the Act-Belong-Commit program; programs to reduce stigma relating to mental health problems; internationally recognised alcohol and other drug mass reach campaigns (e.g. *Alcohol. Think Again* and *Drug Aware*); community action to prevent and reduce suicide and suicide attempts; community action to prevent and reduce alcohol and drug-related harm in local communities; and activities to create and support low risk environments to prevent and reduce the risk of harm from alcohol and other drug use.

WHAT THE MODELLING TELLS US

The Western Australian Mental Illness Prevention and Mental Health Promotion Consultation Group, comprised of a range of experts, recommended that funding for prevention activity dedicated to mental health should increase to at least five per cent of the Mental Health Commission budget over the life of the Plan. This equates to $65 million by the end of 2025 (reported in 2012-13 terms).

An Alcohol and Other Drug Prevention Expert Reference Group estimated there should be 208,000 hours of service on dedicated alcohol and other drug prevention strategies in 2024-25, which along with the identified optimal levels of resourcing for evidence-based prevention strategies (such as mass reach education), would represent approximately 10.1 per cent of the budget for alcohol and other drugs. This is in addition to the five per cent Mental Health Commission budget dedicated to prevention (mental health related).

Further detail on the modelling for prevention is contained in the *Plan Matrix* (page 105).

v The Drug and Alcohol Office is now amalgamated with the Mental Health Commission.

TURNING THE SYSTEM AROUND

STRATEGIES

LEAD THE DEVELOPMENT AND IMPLEMENTATION OF STATEWIDE EVIDENCE-BASED PREVENTION INITIATIVES

To enhance and better coordinate prevention activity, the newly amalgamated Mental Health Commission includes a directorate dedicated to commissioning and providing evidence-based prevention. The new directorate will work with key partners to:

- lead the development of a detailed prevention plan for mental health, alcohol and other drugs, including regionally and culturally appropriate programs and prevention initiatives that address mental health, alcohol and other drug problems across the life course
- build on collaboration between government, non-government, the private sector and the Western Australian community including supporting other sectors and agencies to implement relevant prevention strategies
- commission and deliver new and existing programs, services and initiatives that are targeted at the whole population and, where required, at priority target groups
- monitor and evaluate programs and services to ensure effectiveness and value for money.

Further information on key prevention priority areas is detailed in the strategies that follow. The development of the prevention plan, referred to above, will identify further priority areas for prevention investment over the next ten years.

EXPAND INFANT, CHILD, ADOLESCENT AND YOUTH PROGRAMS TO REDUCE THE INCIDENCE OF MENTAL ILLNESS AND PREVENT HARMFUL IMPACTS OF ALCOHOL AND OTHER DRUGS

Evidence indicates that 75 per cent of mental illness emerges by the age of 25.[25] Individuals may also commence alcohol and other drug use by this age. Early and effective intervention, targeting infants, children and young people, is critical for future health and wellbeing.

Reducing social disadvantage and building the resilience of families and children requires collaboration and targeted approaches from a range of agencies and the broader community. Programs must also be culturally secure and locally relevant. Examples of priority areas where programs need to be established or expanded include:

- education and resilience building in schools
- reducing the effects of alcohol on a foetus during pregnancy (prevention of foetal alcohol spectrum disorder)
- perinatal and postnatal mental health, particularly to support early secure attachment and the 0-5 year age group
- parenting and family support
- early identification of children at risk of developing a mental health and/or alcohol and other drug problems (including children of parents with a mental health, alcohol and other drug problem)
- initiatives targeting the broader community.

TURNING THE SYSTEM AROUND

CLOSELY MONITOR SUICIDE RATES AND BUILD ON EXISTING OR DEVELOP NEW PROGRAMS AND INITIATIVES TO DECREASE THE SUICIDE RATE

Suicide Prevention 2020: Together we can save lives, is the new State Government strategy that aims to reduce the current number of suicides by 50 per cent over the next decade. *Suicide Prevention 2020* proposes a holistic, evidence-based approach to suicide prevention that is informed through the *National Living is for Everyone Framework* and builds on the achievements of the previous strategy, the *Western Australian Suicide Prevention Strategy 2009-2013*.

Suicide Prevention 2020 seeks to balance investment in community awareness and stigma reduction, mental health and suicide prevention training and coordinated services for high risk groups through the provision of activity across six key action areas:

- greater public awareness and united action across the community
- local support and community prevention across the lifespan
- coordinated and targeted responses for high-risk groups
- shared responsibility across government, private and non-government sectors to build mentally health workplaces
- increased suicide prevention training
- timely data and evidence to improve responses and services.

It is intended that additional initiatives will operate alongside *Suicide Prevention 2020*, including counselling and early intervention, crisis lines, grief and bereavement support, and national initiatives such as *beyondblue.*

EXPAND CURRENT EVIDENCE-BASED ALCOHOL AND OTHER DRUG PREVENTION PROGRAMS

A range of evidence-based alcohol and other drug prevention programs are currently implemented and over the next ten years these programs will continue to expand across the State. Programs include mass reach prevention campaigns, community action, initiatives to create and support low-risk environments, increased community support for policy measures to prevent and reduce alcohol and other drug-related harm, and support for initiatives that discourage the inappropriate supply of alcohol and other drugs.

Programs may target a range of alcohol and other drugs or be specific to particular drugs of concern (for example alcohol, cannabis, and amphetamine-type stimulants).

Alcohol continues to be the priority drug of concern for Western Australia. There is a need to continue efforts to change the drinking culture from one of harmful use to one where low-risk drinking is encouraged and supported.

Furthermore, programs may be applied universally or targeted at particular settings (for example sporting clubs, workplaces, schools).

TURNING THE SYSTEM AROUND

DEVELOP AND BUILD UPON A RANGE OF COMPLEMENTARY PREVENTION STRATEGIES TO PROMOTE SOCIAL INCLUSION

Stigma and discrimination can affect access to treatment, support, housing, education, employment and primary care. The research commissioned by the Mental Health Commission on reducing stigma in Western Australia will be utilised to inform future initiatives that create positive attitudinal and behaviour change towards people with mental illness. Building on work to create mentally healthy communities and workplaces is also a priority.

Research has also been conducted in the alcohol and other drug sector to inform strategies which will be developed and implemented to reduce alcohol and other drug-related stigma impacting individuals, families and people who work in the sector.

ESTABLISH AND BUILD UPON TARGETED PROGRAMS FOR GROUPS AT GREATER RISK OF MENTAL HEALTH, ALCOHOL AND OTHER DRUG PROBLEMS

There are a number of groups that are at greater risk of developing or being impacted by mental health, alcohol and other drug problems, including young people; Aboriginal people and communities; older adults; people from culturally and linguistically diverse (CALD) backgrounds; Fly-in Fly-Out (FIFO) workers; people from regional areas, and many other groups. Evidence-based, appropriately targeted prevention strategies will be developed in partnership with key groups over the next ten years. In the case of Aboriginal-specific programs this may include cultural rehabilitation and healing programs. In many cases, effective evidence-based programs already exist and will therefore be further expanded upon in the future.

ACTIONS

IMPLEMENTING EXISTING COMMITMENTS

- complete the development, and commence implementation of a new suicide prevention strategy
- implement legislation and associated strategies to respond to the rapid emergence of new psychoactive substances.

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- develop a comprehensive prevention plan for mental health, alcohol and other drugs which will include a range of evidence-based strategies across the life course (including targeted programs for at risk groups)
- commence the implementation of the prevention plan, including identifying opportunities to partner with existing relevant health promotion programs delivered by the government and non-government sector
- identify opportunities to enhance existing prevention initiatives targeting children, young people, families and the broader community including (but not limited to) school-based programs which incorporate mental health, alcohol and other drug education, and resilience building
- increase the proportion of the Mental Health Commission budget spent on prevention (dedicated to mental health) from one per cent to two per cent; increase the hours of service dedicated to alcohol and other drug prevention from 66,000 to 108,000 hours; and provide the optimal level of resource identified for associated alcohol and other drug prevention programs
- ensure resourcing of existing public education campaigns is sufficient to optimise effectiveness.

TURNING THE SYSTEM AROUND

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- continue the implementation and monitoring of the prevention plan
- increase the proportion of the Mental Health Commission budget spent on prevention (dedicated to mental health) from two per cent to four per cent; increase the hours of service dedicated to alcohol and other drug prevention from 108,000 to 192,000 hours; and provide the optimal level of resource identified for associated alcohol and other drug prevention programs
- complete the rollout of school-based education programs on mental health, alcohol and other drugs, and resilience building until available in all schools
- expand current public education campaigns targeting harmful alcohol and other drug use
- promote the adoption of evidence-based mental health 'first aid' training throughout the community.

BY THE END OF 2025, TO CONTINUE THE REFORM, MODELLING IDENTIFIES THE REQUIREMENT TO:

- continue the implementation and monitoring of the prevention plan and commence development of a new prevention plan
- improve access to web-based/on-line strategies and interventions
- have established a comprehensive suite of universal and targeted mass reach campaigns that promote mental health, prevent mental illness and reduce harmful alcohol and other drug use
- reach the target of five per cent of the Mental Health Commission budget allocated to prevention (dedicated to mental health); 208,000 hours of service dedicated to alcohol and other drug prevention; as well as provide the optimal level of resource identified for associated alcohol and other drug prevention programs.

Table 1: Summary of the *Plan Matrix*

STATE TOTAL	MEASURE	CURRENT	2017	2020	2025
Prevention	Hours ('000) (total)	n/a	n/a	n/a	n/a
MH *	Percentage	1%	2%	4%	5%
AOD	Hours ('000)	66	108	192	208

* Percentage of total Mental Health Commission budget.
Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug
n/a: Data is not applicable.

Research commissioned by the Mental Health Commission on reducing stigma in Western Australia will be utilised to inform future initiatives that create positive attitudinal and behaviour change towards people with mental illness.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

COMMUNITY SUPPORT SERVICES

WHAT ARE COMMUNITY SUPPORT SERVICES?

Community support services provide individuals with mental health, alcohol and other drug problems access to the help and support they need to participate in their community. Community support includes: programs that help people identify and achieve their personal goals, personalised support programs (e.g. to assist in accessing and maintaining employment/education and social activities), 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 harm-reduction programs.

Community support services for people with a mental illness are recovery-oriented, and designed and delivered as part of a personal recovery journey (see page 141 for more information on recovery).

Harm-reduction strategies are a long-standing, public health community support response for people with alcohol and other drug problems. It includes needle and syringe provision, overdose prevention and safe places for intoxicated people (often known as sobering up centres).

Strengthening personalised community support services alongside community treatment and community bed-based services, and improving the ability of consumers and carers to navigate the system, is important. Through building the capacity of the system, improving coordination and ensuring services are personalised, individuals will be supported to stay at lower risk of harm and to obtain recovery focused support earlier in an environment best suited to their needs.

Where relevant, new and expanded programs will be co-designed and delivered by the non-government sector in keeping with the Government's *Delivering Community Services in Partnership* (DCSP) policy. The DCSP policy is intended to focus service providers on outcomes and encourage individuals, families and carers to shape the supports and services they receive.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

HOUSING

Research indicates that mental health, alcohol and other drug problems are contributing factors to a person becoming homeless.[26] It is estimated that by 2025, between 1,474 and 1,867[27] Western Australians who have mental health, and/or alcohol and other drug problems will also be homeless. Furthermore, although the exact number is difficult to quantify, additional groups such as people exiting residential rehabilitation, people currently living in psychiatric hostels, and those with mental health, alcohol and other drug problems living in crowded housing require access to safe housing.

Improving access to safe housing and associated community support will help prevent the specialised treatment and short to medium term accommodation system becoming congested with people who want to, and are able to, live independently in the community.

AIM

Continue to expand harm-reduction services and further develop a high quality, personalised, effective and efficient community support service sector that provides individuals with support to create or rebuild a satisfying, hopeful and contributing life and provides carers, and families with support for their own wellbeing.

CURRENT SERVICES

It has been estimated the Mental Health Commission and the Commonwealth Government funded approximately 842,000 hours of mental health community support[vi] in 2012-13 (with the Commonwealth and State funding approximately 50 per cent each). For alcohol and other drug community support services, the State Government funded 17,000 hours of service[vii] and 168 beds. A range of non-government organisations are contracted to provide community support services, examples of which are provided on the following page.

vi Mental health hours of support include face-to-face time only. For example, hours a person spends in respite care, hours spent undertaking an activity, hours of face-to-face support with peer workers, or health, social and welfare support workers etc.

vii Alcohol and other drug hours of service includes face-to-face time between staff and consumers/carers, staff travel time, and time for other duties such as administrative requirements, training and research.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

The Mental Health Commission currently provides funding subsidies for community support services to 17 private licenced psychiatric hostels delivering 499 beds. Access to community support and assistance to regain skills required for independent living can sometimes be limited for people staying in hostels. This can make it difficult for people to move to more independent living arrangements and reintegrate into community life. Modern, recovery-focused community-based support services, including in-reach services, are important for people living in hostels.

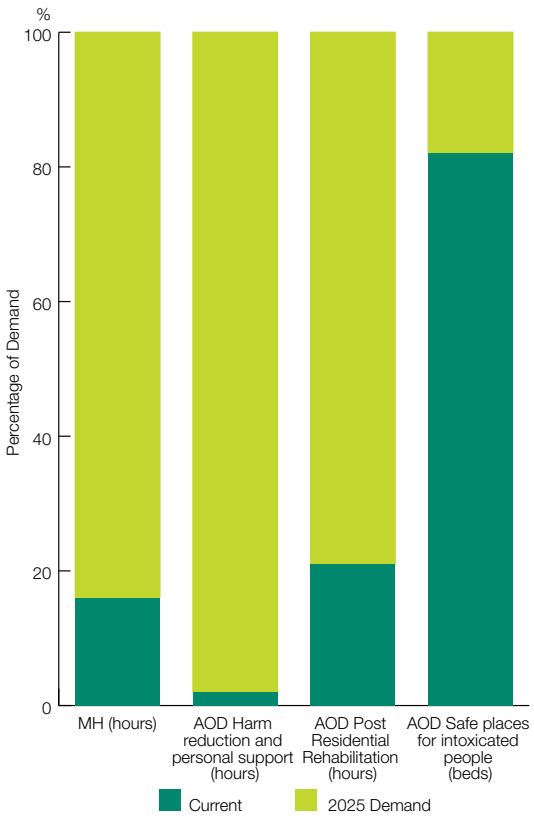
The Individualised Community Living Strategy (ICLS)[viii] is a Mental Health Commission-funded individualised housing and support program. As at 2013-14, 115 houses have been purchased and 138 people supported by the program. The ICLS is currently being evaluated.

In relation to alcohol and other drugs, a range of harm-reduction strategies are currently implemented such as needle and syringe programs, overdose prevention programs and safe places for intoxicated people (also known as sobering up centres).

The Transitional Housing and Support Program (THASP) provides in-reach community support for people staying in short-term accommodation following residential alcohol and other drug treatment. There are currently 15 THASP houses operational across Western Australia. A 2013 evaluation of the program has demonstrated a range of positive outcomes including reductions in relapse rates, improvements in wellbeing, increased life and independent living skills and reduced levels of homelessness.

WHAT THE MODELLING TELLS US

Modelling shows that the hours of community support for mental health are required to increase from 842,000 currently to 5.29 million hours by the end of 2025. The modelling shows that hours of support for alcohol and other drugs are required to increase from the current 17,000 hours to 314,000 hours. The bed numbers for safe places for intoxicated people are required to increase from the current 168 beds to 205 beds by the end of 2025. Figure 5 demonstrates the gap between current and 2025 demand as a percentage.



MH = Mental Health
AOD = Alcohol and Other Drug

Figure 5: Optimal mix and level of service, Community Support[ix]

viii The ICLS is a program (commissioned by the Mental Health Commission) that gives individuals with mental illness, their families and carers greater control over their lives, including the supports and services they access. Organisations work with individuals to develop a personalised plan and assist with utilising portable funding to purchase individualised supports. Key aims of the program are to help people achieve their goals and participate fully in community life.

ix The 2012-13 community support actuals as outlined in the *Plan Matrix* and graph were determined by the Mental Health Commission. Please note that further work is required in the analysis of the actual figures which may result in some variance, therefore impacting on the service gap identified.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

STRATEGIES

PROMOTE THE EXPANSION OF RECOVERY-FOCUSED MENTAL HEALTH COMMUNITY SUPPORT SERVICES

Expanding the availability of personal recovery-oriented support services is a common theme throughout the Plan. Recovery-oriented services are inclusive and holistic, working with an individual (and their carer/family where appropriate) to help them identify and achieve their personal goals. Services can assist individuals through the delivery of personalised support and through linking in with other services and programs (e.g. peer support programs, employment, education and training, housing, social opportunities, support with daily living tasks, health and wellbeing programs).

Service expansion and development will be centred on enabling greater choice of service provider for individuals with mental health problems (including people with co-occurring alcohol and other drug problems), their families and carers. Dedicated community support services for children and young people are a high priority (including those leaving care), as is expanding services for people living in regional areas. Over the lifetime of the Plan a variety of recovery-oriented community support services will be developed, including supporting the growth of the peer workforce and enhancing access to community support through telehealth technology.

FURTHER EXPAND ACCESS TO ALCOHOL AND OTHER DRUG COMMUNITY SUPPORT SERVICES

Current alcohol and other drug community support services, such as safe places for intoxicated people (also known as sobering up centres), needle and syringe programs and overdose prevention programs are essential public health initiatives, therefore we intend to continue expanding their availability. Innovation is fundamental to reducing harm. Other evidence-based harm-reduction initiatives will be explored, for example a pilot program for peer naloxone is currently being evaluated and showing good results.

Holistic, personalised support services are already incorporated in the provision of alcohol and other drug treatment (including support with housing, employment, education and so on). More resources can expand the range of community support services available. The potential for the delivery of individualised funding and self-directed support within alcohol and other drug services is an area for future consideration, and requires development of an evidence-based model of service delivery with support from within the sector. An effective individualised model of service can reduce relapse, have the potential to reduce waiting lists, assist with system navigation and support the achievement of personal goals.

It is expected alcohol and other drug community support services will have the capability to meet the needs of people with co-occurring mental health problems.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

EXPAND CARER AND FAMILY INFORMATION, SUPPORT AND FLEXIBLE RESPITE SERVICES

Carers and families play a pivotal role in supporting people with a mental health, alcohol and other drug problem. Carers and families can sometimes experience pressure and challenges that can in turn impact on their own health and wellbeing.

Improving the availability of timely, accurate and reliable information is essential for carers and families, as is their inclusion in the care, support and treatment of individuals. Support for children who have parents with a mental health problem and/or alcohol and other drug problem is a key priority area.

Over the next ten years we intend to expand access to information, support and, importantly, flexible respite for carers and families. This will include exploring how the Parent Drug Information Service could be expanded to provide personalised support to carers and family members of people with a mental health problem.

EXPAND ACCESS TO INDIVIDUAL ADVOCACY SERVICES

Access to independent, individual advocacy for individuals and their families is an important aspect of the mental health, alcohol and other drug system. Advocacy can help improve the quality and safety of service provision, promote the rights of consumers and carers and ensure consumers' health and wellbeing is maximised. Individual advocacy services are a component of the community support service stream. Further work is required to review existing consumer and carer access to individual, independent advocacy and where appropriate identify areas for expansion. Further information on advocacy can be found on page 145.

WORK WITH HOUSING PROVIDERS TO INCREASE ACCESS TO HOUSING FOR PEOPLE WITH MENTAL HEALTH, ALCOHOL AND OTHER DRUG PROBLEMS

A system-wide multi-agency housing strategy to address the housing needs of individuals with mental health, alcohol and other drug problems is essential. The strategy would include the specification of contemporary housing and, where required, support options for people who have historically had difficulties accessing and maintaining housing. People who experience difficulties with accessing and maintaining housing include people with a mental health, alcohol and other drug problem who have come into contact with the criminal justice system, people who have remained in institutional care for a number of years, people who are homeless, people currently living in psychiatric hostels and people exiting alcohol and other drug treatment programs. Consideration will also be given to the ongoing safety and quality of housing, with housing being located close to services and supports.

If appropriate, and dependent on the outcome of evaluations, the housing strategy will specify the continuation and improvement of the ICLS. Work will also continue with housing providers to identify additional housing and the provision of in-reach treatment and support where required.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

CONTRIBUTE TO THE PILOTING OF THE NATIONAL DISABILITY INSURANCE SCHEME AND MY WAY TRIALS

The National Disability Insurance Scheme (NDIS)[x] and My Way trial sites have commenced in the South West, Cockburn/Kwinana, and in the Perth Hills for residents living in the local government areas of Swan, Kalamunda and Mundaring. These schemes involve trialling two approaches to self-directed individualised funding for people with disability. Evaluation and findings from the trial sites will inform our future investment in individualised funding programs. To meet NDIS eligibility for psychosocial disability, a person must have a psychiatric condition which is permanent, or likely to be permanent, and which significantly limits their ability to undertake routine daily activities. The NDIS does not currently include people with disability resulting from alcohol and other drug problems.

Further actions are dependent on the evaluation results of the NDIS trials. The findings from implementation of the NDIS/My Way trial sites will be included in further modelling for the Plan when the information is available. See page 146 for further information on individualised funding.

ESTABLISH TARGETED PROGRAMS FOR PRIORITY, MARGINALISED GROUPS OR GROUPS WITH COMPLEX CONDITIONS

There are a number of groups that may be disproportionately impacted by mental health, alcohol and other drug problems, for example, Aboriginal people, people from regional areas, homeless people, and CALD groups. Where required, dedicated community support services or programs will be developed in partnership with key priority groups to ensure they have access to support services that effectively meet their needs. In regards to dedicated community support programs for Aboriginal people, this may involve cultural rehabilitation and healing programs.

ACTIONS

IMPLEMENTING EXISTING COMMITMENTS:

- complete the evaluation of the Individualised Community Living Strategy and implement improvements and, if appropriate, commence expansion of the program
- continue to provide alcohol and other drug support services[xi] for residents within existing Transitional Housing and Support Program houses in North Metropolitan, South Metropolitan, the Goldfields, the Midwest, and the Kimberley.

x The NDIS is a disability insurance initiative currently being trialled in selected areas of Australia. Eligible individuals undertake an individualised planning process to identify reasonable and necessary supports needed to enable them to attain their goals. In Western Australia two models are being trialled: the Commonwealth's NDIS (run by the National Disability Insurance Agency) and the State Government's Western Australian NDIS My Way (run by the State Government).

xi Referred to in the *Plan Matrix* as 'post residential rehabilitation' (Page 105).

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- increase mental health community support services by 432,000 hours of support, with a particular focus on regional areas, children and youth
- develop and expand local recovery services that offer assistance and support to individuals to maintain personal recovery and live well in the community. This may involve the delivery of education and training programs and telehealth.
- review existing consumer and carer access to individual, independent advocacy and where appropriate identify opportunities to expand access
- in collaboration with key stakeholders, develop a housing strategy to address the housing needs of people with mental health, alcohol and other drug problems whilst also increasing access to community support services that will assist with daily living tasks and maintaining tenancy. This includes (as a priority) appropriate housing and support for people who have mental health, alcohol and other drug problems and are homeless.
- in consultation with housing providers, establish new Transitional Housing and Support Program houses and commission alcohol and other drug support services (expand the total by approximately 9,400 hours of support) across the North Metropolitan (4,000 hours), South Metropolitan (2,900 hours), Goldfields (400 hours), Pilbara (600 hours), Great Southern (400 hours), South West (600 hours), and the Wheatbelt (400 hours) regions
- explore with the Department of Child Protection and Family Support and key stakeholders, how youth-friendly safe places for those with alcohol and other drug (including volatile substances) use issues in identified regional and remote areas can be established.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- increase safe places for intoxicated people (also known as sobering up centres) in Fremantle, the Pilbara and for young people in the metropolitan area by a total of 27 beds
- develop and commission personalised support and harm-reduction services for people with alcohol and other drug problems (approximately 225,000 hours of support), which would include peer workers and the commissioning of in-reach and outreach support in the metropolitan area for people in crisis accommodation
- in collaboration with key stakeholders, progress implementation and monitoring of the housing strategy and associated community support services
- in consultation with housing providers, continue to expand the number of Transitional Housing and Support Program houses and commission alcohol and other drug support services (expand the total by approximately 19,600 hours of support) across the North Metropolitan (6,600 hours), South Metropolitan (6,900 hours), Pilbara (600 hours), South West (3,000 hours), Wheatbelt (600 hours) and Goldfields (1,900 hours) regions

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

- expand mental health community support services across the state from 1.7 million hours of support to 3.2 million hours of support including expanding services for family and carers through information, support, education and skill development opportunities.

BY THE END OF 2025, TO CONTINUE THE REFORM, MODELLING IDENTIFIES THE REQUIREMENT TO:

- expand community mental health support services across the State from 3.2 million hours of support to 5.3 million hours of support
- in collaboration with key stakeholders, continue to progress implementation and monitoring of the housing strategy and associated community support services
- in consultation with housing providers complete delivery of alcohol and other drug transitional support services, with a further 16,000 hours of support.

Table 2: Summary of the *Plan Matrix*

STATE TOTAL	MEASURE	CURRENT	2017	2020	2025
Community Support Services	Hours ('000) (total)	859	1,687	3,438	5,600
	Beds (total)	168	178	205	205
MH	Hours ('000)	842	1,661	3,171	5,286
AOD (Harm-reduction and personal support)	Hours ('000)	5	5	225	258
AOD (Post Residential Rehabilitation)	Hours ('000)	12	21	41	57
AOD (Safe places for intoxicated people)	Beds	168	178	205	205

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

COMMUNITY TREATMENT SERVICES

WHAT ARE COMMUNITY TREATMENT SERVICES?

Community treatment services provide clinical care in the community for individuals with mental health, alcohol and other drug problems. Community treatment services generally operate with multidisciplinary teams who provide outreach, transition support, relapse prevention planning, physical health assessment and support for good general health and wellbeing.

Services provided to individuals are non-residential, and can be intensive, acute or ongoing. All community treatment services include carers in relevant treatment decisions, are family inclusive, trauma informed and mental health community treatment services are recovery-oriented. Alcohol and other drug community treatment services include pharmacotherapy programs, screening and assessment programs, and counselling.

As with the expansion of community support services, expanding personalised and coordinated community treatment services will enable individuals to be treated in an environment best suited to their needs. More people being supported in the community will ease pressure on the hospital system, making hospital services available for those who need them. Greater access to community treatment services also supports people close to home and keeps them connected to their local community and family.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

PRIMARY CARE AND PHARMACY

Effective primary care services[xii] have the capacity to prevent and reduce the severity of mental health, alcohol and other drug problems through early identification, treatment, support and timely referral. There is strong evidence that GPs can provide effective treatment and reduce risks for people with mild to moderate alcohol and other drug problems (including reducing the use of alcohol use during pregnancy). Primary care can also work together with community treatment services to optimise the care provided to individuals with mental health, alcohol and other drug problems.

Western Australia has consistently received the lowest Commonwealth Medicare expenditure per capita of all States, with $27.60 per capita spent in 2012-13, compared with a national average of $39.54. This gap has also almost doubled over the past five years.[28] Western Australia also has lower:

- Medicare-subsidised mental health related GP patient rates (42.3 per 1,000 population), compared to the national average (55.6 per 1,000 population)[21]
- services provided by psychiatrists, GPs, psychologists, and other allied health professionals (256.2 services per 1,000 population) compared to the national average (352.9 services per 1000,000 population)[21]
- rates of GPs per capita (183.5 per 100,000 persons).[29]

The undersupply and underutilisation of primary care services is a significant contributor to a sub-optimal service mix. This results in deterioration in access for individuals to appropriate services, and higher system costs. Improving access to primary care services will help to ease pressure on other parts of the system.

In Western Australia, pharmacotherapies play an important and effective role in maintenance or substitution therapies for those with problems relating to alcohol or opioids through the Community Program for Opioid Pharmacotherapy (CPOP). In a small number of locations pharmacies have begun to play a greater role in assisting with the dispensing and management of medications, as well as the monitoring of side effects, for people with mental illness. It is also important to link people in the program to other treatment and supports.

AIM

Increase the availability and effective coordination of relevant community treatment services to ensure individuals with a mental health, alcohol and other drug problem are provided with appropriate treatment and care in the community, families and carers are better supported.

xii Includes GPs, pharmacists, mental health nurse practitioners and allied health.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

CURRENT SERVICES

In 2014, approximately 2.1 million mental health, and 565,000 alcohol and other drug community treatment hours of service[xiii] were publicly funded. There are also a number of private/non-government providers who offer community treatment services for individuals with severe mental health, alcohol and other drug problems (e.g. Youth Focus who provide services for young people with a mental health problem), however, at this time, the hours of service cannot be accurately quantified.

Mental health community treatment services are currently primarily provided by the public health system whereas alcohol and other drug community-based treatment services are predominantly in the community-managed sector.

The main model for alcohol and other drug community treatment is the Community Alcohol and Drug Service which has evolved in the metropolitan area through an innovative partnership between a number of non-government organisations integrating with the Next Step clinical service, which is a Government funded service. This integrated services model offers a multidisciplinary approach including medical, nursing, clinical psychology and counselling services.

There are other community treatment service models in the system which provide diversity and choice, including dedicated services for specific groups such as women and Aboriginal people.

WHAT THE MODELLING TELLS US

The modelling indicates a requirement for community treatment services to increase from 2.1 million to 3.8 million hours of service for mental health, and from 565,000 to 2.1 million hours of service for alcohol and other drugs by the end of 2025. Hours of service to deliver the optimal level of community treatment services are shown in Figure 6 following and in the *Plan Matrix* (page 105).

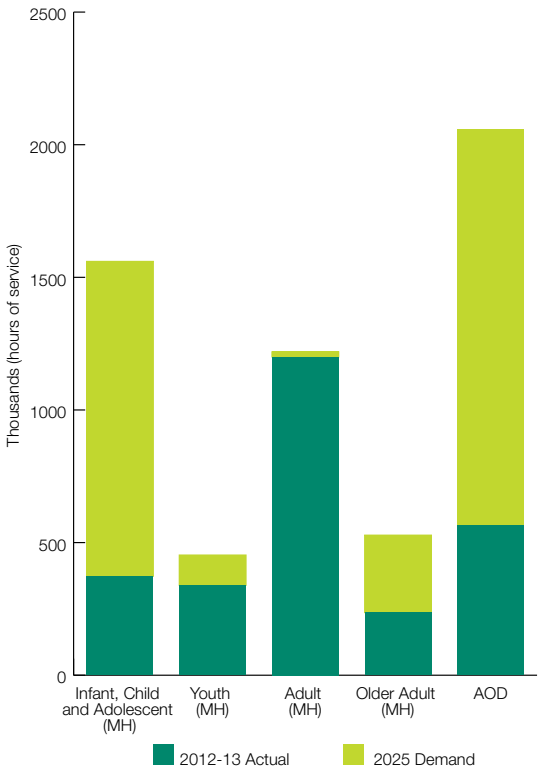
Evidence on current hours of community treatment service was provided by the Department of Health and Area Health Services. According to current hours of service compared to the modelled hours of service, the gap in public infant, child and adolescent community mental health treatment services is substantial and therefore requires urgent resources.

Furthermore, based on the best available evidence from Area Health Services, the current adult mental health community treatment services are almost at the level required to meet 100 per cent of 2025 demand. This finding must be interpreted with caution as currently there is increasing demand on adult community treatment services as other elements of the system are not delivering at adequate levels (e.g. primary care and community support services). If other elements of the system are not boosted, there will be a continuing high demand for adult community treatment services that is challenging to meet.

xiii 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.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

There is an overall requirement for alcohol and other drug community treatment hours of service to grow by around 265 per cent by the end of 2025. Figure 6 below shows the current services mapped against the 2025 demand according to the optimal mix and level of services. These services are required across the State, with a need for additional regional hubs, all providing outreach support to nearby areas with no local services. Outer metropolitan regions and non-metropolitan regions are the areas requiring the greatest increase in service provision.



MH = Mental Health
AOD = Alcohol and Other Drug

Figure 6. The optimal mix and level of service, community treatment[xiv]

xiv The 2012-13 community treatment actuals as outlined in the graph were supplied by Area Health Services and the Department of Health. Please note that further work is required in the analysis of the actuals figures which may result in some variance, therefore impacting the service gap identified.

STRATEGIES

DEVELOP A 'ONE STOP SHOP' THAT WILL PROVIDE A 24-HOUR MENTAL HEALTH EMERGENCY RESPONSE SERVICE, TRAINING FOR FRONTLINE STAFF AND PROVIDE SYSTEM NAVIGATION

The need for improved community-based mental health crisis and emergency responses services has been identified by a range of stakeholders, including consumers, carers and families. Similarly there has been a strong call for a single point of access to assist with system navigation. The requirement for improved 24-hour crisis support has also been identified in the recently released National Mental Health Commission *Report of the National Review of Mental Health Programmes and Services.*[30]

Services are currently being remodelled to align with best practice so that consumers and carers have access to a service that has a single point of access, and is responsive and effective. This includes providing services accessible to regional areas (including through the use of telehealth technology) and providing a single point of access to 24-hour emergency mental health services. The crisis service will also have the capability to assist people with co-occurring mental health, alcohol and other drug problems who are in crisis. The 'one stop shop' will also carry out the following functions:

- offer time limited telephone consultation and counselling services with trained coaches and counsellors
- provide a single point of access to information for consumers, carers and families (including telephone advice and online/hard copy resources) to ensure access to services occurs at the earliest

point of contact and is streamlined and seamless. Information resources will be appropriate and accessible for Aboriginal people and CALD people.

- establish a comprehensive service directory and clear pathways, including with the Commonwealth, Primary Health Networks, GPs and the tertiary sector, to assist consumers, carers and service providers with system navigation
- work closely with the community coordination pilot staff where appropriate (see page 157 for more information on the community coordination pilot)
- provide expert clinical advice to clinicians (including GPs) across the State (building on the Clinical Advisory Service currently available in the alcohol and other drug sector)
- deliver training to relevant frontline and emergency response staff (e.g. police, ambulance officers, GPs, nurses and nurse practitioners) in how to respond to people with a mental illness in an emergency situation, including providing outreach to regional areas.

Consultation with the alcohol and other drug sector will be undertaken throughout the planning process for this service to consider the current role and function of alcohol and other drug helplines and to map synergies in relation to system navigation, helpline function and future service delivery models.

ENGAGE WITH PRIMARY CARE AND PHARMACY TO IMPROVE THE SERVICES DELIVERED THROUGH THESE SECTORS

More capacity to respond effectively to mental health, alcohol and other drug problems is needed in primary health services, both in terms of number of service providers and the skills in the workforce. Community treatment services also need to work together with primary care to optimise the care provided to individuals.

To further improve the provision of seamless services, work will progress in collaboration with the new Primary Health Networks to develop a joined-up service directory for mental health, alcohol and other drugs. This would include information on services across primary, secondary and tertiary care.

Pharmacies have begun to play a greater role in providing services to people with mental health, alcohol and other drug problems. Opportunities to expand the role of pharmacies are important, such as through increasing the use of nurse practitioners in pharmacies. Other options to be explored include shared care models, incentives and access to specialist support and advice.

Further, engagement across the whole system can be enhanced through partnerships and improved referral pathways.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

EXPAND ALCOHOL AND OTHER DRUG TREATMENT SERVICES TO MEET THE NEEDS OF THE GROWING POPULATION

There are community alcohol and drug services in each regional area; however modelling shows increased access to treatment is required in locations of current and future high need. Responding to diverse local needs and situations is important in the development of new or expanded services, as is the need to be flexible and responsive.

In-reach into other services, such as accommodation services, the provision of outreach from key hub locations and the use of telehealth technology will increase responsiveness and improve access in regional areas. In-reach and outreach supports treatment access for specific groups such as people who are homeless, older adults or at risk groups who do not readily access services.

The development of a real time Schedule 8 (drugs of addiction) medicine dispensing tracing system is also a priority to make visible the legal prescribing of Schedule 8 medicines, assist with reducing the emergence of dependence, and improve quality of use. The dispensing tracing system will:

- record all statewide Schedule 8 dispensing
- be accessible to all statewide Schedule 8 prescribers and dispensers
- have the capacity to link into a national prescribing system.

Improvement of services for people with co-occurring mental health, alcohol and other drug problems is also a continued focus and where appropriate, integration with mental health community treatment services will be progressed. Services also need to be responsive to young people and family friendly.

Consumer, family and other stakeholder participation are essential to ensuring services support communities. Alcohol and other drug services will continue to work in partnership with other health, justice and community services to maximise meeting the holistic needs of people with alcohol and other drug problems.

DELIVER INTEGRATED MENTAL HEALTH COMMUNITY TREATMENT SERVICES THROUGH THREE KEY SERVICE TYPES AND ESTABLISH DEDICATED TEAMS OR PROGRAMS WHERE REQUIRED

To address the full continuum of need in mental health community treatment settings, our focus will be on three key service types detailed on page 51 (Acute, Intensive, Continuing). Where appropriate, the use of telehealth technology will be progressed across all community treatment services to increase service access and responsiveness.

Further to this, dedicated evidence-based community treatment programs or services may be established as required for particular population groups or complex conditions. Where possible and appropriate, public mental health and alcohol and other drug services will be integrated and will work closely with primary care and community support services to ensure a seamless service is provided to consumers.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

Where a person has a primary diagnosis of a mental health, alcohol and other drug problem, with a co-occurring Foetal Alcohol Spectrum Disorder (FASD) diagnosis, personalised treatment and support would be provided by mental health, alcohol and other drug services.

Other agencies such as the Disability Services Commission, the Department of Education, the Department of Health and the Department of Child Protection and Family Services also play a role in the assessment, diagnosis and support provided to people with FASD.

It is acknowledged further work is required to ensure people with suspected or confirmed FASD receive appropriate treatment and support and do not fall through the gaps. Further discussions will be held with the relevant services to ensure people and families affected by FASD are provided with appropriate services.

All community treatment teams have a responsibility to include carers in treatment decisions where appropriate and provide family inclusive care, (including implementing mechanisms to identify children of parents with a mental illness and ensuring they have access to appropriate community treatment services and supports).

The need to boost post-discharge mental health community treatment follow-up is important as Western Australia currently performs poorly compared to other States. In 2012-13, the percentage of separations from acute psychiatric inpatient units that were followed up by a community mental health service within seven days was 53.3 per cent in Western Australia, compared with a national average of 60.7 per cent.[31]

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

Acute services: provide a service to people living in the community who require crisis response, urgent assessment and support. Acute services can be delivered by multidisciplinary teams that operate 24-hour services and provide specialist expertise in the initial intake, timely responses to an individual experiencing a mental health crisis and short-term specialist clinical assessment and treatment. These services will work closely with the 'one stop shop'. Some instances of crisis require attendance by the police, and it is necessary for the police to have the skills and immediately available clinical advice to address the situation.

Intensive services: provide assessment, proactive treatment and interventions, delivered within a recovery-oriented context that supports individuals, families and carers to manage illness and improve their quality of life. Services are delivered via mobile outreach by multidisciplinary community treatment teams.

Continuing Intervention services: primarily focused on services for people living with serious conditions that may have co-existing conditions and require ongoing recovery-oriented specialist case management.

ESTABLISH A POLICE CO-RESPONSE PROGRAM

When the police come into contact with individuals with mental health problems, there is an opportunity to divert people towards suitable treatment and support. A police and mental health co-response program will provide a coordinated response by mental health services and police for people experiencing a mental health crisis in the community. It is expected such a program will improve community perceptions regarding the role of the police in mental health-related incidents, reduce the rate of recidivist police contact with people with a mental illness and reduce the numbers of people with mental illness involved in the justice system.

The mental health community treatment staff component of the police co-response program forms part of the total modelled community treatment hours of service (i.e. will not be an additional staff requirement). The police resource requirement for the co-response program is not included within the modelled community treatment hours of service.

Once established and running effectively, consideration will be given to the benefits of including alcohol and other drugs in a co-response model.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

MAINTAIN AND STRENGTHEN AN APPROPRIATE ABORIGINAL MENTAL HEALTH SERVICE

The Statewide Specialist Aboriginal Mental Health Service (SSAMHS) increases the accessibility and responsiveness of mainstream public mental health services for Aboriginal people with severe and persistent mental illness. The SSAMHS model delivers whole-of-life mental health care, which involves the family and engages traditional healers identified by individuals and their families through community networks. It is expected the SSAMHS service will have capability to appropriately meet the needs of Aboriginal people with co-occurring mental health, alcohol and other drug problems.

SSAMHS will have a fundamental role in ensuring compliance with particular provisions and requirements of the new *Mental Health Act 2014* that impact on Aboriginal people. The Aboriginal community treatment hours of service are included in the total modelled community treatment hours of service.

ACTIONS

The actions in the area of community treatment services are detailed below. For further information refer to the *Plan Matrix* (page 105).

IMPLEMENTING EXISTING COMMITMENTS:

- continue the implementation of the Statewide Specialised Aboriginal Mental Health Services including specific strategies to enhance access for Aboriginal children, families and people with co-occurring alcohol and other drug problems
- establish a new integrated alcohol and other drug treatment service in Joondalup
- complete an evaluation of the Royalties for Regions funded North West Drug and Alcohol Support Program expansion (Kimberley, Pilbara and Gascoyne regions) to inform future funding decisions
- implement an Alcohol Interlock Assessment and Treatment Service in support of the *Road Traffic Amendment (Alcohol Interlocks and other Matters) Act 2015*.

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- boost infant, children and adolescent mental health community treatment services across the State by 374,000 hours of service, which includes early intervention services and services for families
- build on current youth services and commission new youth services to establish a dedicated youth community treatment service stream

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

- establish a new integrated alcohol and other drug treatment service in the South Metropolitan area (70,000 hours)
- further develop community alcohol and other drug services in the Midwest (9,000 additional hours) and South West (33,000 additional hours)
- work with the Western Australian Police to develop and commission a mental health police co-response program
- establish an effective 'one stop shop' service that provides 24-hour mental health crisis and emergency services, system navigation assistance and frontline staff training
- work with the Commonwealth Government to ensure the State has equitable access to Medicare funded services
- further progress the development of partnerships, where appropriate, between community treatment, primary care services and existing health promotion programs to optimise the health and wellbeing of people with mental health, alcohol and other drug problems
- expand training and engagement of GPs and other primary care providers to increase screening, brief interventions, early interventions, and referrals for mental health, alcohol and other drug problems in all regions
- work with peak bodies representing pharmacies in Western Australia to determine how pharmacists can become more involved in the dispensing of medications and monitoring of people receiving medications for mental health, alcohol and other drug problems
- commence the development of a real time Schedule 8 (drugs of addiction) medicine dispensing tracing system.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- increase the total mental health community treatment hours of service across the State from 2.6 million hours to 3.2 million hours with a priority on developing telehealth, after hours services and expanded clinical services for the South West
- expand metropolitan alcohol and other drugs treatment services to provide an additional 320,000 hours of outpatient withdrawal, pharmacotherapy maintenance and specialist counselling and support in the metropolitan area
- expand the number of alcohol and other drug service hubs in the Northern and Remote, and Southern Country through an additional increase of 136,000 hours of community treatment. This will increase the capacity to provide additional services such as outreach. The focus will initially be on the South West, Great Southern, Wheatbelt, Midwest, and Goldfields areas.
- continue to engage with the primary care sector across the State to increase screening, brief intervention and early intervention to assist people with mental health, alcohol and other drug problems as early as possible
- expand the Community Program for Opioid Pharmacotherapy across the State, particularly regional areas.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

BY THE END OF 2025, TO CONTINUE THE REFORM, MODELLING IDENTIFIES THE REQUIREMENT TO:

- continue the expansion of community mental health, alcohol and other drug services (co-located where possible) through:
  - expanding the metropolitan and regional community alcohol and drug hours of service by a further 926,000 hours (including establishing smaller hub sites)
  - increasing the total mental health community treatment hours of service across the State from 3.2 million hours to 3.8 million hours.

Table 3: Summary of the *Plan Matrix*

STATE TOTAL	MEASURE	CURRENT	2017	2020	2025
Community Treatment Services	Hours ('000) (total)	2,713	3,302	4,307	5,820
MH Infant, Child and Adolescent	Hours ('000)	373	747	1,170	1,560
MH Youth	Hours ('000)	339	360	398	453
MH Adult	Hours ('000)	1,200	1,183	1,183	1,218
MH Older Adult	Hours ('000)	236	335	422	528
AOD – All (non-residential treatment)	Hours ('000)	565	677	1,133	2,060

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

COMMUNITY BED-BASED SERVICES

WHAT ARE 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 structured, intensive residential rehabilitation for people with an alcohol and other drug problem (following withdrawal). Both mental health community beds and residential rehabilitation services need to have the capability to meet the needs of people with co-occurring mental health, alcohol and other drug problems where appropriate.

Community bed-based services support a person to enable them to move to more independent living. The primary aim of interventions is to improve functioning and reduce difficulties that limit an individual's independence. They assist people with mental health, alcohol and other drug problems who may need additional support, but where admission to hospital is not required. They can also provide additional supports to assist people to successfully transition home from hospital, as well as work with an individual to prevent relapse and promote good general health and wellbeing.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

The provision of adequate community beds and the strengthening of appropriate services in the community are crucial to reducing inappropriate and therefore excess demand for acute hospital beds. Evidence shows that individuals with mental illness are occupying hospital inpatient beds for longer than necessary due to the absence of more appropriate community services. This is illustrated by survey results in 2009 which consistently indicate that more than 40 per cent of individuals occupying mental health inpatient beds at any given time could be discharged if appropriate community services were available.[20] Currently, people who are unable to access the help they need in the community have little choice but to rely on inpatient acute beds, irrespective of whether this is the most appropriate form of care.

In Western Australia in 2013-14 the cost per day for a mental health bed was

$1,234
in a hospital

$453
in a fully occupied community-based subacute facility

AIM

Further develop a broad range of community bed-based services for individuals with mental health, alcohol and other drug problems.

CURRENT SERVICES

In 2012-13, there were a total of 281 mental health community beds, and 358 for alcohol and other drug services (14 low medical withdrawal beds and 344 residential rehabilitation beds). The State Government has recently committed new investment in mental health community bed-based services, with the first subacute service opening with 22 beds at Joondalup in 2013.

The vast majority of residential rehabilitation services are currently located within the metropolitan area and the Northern and Remote Region. There are a number of different service delivery models provided in Western Australia, including therapeutic communities that emphasis self-help and mutual support and other specialist residential treatment services.

Currently the Mental Health Commission provides subsidies for 499 beds in 17 psychiatric hostels. These community beds are not reflected in the current community bed numbers, but are discussed in the *Community Support Services* section (page 38).

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

WHAT THE MODELLING TELLS US

There are four key types of mental health community beds, and a variable length of stay is offered depending on the person's needs and the type of service. Services are recovery-focused, family inclusive, are often delivered in home-like cluster- style facilities and are staffed 24 hours per day, seven days per week.

Mental health community bed-based services are expected (where appropriate), to have the capability of meeting the needs of people with co-occurring mental health, alcohol and other drug problems. Services include:

Subacute community short-stay (Youth and Adult): For adults, the average length of stay is 14 days with an expected maximum of 30 days, and for youth the average length of stay is 28 days. This service provides short-term residential care, including intensive clinical treatment and support. Services are aimed at two groups of consumers: firstly, consumers who are living in the community and require short-term residential support, intensive clinical treatment and intervention to prevent risk of further deterioration or relapse which may lead to a hospital admission (step-up); and secondly, consumers who are in hospital, but are not ready to return home. For this group, subacutes offer a safe and supportive short-term residential option before they transition home (step-down).

Subacute community medium-stay (Youth, Adult and Older Adult): The average length of stay is 120 days (four months), with an expected maximum of 180 days (six months). These services are residential in nature and are delivered in a partnership between clinical and community support services. They provide accommodation, and staffing is available on-site 24 hours a day, seven days a week to deliver recovery-oriented psychosocial rehabilitation programs.

Non-acute community long-stay (Youth, Adult and Older Adult): The average length of stay is 365 days. The functions of this service mirror that of the subacute community medium-stay service (above). The two services differ in their length of stay.

Non-acute community long-stay (Nursing Home – Older Adult): The average length of stay is 365 days. Services are specifically designed for older adults who have severe and persistent symptoms of mental illness, and who have risk profiles that preclude them from living in mainstream aged care settings. The service provides assessment, ongoing treatment, rehabilitation and residential support for consumers.

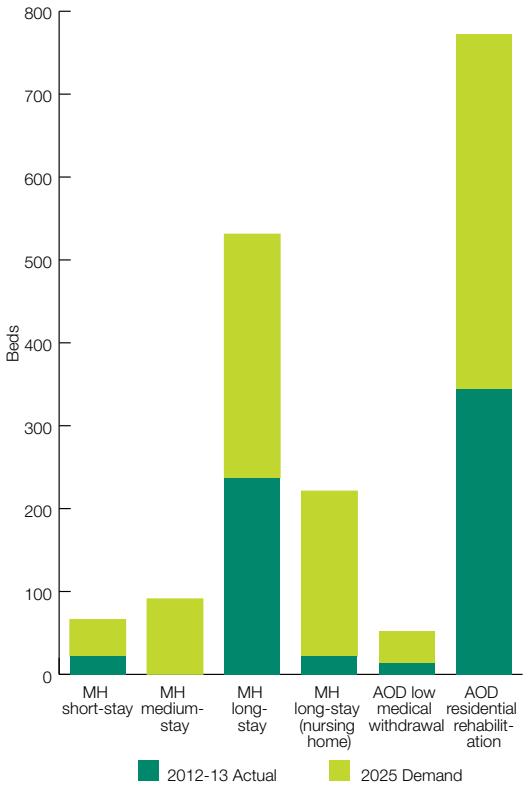
For alcohol and other drugs, there are two main types of community beds which are described below. Again, services are expected (where appropriate) to meet the needs of people with co-occurring mental health, alcohol and other drug problems.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

Low medical withdrawal: The average length of stay is five to seven days and is most appropriate when symptoms are likely to be low to moderate. This type of service provides 24-hour supervised alcohol and other drug detoxification or withdrawal programs from a psychoactive drug of dependence. Where appropriate, low medical withdrawal services can also be provided in the home by registered nurses and GPs.

Residential rehabilitation: The average length of stay is 13 weeks, but can range between five and 26 weeks. These services offer 24-hour community-based residential treatment programs, and intensive and structured interventions following withdrawal. Programs usually include psychological therapy, education, development of skills and peer support. Therapeutic communities are considered a type of residential rehabilitation service. There are also dedicated services for specific groups such as women, young people and Aboriginal people.

To meet 100 per cent of demand, modelling indicates that mental health community bed numbers are required grow to from 281 to 909, and for alcohol and other drugs are required to grow from 358 to 824 by the end of 2025 (see the *Plan Matrix* on page 105). For mental health community beds, the greatest expansion is required in the long-stay beds. For alcohol and other drug community beds, the residential rehabilitation beds require the greatest growth, in order to meet the optimal service mix by the end of 2025 (see Figure 7).



MH = Mental Health
AOD = Alcohol and Other Drug

Figure 7: The optimal mix and level of service, community beds

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

STRATEGIES

EXPAND THE NUMBER OF MENTAL HEALTH COMMUNITY BED-BASED SERVICES, PARTICULARLY IN THE REGIONS

We will progress the commissioning of a range of community bed-based services over the next ten years (see the *Plan Matrix* for details of the number and location). The range of community bed-based services is shown on page 57 and in Figure 7. The State Government has committed to building a number of mental health community subacute services in areas such as Rockingham, Kalgoorlie, Karratha, Bunbury and Broome.

Where relevant, community treatment services will work closely with community bed-based service providers, providing in-reach, clinical assessment, admission and discharge oversight. Community bed-based services are expected to, where appropriate, have the capability to meet the needs of people with co-occurring mental health, alcohol and other drug problems and those exiting the criminal justice system.

INCREASE THE AVAILABILITY OF LOW MEDICAL WITHDRAWAL AND RESIDENTIAL REHABILITATION SERVICES FOR PEOPLE WITH ALCOHOL AND OTHER DRUG PROBLEMS

Alcohol and other drug residential rehabilitation beds are concentrated in the metropolitan area and the north of the State. There are very limited residential rehabilitation services in the southern region of the State.

The modelling shows that a strong emphasis in boosting the availability of residential rehabilitation beds is required, to ensure consumers with alcohol and other drug problems are able to access timely, personalised services, as close as possible to where they live. There are diverse models of rehabilitation, including therapeutic communities, non-bed-based rehabilitation services (sometimes referred to as day rehabilitation models), and also services targeting specific groups such as families, women, young people and Aboriginal people.

Equitable access across the State will be considered in future planning, but factors other than location can also be barriers for accessing services. In developing new residential rehabilitation services attention will be given to developing a diversity of models within the service system to reduce such barriers and support specific needs. Services can be developed to provide rehabilitation support for people on pharmacotherapies, integrated services for people with co-occurring mental health and alcohol and other drug problems, and services for different age groups and population groups.

Currently, there are not enough dedicated alcohol and other drug community beds for young people in any non-metropolitan region. Also, currently, the only Aboriginal specific residential rehabilitation treatment services are located in the Kimberley. A culturally secure treatment and support service is required in the southern region of Western Australia for Aboriginal people and their families.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

Offering low medical withdrawal within existing rehabilitation services can improve transition between withdrawal and longer term treatment and support. However, this needs to be coordinated with sufficient places to continue longer-term treatment, either residential or non-residential. Medical withdrawal and rehabilitation services are expected to, where appropriate, have the capability to meet the needs of people with co-occurring mental health, alcohol and other drug problems.

TRIAL A COMPULSORY ALCOHOL AND OTHER DRUG TREATMENT FACILITY TO RESPOND TO HIGH RISK METHAMPHETAMINE DEPENDENCY, PENDING ESTABLISHMENT OF APPROPRIATE LEGISLATION

Voluntary services provide appropriate treatment opportunities for the vast majority of people with an alcohol or other drug problem. However for a small number of individuals with a severe dependency to drugs such as methamphetamines, compulsory treatment may be required as a short-term protective role in emergency situations to prevent death or immediate harms to an individual, their family or community. Compulsory treatment is an option of last resort. It provides assessment, treatment and management for those with a severe dependence, whose capacity is severely compromised because of their dependency. Compulsory treatment is only appropriate where less restrictive forms of treatment are not an option.

A trial compulsory alcohol and other drug treatment service will include both community treatment options and facility based options. It is proposed to respond to the increased harm seen in communities as a result of alcohol or other drug problems including severe methamphetamine dependency. This would require the development and approval of relevant legislation.

INCREASE THE AVAILABILITY OF OLDER ADULT SERVICES

With an ageing population, an increased number of people are staying in hospital for longer than necessary due to a limited number of community bed places for older adults. To address this increasing need, more focus and investment will occur in the area of older adult services, particularly subacute community long-stay services. Community long-stay services provide a more home-like environment compared to hospital services and can reduce the inappropriate use of hospital-based older adult services.

For older adults, integration and collaboration between aged care and alcohol and other drug community treatment is needed, including supporting home-based withdrawal.

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

ACTIONS

The actions in the area of community bed-based services are detailed below. For further information, particularly on the location of services, refer to the *Plan Matrix* on page 105.

IMPLEMENTING EXISTING COMMITMENTS:

- open new mental health community bed-based services approved by Government:
  - Rockingham (Peel – 10 beds)
  - Broome (Kimberley – six beds)
  - Kalgoorlie/Boulder (Goldfields – six beds)
  - Karratha (Pilbara – six beds)
  - Bunbury (South West – 10 beds).

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- increase the subsidy provided for non-acute long-stay (nursing home) places for older adults with mental illness by 63 places, (32 places in the North Metropolitan region, 10 places in South Metropolitan region, six places in Northern and Remote, and 15 places in Southern Country)
- work with regional stakeholders to deliver approximately 10 community beds in the Midwest area, which will be supported by comprehensive community and inpatient services
- expand low medical alcohol and other drug withdrawal services in the metropolitan area by 10 beds, Northern and Remote by eight beds and Southern Country by three beds
- expand existing alcohol and other drug residential treatment and rehabilitation services by 55 beds (10 beds in North Metropolitan, 23 beds in South Metropolitan, 12 beds in Geraldton and 10 beds in Kalgoorlie)
- commence the development and implementation of a residential alcohol and other drug treatment and rehabilitation service (30 beds) for Aboriginal people and their families in the south of the State
- commence the development and implementation of a new alcohol and other drug residential treatment and rehabilitation service in the South West (36 beds)
- commence planning for a trial compulsory treatment facility to respond to the increased harm seen in communities as a result of alcohol and other drug use including severe methamphetamine dependency. This will involve the development of relevant legislation.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- increase the total number of mental health community beds by 71 beds, including 41 subsidised beds for non-acute long-stay (nursing home) places (North Metropolitan (14 beds), South Metropolitan (16 beds), Northern and Remote (four beds), and Southern Country (seven beds))
- deliver a new service specifically designed for youth alcohol and other drug treatment and rehabilitation (23 beds) in the metropolitan area

KEEPING PEOPLE CONNECTED AND CLOSE TO HOME

- pending relevant legislation approval, trial a compulsory treatment facility to respond to the increased harm seen in communities as a result of alcohol and other drug use including severe methamphetamine dependency
- expand low medical alcohol and other drug withdrawal services in the metropolitan area by a further four beds
- expand alcohol and other drug residential treatment and rehabilitation services by a further 70 beds (21 beds in South Metropolitan, 49 beds in North Metropolitan).

BY THE END OF 2025, TO CONTINUE THE REFORM, MODELLING IDENTIFIES THE REQUIREMENT TO:

- further expand alcohol and other drug residential treatment and rehabilitation in the North Metropolitan (81 beds), Southern Metropolitan (65 beds), Northern and Remote (nine beds) and Southern Country (59 beds)
- complete delivery of low medical withdrawal beds in the metropolitan area (nine beds) and Southern Country (four beds)
- increase the number of mental health community beds across the State (all metropolitan and regional areas) from 475 beds to deliver the modelled target of 909 beds.

Table 4: Summary of the *Plan Matrix*

STATE TOTAL	MEASURE	CURRENT	2017	2020	2025
Community Bed-Based Services	Beds (total)	639	838	1,072	1,733
MH Community-Based	Beds	281	404	475	909
AOD – Low Medical Withdrawal	Beds	14	35	39	52
AOD – Residential Rehabilitation	Beds	344	399	558	772

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

HOSPITAL-BASED SERVICES

WHAT ARE HOSPITAL-BASED SERVICES?

Hospital-based services include acute, subacute and non-acute inpatient units, emergency departments, consultation and liaison services, mental health observation areas, and alcohol and other drug detoxification services. Hospital-based services provide treatment and support in line with mental health recovery-oriented service provision, including promoting good general health and wellbeing. Hospital services, where appropriate, can utilise telehealth technology to increase service access and responsiveness. Staff working in hospital services will have the capability to meet the needs of people with co-occurring mental health, alcohol and other drug problems. The full range of hospital-based services is detailed on pages 65-66.

More than 40 per cent of mental health patients in acute hospital beds would not need to be in acute care if appropriate community services were available.[20] Currently, people who are unable to access the help they need in the community have little choice but to rely on emergency departments and inpatient services, irrespective of whether this is the most appropriate form of care. Pressure on emergency departments is also currently unacceptable, at times resulting in people waiting too long to access an inpatient bed.

Although modelling suggests a rebalancing of the mental health system is required to boost community services as the first priority, modelling shows that hospital bed growth is required from 2020 onwards.

Hospital-based service growth for the alcohol and other drug sector is identified as an early priority due to a current inability to meet demand, particularly in regional areas.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

AIM

Develop a high quality, efficient and effective hospital-based system that offers evidence-based services, in the right locations.

CURRENT SERVICES

As at 30 June 2014, there are a total of 696 public mental health, alcohol and other drug hospital beds in Western Australia. Figure 8 shows in some cases current bed numbers as a percentage of 2014 demand is greater than 100 per cent – suggesting there are currently more beds than modelling indicates is required. This level of demand, however, would only hold true in an optimal and efficient system, which is currently not the case.

Since 2010, the development of public mental health inpatient units closer to local communities has provided 50 additional beds including 30 beds at Rockingham Hospital, 13 beds at Broome Hospital and seven additional beds at Albany Hospital. Construction of more new mental health inpatient services is underway, with 136 new and relocated mental health beds expected to become operational by the end of 2016. These include 20 beds at the Perth Children's Hospital, 30 beds at Fiona Stanley Hospital, 30 beds at Sir Charles Gairdner Hospital, and 56 beds at Midland Hospital.

WHAT THE MODELLING TELLS US

For mental health, the bed types are described below:

Acute hospital: provides hospital-based inpatient assessment and treatment services for people experiencing severe episodes of mental illness who cannot be adequately treated in a less restrictive environment. The average length of stay in this service is 14 days. Acute inpatient services are modelled for all age groups separately, that is, infants, children and adolescents; youth; adults; and older adults.

Subacute short-stay hospital: provides hospital-based treatment and support in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their receiving treatment in a less restrictive environment. This service provides for adults, older adults and a selected number of young people with special needs. Average length of stay is between 35 days to six months.

Non-acute long-stay hospital: provides hospital-based treatment and support in a safe, structured environment for people with unremitting and severe symptoms of mental illness and an associated significant disturbance in behaviour which precludes their living in a less restrictive environment. Programs have a strong focus on safety, security and risk assessment and management. Services include specialist behavioural and symptom management programs, individualised and group programs aimed at maximising individual functioning. This service provides for youth, adults, and older adults separately, and the average length of stay is 365 days.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

Mental Health Observation Areas: Mental Health Observation Areas (MHOA), or similar and equivalent models, can aid individuals in emergency departments who may not require admission into an inpatient unit, but need close observation and intervention for up to 72 hours. MHOAs are expected to meet the needs of people with mental health, alcohol and other drug problems. They can also be used for people with complex alcohol and other drug problems, including co-occurring alcohol and other drug use or toxicity.

Consultation and Liaison: dedicated hospital-based consultation and liaison services are usually located in tertiary hospitals to support hospital staff to better manage mental health, alcohol and other drug problems, including alcohol and other drug withdrawal. As well as providing services in various geographic locations, consultation and liaison teams also use telehealth services to support smaller remote hospitals. Consultation and liaison services can be provided in hospitals, and emergency departments.

ALCOHOL AND OTHER DRUG SPECIFIC BEDS INCLUDE:

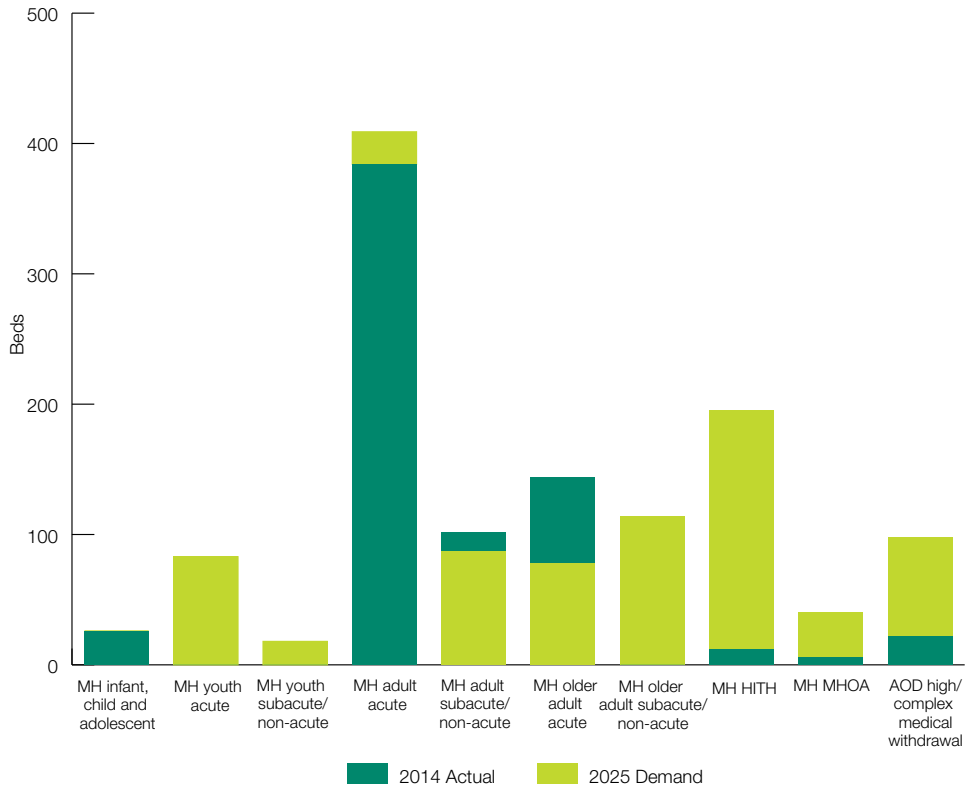
High medical withdrawal services: inpatient services that provide medically supervised alcohol and other drug withdrawal, and are staffed 24-hours a day by a combination of specialist alcohol and other drug doctors, GPs, nurses and allied health workers. Generally withdrawal takes place over a short-term inpatient admission period (e.g. seven days). High medical inpatient withdrawal is for clients with withdrawal symptoms that are moderate to severe.

Complex medical withdrawal services: Complex medical inpatient withdrawal is similar in all aspects to the high medical withdrawal service, except it provides a greater level of service with regard to complicating medical issues, mental health issues, and those with a history of complicated withdrawals.

Figure 8 shows that both expansion and realignment of hospital beds is required in the system to meet the optimal mix of services. Realignment would involve a reduction in those beds that are currently oversupplied (i.e. adult subacute and older adult acute) and a proportionate increase in other bed types that are currently undersupplied (e.g. adult acute and older adult subacute). Realigning the system would involve configuring excess beds into a different acuity, a different age cohort or both. Realigning the system also requires bed relocation, with the closure of Graylands Hospital and transfer of these beds to mental health Hospital in the Home (HITH) beds or other mental health units within general hospitals, closer to where people need them.

The modelling also reveals a strong reliance on adult beds being used for young people with a mental health problem as there are currently no dedicated beds for youth (aged 16 to 24 years). As a result, young people aged 18 to 24 use adult beds across the system and those up to age 18 years access adolescent beds such as those at the Bentley Adolescent Unit. It is important to note that hospital beds cannot be realigned without substantial investment and expansion of community-based services.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT



MH = Mental Health
AOD = Alcohol and Other Drug

Figure 8: The optimal mix and level of service, hospital-based services

Currently, there are a total of 231 mental health beds located in private hospitals throughout Western Australia. However, at this time, the number of individuals seen by private providers, who have a severe condition, cannot be comprehensively quantified; therefore have not been counted in the 'current beds'. Further, there are currently 19 private alcohol and other drug inpatient beds: these have also not been included in the 'current beds'. It is anticipated private and non-government providers will continue to expand provision of mental health, alcohol and other drug inpatient beds as these beds constitute an essential component of the overall mental health, alcohol and other drug system.

Dedicated hospital-based consultation and liaison services in the emergency departments and across general hospitals have also been modelled. The public system currently provides 218,000 hours of consultation liaison services, with a modelled requirement of 309,000 hours of service by the end of 2025.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

The modelling tools used to estimate demand for services show inpatient resource requirements as beds. The Mental Health Commission purchases inpatient services using Weighted Activity Units (WAUs), which is a measure of mental health service activity expressed as a common unit. The Plan does not outline the amount of WAUs required as demand by the end of 2025, as the number of WAUs per bed differs due to differing acuity, case mix and models of service (which are not determined in the Plan). In addition, the Independent Hospital Pricing Authority (IHPA) is currently developing an Australian Mental Health Care Classification (AMHCC), for implementation from 1 July 2016. The development and implementation of a mental health classification will have a significant impact on the volume of WAUs and consideration of the impacts of the new classification will be considered once it is available.

STRATEGIES

REALIGN THE TYPE, QUANTITY AND LOCATION OF HOSPITAL BEDS

Realignment of bed-based services requires the right types of beds, in the right places, in the right quantity, and delivered at an efficient price. There is a need for contemporary inpatient units located within general hospitals, which can provide recovery-oriented treatment for individuals with a serious mental illness (including those with co-occurring alcohol and other drug problems) on a short-term basis. There is also a need to ensure the right number of acute and/or subacute hospital beds are made available for youth and older adults.

The future distribution and location of hospital beds has been shown in the *Plan Matrix* on page 105, however it should be noted exact locations and distributions will be determined by a combination of consultation processes and the assessment of relative feasibility to deliver the service. It is anticipated that there will be a mix of public and private providers to establish new services to meet overall demand. Units will be established for voluntary and involuntary patients; however the quantity of each bed type will be determined during Plan implementation.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

CONTINUE TO EXPAND THE HOSPITAL IN THE HOME PROGRAM

The mental health HITH program offers some individuals the opportunity to receive hospital level treatment delivered in their home, where clinically appropriate. HITH is consistent with the approach of providing care in the community, closer to where individuals live. HITH is delivered by multidisciplinary teams including medical and nursing staff. People admitted into this program remain under the care of a treating hospital doctor.

HITH services already exist in the metropolitan area, therefore future service models will draw upon effective existing service models. Close monitoring of the effectiveness and safety of the model will be ongoing and inform future expansion plans. HITH beds must be capable of providing services for people with co-occurring mental health, alcohol and other drug problems.

It is intended HITH services will be available to youth, adults and older adults. The appropriateness of this model for infants, children and adolescents will be further explored.

HITH is delivered in the community, but measured and funded via 'beds' and 'WAUs', and therefore falls under the hospital beds stream for funding purposes. Our target is to move towards delivering approximately 20 per cent[xv] of inpatient mental health beds as HITH beds by the end of 2025.

In the future, HITH may also be an option for people requiring high medical withdrawal where clinically appropriate.

xv Based on the results of a 2000 Cochrane Systematic Review, it is estimated up to 55 per cent of people requiring inpatient mental health care could be treated through a Hospital in the Home type program instead of in a hospital-based inpatient mental health bed.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

PROGRESS THE CLOSURE AND DIVESTMENT OF GRAYLANDS HOSPITAL

Since the first National Mental Health Plan in 1992, most large stand-alone psychiatric institutions across Australia closed. Stand-alone psychiatric institutions were built based on a Victorian era asylum model therefore are unsuitable for the delivery of modern health care. Services provided in these institutions are often divested to general hospitals.

Graylands Hospital is one of the last stand-alone psychiatric institutions in Australia.

The divestment of mental health services from Graylands Hospital and Selby Older Adult Unit will be progressed over the lifetime of the Plan. Planning has already commenced between the Mental Health Commission and the Department of Health. With some wards in Graylands Hospital no longer meeting accreditation standards, the move to close these services and replace them with contemporary services is already progressing.

New services will be established before any services at Graylands close. The mix of new services will be dependent on the needs of people who utilise services at Graylands Hospital. New services may include a mix of HITH, and inpatient beds (e.g. at Osborne Park Hospital), which would be located across the State. A limited number of contemporary services are likely to remain on the Graylands site, which may include forensic beds.

In order to reduce the financial impact to the State regarding dual site operations, further detailed transition planning needs to be undertaken as a high priority. This would include the timing and phasing of the land sale of Graylands, which can be used as a source of funding for further investment into the mental health system and the replacement for those services to be decommissioned at Graylands.

There is a small group of people who have remained at Graylands for a number of years due to the complexity and severity of their illness, and the absence of an alternative, contemporary service. Planning for the Graylands divestment will, as an early priority, include the establishment of new home-like, contemporary and personalised services to meet the needs of this group. This will provide people who have stayed at Graylands for extended period of time the option to remain in the area, close to family, friends and their local community.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

FURTHER EXPAND THE AVAILABILITY OF A RANGE OF WITHDRAWAL BEDS

A range of inpatient withdrawal services are necessary to meet the varying needs of people requiring withdrawal from alcohol and other drugs. Complex withdrawal beds need to be provided in hospitals which would enable a short-term inpatient admission for individuals with withdrawal symptoms that are moderate or severe, and where treatment is complicated by medical or mental illness.

The Plan articulates that services need to expand to provide supervised medical inpatient withdrawal for individuals across the State. In support of this, there is also the requirement for access to addiction medicine specialists to provide consultancy and advice to other relevant health services. Individuals who require residential withdrawal, but do not have the need for specialist medical support, would have access to withdrawal services and beds within existing residential rehabilitation services in the community to promote smooth transition and continuing care. Home-based withdrawal services would also be provided for those who can be medically supported in the home, as an alternative to an inpatient admission.

ESTABLISH ADDITIONAL MENTAL HEALTH, ALCOHOL AND OTHER DRUG EMERGENCY DEPARTMENT SERVICES

The responsiveness of hospital emergency departments to individuals presenting with mental health, alcohol and other drug problems can improve through the expansion of hospital-based consultation liaison services in the emergency departments and across general hospitals. As well as providing services in various geographic locations, consultation and liaison teams can use telehealth services to support smaller 'satellite' hospitals.

We will aim to progress the establishment of dedicated MHOAs, or equivalent service models, in hospitals which will aid individuals who do not require admission into an inpatient unit, but need close observation and intervention for up to 72 hours. This includes exploring how these services can be best provided in regional areas.

The *National Mental Health Service Planning Framework* indicates that only hospitals with a bed base of 500 plus would be considered in developing a MHOA adjacent to an emergency department or mental health inpatient unit. When applying this rationale in the Western Australian context, consideration has been given to hospitals that have a high rate of mental health presentations in emergency departments (regardless of bed numbers in the hospital).

This may also apply to highly-populated regional areas where mental health presentations are high, and where it is feasible to establish this type of service.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

CONTINUE TO COMMISSION A TRANSPORT SERVICE FOR PEOPLE REQUIRING TRANSFER UNDER THE *MENTAL HEALTH ACT 2014*

The pilot Mental Health Inter-Hospital Patient Transfer Service assists people requiring transport under the *Mental Health Act 2014*. The current pilot service, which provides transfer between hospitals only, is undergoing an evaluation and following the results of the evaluation, it is intended that a full service will be commissioned.

CONTINUE TO MONITOR MENTAL HEALTH READMISSION RATES

Mental health inpatient services aim to provide treatment that enables individuals to return to the community as soon as possible. Within Australia, national publications such as the *Fourth National Mental Health Plan* and *Report on Government Services (ROGS)* either highlight the importance of, or routinely publish data on, mental health readmission rates as a mental health performance measure.

Readmissions to an acute mental health inpatient unit following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to prevent an individual returning to hospital. In this sense, deficiencies in the functioning of the overall care system may be identified. In 2012-13, the rate of readmissions to acute public mental health inpatient facilities in Western Australia within 28 days of discharge was 13.4 per cent, which compares to the national average of 13.9 per cent.[32]

Nationally, a readmission rate target of '12 per cent or less by mid-2014' was outlined as part of *the Roadmap for National Mental Health Reform 2012-2022,* a Council of Australian Governments initiative.[33]

With implementation of reconfigured services, it's important that appropriate monitoring and clinical strategies to reduce readmissions to designated mental health units are designed and implemented. In order to better understand mental health readmission trends, continual monitoring and reporting of mental health readmissions will occur.

ACTIONS

The actions for the hospital-based services are detailed below. For further information, particularly on the location of services, refer to the *Plan Matrix* on page 105.

IMPLEMENTING EXISTING COMMITMENTS:

- open 36 new and 100 replacement mental health inpatient services at:
  - Perth Children's Hospital – 20 bed acute mental health unit for children up to 16 years (six new beds, and 14 replacement beds (six Bentley Hospital, eight Princess Margaret Hospital))
  - QEII – 30 bed adult acute mental health unit (30 replacement beds)
  - Midland – 56 bed acute mental health unit, including 41 replacement beds from Swan (16 Older Adult, 25 Adult), nine replacement beds from Graylands Hospital and six replacement beds from Sir Charles Gairdner Hospital

  - Fiona Stanley Hospital – 30 bed acute mental health unit, including eight new mother and baby (perinatal) beds, 14 new youth beds, and eight new mental health assessment beds (short-stay)
- complete the evaluation of the pilot transport service and continue to commission an effective and safe transfer service for people who require transport under the *Mental Health Act 2014*.

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- commence the process of divestment of services on the Graylands and Selby hospital campuses
- convert the Bentley Adolescent Unit into a statewide 14 bed subacute inpatient service for youth
- work with regional stakeholders to deliver approximately 16 inpatient beds in the Midwest area (which may include MHOA, inpatient and HITH beds), which will be supported by a comprehensive community-based service (including community beds)
- expand MHOAs across the State (Royal Perth Hospital, Rockingham Hospital, Midland Hospital, Joondalup Health Campus)
- further explore the requirement for MHOAs (or equivalent model) in regional hospitals across the State
- increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 218,000 to 274,000 hours of service
- expand the capacity of country hospitals by 11 beds across the Goldfields, Midwest and Pilbara to provide high medical alcohol and other drug withdrawal
- increase capacity for Telehealth links (i.e. telepsychiatry and specialised services) into small hospitals in regional areas
- expand HITH beds by 5 per cent and further investigate the appropriateness of this model for infants, children and adolescents.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- work with regional stakeholders to determine how best to provide 16 inpatient beds for the Pilbara area (which may include MHOA, inpatient and HITH beds)
- work with regional stakeholders to determine how best to provide 16 inpatient beds for the Wheatbelt area (which may include MHOA, inpatient and HITH beds)
- expand high medical withdrawal capacity in the North Metropolitan area (increase from 22 to 33 beds)
- expand the capacity of hospitals by 26 beds across the Great Southern, Kimberley, South West, Wheatbelt and South Metropolitan area to provide high medical alcohol and other drugs withdrawal
- increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 274,000 to 292,000 hours of service

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

- continue to expand MHOAs across the State (Armadale Hospital, Peel Health Campus, and Perth Children's Hospital)
- continue the closure of Graylands wards in a staged process as HITH and new hospital wards become operational across the State
- expand HITH beds to meet the target of approximately 10 per cent of inpatient mental health beds to be delivered as HITH.

BY THE END OF 2025, TO CONTINUE THE REFORM, MODELLING IDENTIFIES THE REQUIREMENT TO:

- increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 292,000 to 309,000 hours of service
- continue the expansion of high medical withdrawal beds by 28 beds (South Metropolitan, North Metropolitan and the South West)
- complete the closure of the existing Graylands facilities, with final transition by the end of 2025
- expand HITH beds to meet the target of approximately 20 per cent of inpatient mental health beds to be delivered as HITH.

Table 5: Summary of the *Plan Matrix*

STATE TOTAL	MEASURE	CURRENT	2017	2020	2025
Hospital-based Services	Beds (total)	696	822	956	1,150
	Hours ('000) (total)	218	274	292	309
MH Infant, Child and Adolescent	Beds	26	20	20	27
MH Youth Acute	Beds	–	18	42	83
MH Youth Subacute/Non-acute	Beds	–	14	14	18
MH Adult Acute	Beds	384	386	388	409
MH Adult Subacute/Non-acute	Beds	102	102	102	87
MH Older Adult Acute	Beds	144	93	95	78
MH Older Adult Subacute/Non-acute	Beds	–	55	63	114
MH Hospital in the Home (HITH)**	Beds	12	73	121	195
Mental Health Observation Area (MHOA)	Beds	6	28	40	40
MH Private ^	Beds	231	231	231	231
AOD (High/Complex Medical Withdrawal)	Beds	22	33	70	98
AOD Private ^	Beds	19	19	19	19
MH/AOD Consultation Liaison	Hours ('000)	218	274	292	309

** HITH beds are a substitution for Acute and Subacute/Non-acute hospital beds.
^ Current private beds, unknown whether they will grow.

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug
– : Service is not available.

SPECIALISED STATEWIDE SERVICES

WHAT ARE 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 for extended periods, and support to general services. Some services can be developed as centres of excellence that are located in the metropolitan area and provide expert advice and assistance across the State. Other services, where possible, can be delivered through a hub and spoke model.[xvi]

Specialised statewide services include services for: eating disorders; neuropsychiatry and neurosciences; perinatal; Attention Deficit Hyperactivity Disorder (ADHD); co-occurring mental illness and intellectual, cognitive or developmental disability (including autism spectrum); children in care; sexuality, sex and gender diverse people; transcultural people; people who are hearing and vision impaired; and people who are homeless.

In some cases new specialised statewide services need to be developed where none have existed before, and in other cases existing services need to be expanded to meet demand.

It is expected general community treatment and inpatient services will have the capacity, capability and expertise to deliver effective, evidence-based care for a range of people with complex conditions such as personality disorder, conduct disorder, mood disorder, emotional dysregulation and those with a history of trauma.

AIM

Expand the availability of a range of high quality, effective and efficient specialised statewide services to meet demand.

CURRENT SERVICES

Current community specialised statewide services include transcultural mental health services; perinatal services; and homelessness services. Specific specialised statewide services for children and young people (up to the age of 18 years) include ADHD services, multi-systemic therapy, and eating disorder community services (for children who are in contact with services prior to the age of 16 years).

Current inpatient specialised statewide services include general inpatient eating disorder beds, which are available for children and young people (up to the age of 16 years), however, these are not dedicated beds. There are currently eight dedicated specialised statewide inpatient beds for mothers and babies (perinatal).

xvi Hub and spoke models refer to services that have a central, coordinating service located in one location (e.g. metropolitan area) with smaller outreach services located in other locations (e.g. regional areas).

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

WHAT THE MODELLING TELLS US

The modelling shows a requirement for eating disorder and perinatal inpatient beds to increase. Dedicated eating disorder beds are required to grow by 47 beds over ten years. Perinatal beds are required to grow by 20 beds over the same period (from the current eight beds at King Edward Memorial Hospital, to a total modelled need of 28 beds).

There is a need for dedicated beds for neuropsychiatry and neurosciences. This requirement can be met through a realignment of the existing beds and are within the overall modelled inpatient beds estimated by the end of 2025. There is also a requirement for expansion or establishment of specialised statewide community treatment services which includes:

- Eating disorder services
- Perinatal services
- Neuropsychiatry and Neurosciences
- Attention Deficit Hyperactivity Disorder (ADHD)
- Co-occurring mental illness and intellectual, cognitive or developmental disability (including autism spectrum) service
- Sexuality, Sex and Gender Diversity service
- Children in Care program
- Transcultural services
- Hearing and vision impaired
- Homelessness program.

STRATEGIES

ENHANCE YOUTH AND ADULT EATING DISORDERS SERVICES

Eating disorders are the 12th leading cause of mental health hospitalisation costs within Australia.[34] The window of opportunity for a successful outcome of treatment for an individual with an eating disorder begins to fade after three to four years, underscoring the importance of intervening early. Approximately 55 per cent of individuals treated for eating disorders in Western Australian public hospitals are aged 16 to 25.[35] The majority of these individuals access adult mental health services.

Currently, Western Australia does not have any dedicated public inpatient mental health services for individuals who have an eating disorder. The Plan articulates, as a high priority, the need to commission dedicated eating disorder inpatient beds and community teams.

The modelling shows a requirement of 47 eating disorder beds by the end of 2025. The eating disorder community treatment hours of service are included in the total modelled community treatment hours of service (see the *Community Treatment Services* section).

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

BUILD ON EXISTING PERINATAL SPECIALISED SERVICES

The Plan articulates a need to build on current services that assess women, provide treatment prior to giving birth, as well as providing specialised follow-up after discharge from inpatient care. The Plan requires that the perinatal service be complemented by the Women and New Born Drug and Alcohol Service (WANDAS) that provides inpatient and outpatient services, as well as the new Fiona Stanley Hospital eight bed mother and baby unit. Also, further capacity of WANDAS is required, across King Edward Memorial Hospital staff to provide alcohol and other drug assessment, treatment and referral for ongoing care through established pathways.

Together these services will up-skill the workforce to provide timely screening of women prenatal and postnatal.

The modelling shows a requirement of 28 perinatal inpatient beds by the end of 2025. The perinatal community treatment hours of service are included in the total modelled community treatment hours of service (see the *Community Treatment Services* section).

ESTABLISH APPROPRIATE NEUROPSYCHIATRY AND NEUROSCIENCES SPECIALISED SERVICES

Specialised neuropsychiatric treatment services are limited in Western Australia. The Plan requires that a dedicated statewide neuropsychiatry service be developed which offers a suite of specialised services for all age groups and disorders, including Huntington's disease and Parkinson's disease. The placement of a transcranial magnetic stimulation service, in close proximity to the deep brain stimulation and electroconvulsive therapy service will allow for the development of best practice across these similar and highly specialised treatment approaches.

The optimal service mix includes a specialised neuropsychiatric inpatient service and specialised statewide community service. Neuropsychiatry and neurosciences inpatient beds are modelled in the total hospital bed numbers (see the *Hospital-Based Services* section) and neuropsychiatry and neurosciences community treatment hours of service are included in the total modelled community treatment hours of service (see the *Community Treatment Services* section).

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

EXPAND ACCESS TO PUBLICLY FUNDED ATTENTION DEFICIT AND HYPERACTIVITY DISORDER SERVICES

In Western Australia, ADHD treatment for individuals up to 18 years of age is delivered largely through public services. Most services for adults (18+ years) with ADHD are delivered by privately practicing psychiatrists working with co-prescribing GPs. This presents challenges for youth transitioning from child and adolescent services. To address this need, the Plan requires the commissioning of a new specialised statewide youth and adult ADHD service which provides direct services to individuals with complex ADHD, and consultation and liaison to treatment and support services throughout the State.

The ADHD service is modelled in the total modelled community treatment hours of service (see the *Community Treatment Services* section).

ESTABLISH A SPECIALISED SERVICE TO MEET THE NEEDS OF PEOPLE WITH CO-OCCURRING MENTAL ILLNESS AND INTELLECTUAL, COGNITIVE OR DEVELOPMENTAL DISABILITY (INCLUDING AUTISM SPECTRUM)

Children with intellectual disability have three to four times higher rates of mental illness compared to other children.[36] The optimal mix includes a Statewide intellectual, cognitive and developmental disability service, to support and treat individuals with co-occurring mental illness. The service would also support mainstream services to respond effectively.

The statewide service is modelled in the total modelled community treatment hours of service (see the *Community Treatment Services* section).

ESTABLISH A SEXUALITY, SEX AND GENDER DIVERSITY SERVICE[xvii]

Services for people who require support with their gender identity have been identified as an area of need for future service delivery. Furthermore, all mental health services need to provide an environment that Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people who require support with their gender identity feel comfortable to access. The Plan articulates that the needs of LGBTI people and people who require support around their gender identity are required to be met through the establishment of a new service for youth and adults.

Along with the existing infant, child and adolescent team, these teams offer services to people who require support around their gender identity (including linking with endocrinology services where required), support mainstream services to provide responsive services through best practice policies, service models and workforce education and training.

Services for Sexuality, Sex and Gender Diversity requires resources in addition to the total modelled community treatment hours of service (see the *Community Treatment Services* section).

xvii National Lesbian, Gay, Bisexual, Transgender and Intersex Health Alliance – In its *Sex and Gender Diversity Project*, the Australian Human Rights Commission used the phrase "sex and gender diversity" as a celebration of and recognition of variations in sex and gender. This found resonance with large parts of the community, and we also use this where we can, expanding it to 'sexuality, sex and gender diversity', in order to be as inclusive as possible. Rather than trying to be entirely consistent, we try to mix use of this phrase with use of LGBTI and identity labels, depending on the context, to reflect the different preferences of our members. http://lgbtihealth.org.au/LGBTI.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

COMMISSION A CHILDREN IN CARE PROGRAM

There are approximately 4,300 children and adolescents in Western Australia who are currently in State care, many of whom will have experienced child abuse, neglect and cumulative trauma. A large proportion of this group will experience substantial mental health problems and others may be at high risk of short and long-term mental health, alcohol and other drug problems, educational failure, employment difficulties, juvenile offending, incarceration and homelessness.

Infants, children and adolescents who are in care can also have high rates of co-occurring problems, and as a consequence have a number of agencies involved in their care such as alcohol and other drug services, education, physical health providers, juvenile justice and homelessness services. As a result of these complexities a multi-agency approach is required. Without coordination, care can become fragmented, potentially perpetuating problems. If effective outcomes for children in care are to be achieved, interventions need to be intensive, coordinated and highly specialised.

Effective intervention for children in care is essential – not only to mitigate the devastating impact for children and adolescents who have experienced child abuse and neglect, but to reduce the overall significant financial and social costs that will accrue, as well as improving the outcomes for children in care.

Due to the critical need to improve services for children in care, we will aim to establish a specialised Children in Care program as a matter of urgency. The service will play a key role in early intervention, including in relation to preventing the harmful use of alcohol and other drugs. The service will see people up to the age of 18 years, except in the case of cognitive impairments, where an extension to the age limit will be considered on a case by case basis.

The Children in Care program requires resources in addition to the total modelled community treatment hours of service (see the *Community Treatment Services* section).

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

FURTHER DEVELOP TRANSCULTURAL MENTAL HEALTH SERVICES

Western Australia's population includes 15 per cent of residents who were born in non-English speaking countries.[47] People from Culturally and Linguistically Diverse (CALD) backgrounds may face particular barriers to accessing services, including language and cultural differences, past trauma and stigma.

To better meet the needs of the transcultural community, the optimal mix includes the expanding access to transcultural mental health services. This would involve increasing consultation and liaison to mainstream services, assist with access to multi-lingual information and services, and assist with the establishment of partnerships with local CALD services. In addition, the service would inform policy development, service modelling, and facilitate training to ensure all staff are competent in using interpreter services. It is expected the service will have the capability to meet the needs of people with co-occurring mental health, alcohol and other drug problems.

Transcultural community treatment hours of service will be in addition to those modelled in the total modelled community treatment hours of service (see the *Community Treatment Services* section).

ESTABLISH A HEARING AND VISION IMPAIRED SERVICE

Individuals with hearing and vision impairment are recognised to experience mental health problems[37] that can require specialised services. Services would be delivered by staff that have a particular interest, skills and knowledge in delivering services for people with hearing and/or vision impairment. It is expected the service will have the capability to meet the needs of people with co-occurring mental health, alcohol and other drug problems.

The hearing and vision impaired service is modelled in the total modelled community treatment hours of service (see the *Community Treatment Services* section).

EXPAND SPECIALISED HOMELESSNESS SERVICE CAPABILITY

As mentioned in the *Community Support Services* section, research indicates that mental health, alcohol and other drug problems rank high in factors related to homelessness.[21] An early priority is to ensure people who are homeless can access mental health, alcohol and other drug services as well as be supported to attain suitable accommodation if that is what they want to do. It is envisaged both in-reach to homelessness services and outreach will be required.

Homelessness services will be in addition to the total modelled community treatment hours of service (see the *Community Treatment Services* section).

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

ACTIONS

The actions for the specialised statewide services are detailed below.

IMPLEMENTING EXISTING COMMITMENTS:

- continue to develop specialised statewide inpatient services for perinatal (eight beds) at the Fiona Stanley Hospital.

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- establish specialised statewide inpatient services for:
  - Eating disorders (24 beds)
  - Neuropsychiatry and Neurosciences disorders.[xviii]
- commence establishment or enhance community-based specialised statewide services including:
  - Eating disorder services
  - Perinatal services
  - Neuropsychiatry and Neurosciences
  - Attention Deficit Hyperactivity Disorder (ADHD)
  - Co-occurring mental illness and intellectual, cognitive or developmental disability (including autism spectrum) service
  - Hearing and vision impaired.
- commence planning of community-based specialised statewide services including:
  - Sexuality, Sex and Gender Diversity service
  - Children in Care program
  - Transcultural services
  - Homelessness program.
- build on and improve programs such as Young People with Exceptionally Challenging Needs (YPECN) and People with Exceptionally Challenging Needs (PECN) to ensure people with multiple, high-level needs receive seamless, comprehensive treatment and support.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- continue to develop specialised Statewide inpatient services for:
  - Eating disorders (10 additional beds)
  - Perinatal (four additional beds)
  - Neuropsychiatry and Neurosciences disorders.[xviii]

BY THE END OF 2025, TO CONTINUE THE REFORM, MODELLING IDENTIFIES THE REQUIREMENT TO:

- continue to develop specialised statewide inpatient services for:
  - Eating disorders (13 additional beds)
  - Perinatal (eight additional beds)
  - Neuropsychiatry and Neurosciences disorders.[xviii]

xviii Bed number to be confirmed during business case development.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

Table 6: Summary of the *Plan Matrix*

STATE TOTAL	MEASURE	CURRENT	2017	2020	2025
Specialised Statewide Services (inpatient) ***	Beds (total)	8	40	54	75
Eating Disorders	Beds	–	24	34	47
Perinatal	Beds	8	16	20	28

*** 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).

– : Service is not available.

FORENSIC SERVICES

WHAT ARE FORENSIC SERVICES?

Forensic services aim to prevent people with severe mental health, alcohol and other drug problems becoming involved in the criminal justice system. Where people require services, forensic services provide treatment and support at all stages through the criminal justice system (equivalent services to that available to the general community).

The Plan endorses the *National Statement of Principles for Forensic Mental Health* (2006),[38] which were developed by the Mental Health Standing Committee and endorsed by the Australian Health Minister's Conference (2002) and Correctional Services Ministerial Council (2007). Thirteen principles guide planning and provision of forensic mental health services:

1. Equivalence to the non-offender
2. Safe and secure treatment
3. Responsibilities of the health, justice and correctional systems
4. Access and early intervention
5. Comprehensive forensic mental health services
6. Integration and linkages
7. Ethical issues
8. Staff: knowledge, attitudes and skills
9. Individualised care
10. Quality and effectiveness
11. Transparency and accountability
12. Judicial determination of detention/release
13. Legal reform/issues.

Compared to the general community, the prevalence of mental health issues is higher at every stage of the criminal justice process. Internal modelling shows that approximately 65 per cent of the juvenile and 59 per cent of the adult prison population have mental health problems.[5]

Co-occurring mental illness and substance use is also a major issue in Western Australian prisons. A 2015 Western Australian study[39] showed that 52.9 per cent of adult female prisoners had a co-occurring mental illness and substance use disorder, which compared to 37.9 per cent of adult male prisoners.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

A 2012 Western Australian whole-of-population study on prevalence of mental illness and substance misuse in the criminal justice system found that during the study period:

- the prevalence of arrest for people with any psychiatric illness was 32.1 per cent
- the highest arrest prevalence, by diagnostic category, was for substance use disorders (59.4 per cent).[40]

Further, a Forensicare review in 2008 suggests that for prisoners and offenders appearing before the courts in Western Australian more than 80 per cent had substance abuse issues.[41]

Compared to the general community, individuals in the criminal justice system also differ demographically, for example, there are:

- disproportionally high numbers of young men (median age is 33 years)
- small numbers of women and young people
- a large over-representation of Aboriginal people
- high rates of mental illness, problematic alcohol and other drug use, personality disorder, and cognitive impairment.

When people come into contact with the criminal justice system, there is an opportunity for mental health, alcohol and other drug services to engage them in treatment and support. This is particularly the case for people who may not otherwise access services. This provides an opportunity for individuals to potentially break the cycle of moving in and out of prison, and gives them the best chance of recovering and staying well in the community. Untreated mental health, alcohol and other drug problems may lead to longer time spent in custody, and may exacerbate existing problems.

Intervening early, preventing imprisonment and hospitalisation, and decreasing the length of stay for those hospitalised can also provide a cost benefit. Reduced criminalisation and community incidents leading to arrests allow forensic mental health authorities to divert individuals away from the criminal justice system and decrease imprisonment time. One study has demonstrated that for every dollar spent on early intervention, a saving of $1.40-$2.40 in Government cost is made.[42]

Within the criminal justice system there are some groups that require special consideration in the development and the method of delivery of forensic services, including:

- women
- young people
- Aboriginal people
- people from CALD backgrounds
- those with co-occurring alcohol and other drug problems
- individuals with intellectual and other cognitive disabilities
- mentally impaired accused.

Various stakeholders must be involved in the planning, commissioning and delivery of forensic mental health, alcohol and other drug services. These include the Mental Health Commission, the Disability Services Commission, the Department of Health, the Department of Corrective Services, Western Australian Police, the Department of the Attorney General, the Department of Training and Workforce Development, the Department of Education, the Department of Housing, the Department of Child Protection and Family Services, non-government organisations, consumers, carers, families and other stakeholders.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

It is imperative that forensic mental health, alcohol and other drug services are standardised across Western Australia, with standard models of care developed for all prison, community and inpatient services. Whilst facilitating standardisation, the models of care will also support implementation to meet local and regional needs and address factors such as service availability, population profile, diversity and cultural factors.

AIM

Build a comprehensive, responsive, effective and efficient forensic service system that:

- prevents individuals with mental health, alcohol and other drug problems coming into contact with the criminal justice system
- provides diversion, treatment and support across the service spectrum for those who do come into contact criminal justice system
- provides increased safety for prison staff and the general community.

CURRENT SERVICES

CURRENT LEGISLATION AND MENTAL IMPAIRMENT

The *Criminal Law (Mentally Impaired Accused) Act 1996* (CLMIA Act) outlines how individuals who are mentally impaired accused move through the criminal justice system. Mentally impaired accused are defined as individuals charged with a criminal offence but who are either not guilty due to unsoundness of mind, or who are mentally unfit to stand trial. For the purposes of the CLMIA Act, mental impairment includes mental illness, intellectual disability, brain damage and senility.

The legislation creates custody orders, which authorise the indefinite detention of a mentally impaired accused person at the discretion of the Governor. A person subject to a custody order must be detained in a prison or juvenile detention centre; an authorised hospital (if he or she has a treatable mental illness); or in a declared place. A declared place is defined as an authorised place that is neither an authorised hospital nor a prison or juvenile detention centre. The place of residence in Western Australia is a matter for the Mentally Impaired Accused Review Board, a quasi-judicial body established under the legislation. The CLMIA Act is currently being reviewed by the Attorney General.

When a mentally impaired accused person is detained in an authorised hospital, his or her treatment and care is subject to various provisions of Western Australia's civil mental health legislation, the *Mental Health Act 1996.* For example, mentally impaired accused persons may be provided with treatment without consent and are entitled to advocacy support from the Council of Official Visitors. The *Mental Health Act 2014* builds on these provisions by making the treatment and care of mentally impaired accused persons subject to new requirements in areas such as discharge planning and mandatory reporting.

SERVICES

The Frankland Centre at Graylands Hospital was commissioned in 1993 with 30 acute forensic inpatient beds. In 1995, a further eight subacute forensic inpatient beds were commissioned at Graylands Hospital, with daily prison muster numbers reflecting 2,197 in the same year.[43]

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

Since this time, no further forensic inpatient beds have been commissioned in the State, however, prison muster numbers are increasing and were at 4,956 people in 2013 (see Table 7). The planning for decommissioning of Graylands Hospital services (see page 70) will involve consideration of the future of forensic services on the site.

Currently, there are no dedicated services for women or young people in the forensic services system. Women and young people who require specialised mental health treatment are admitted to the Frankland Centre, which is not purpose-built to cater for the mix of gender and age cohorts.

A range of alcohol and other drug diversion programs are currently delivered across the State, including police diversion programs for the possession of small amounts of illegal drugs and court diversion programs for people with alcohol and other drug problems. Alcohol and other drug diversion programs aim to divert offenders with drug related problems into treatment to break the cycle of offending and to address their alcohol and/or other drug use. The Western Australian Diversion Program consists of a number of police and court based programs that provide brief early intervention sessions to more intensive, supervised programs.

Police drug diversion has an early intervention focus by providing access to education and treatment services. Court diversion programs are voluntary and offer the offender the opportunity to engage in treatment programs prior to sentencing. Those offenders with previous convictions for sexual offences, drug trafficking, offences with a high level of violence or are facing a mandatory prison sentence are not eligible.

A Mental Health Court Diversion and Support pilot program has been operating in the Perth Magistrates Court and the Perth Children's Court since early 2013. The pilot program provides a tailored response to offending behaviour that is linked to a mental health problem. Program participants are supervised by a court while they receive treatment and support that addresses the underlying causes of their offending behaviour.

The pilot program comprises an adult program, the Start Court, and a children's program, Links. The Start Court is a specialist mental health court operated by dedicated judicial, legal, court and clinical staff. Links is a small team that provides clinical and psychosocial support to the Perth Children's Court. The pilot program is not supported by dedicated legislation.

Table 7: Forensic services: beds and daily average prison muster numbers[43]

	1995	1998	2003	2008	2013
Forensic Inpatient Beds	38	38	38	38	38
Prison Muster	2,197	2,388	2,915	3,824	4,956
Beds per 1,000 head prison muster	17.3	15.9	13.0	9.9	7.7

Instead, existing provisions of the *Bail Act 1982* enable program participants to receive treatment and support in the community. Participation is on a strictly voluntary basis.

Originally funded until 30 June 2014, the pilot has twice been extended and is now funded until 30 June 2016. Decisions regarding the program's long-term future will be informed by an ongoing evaluation process.

There are currently no declared places for mentally impaired accused persons who are detained under the CLMIA Act. However, construction has commenced on a 10-bed Disability Justice Centre[44] in Caversham for mentally impaired accused persons who have an intellectual or cognitive disability.[xix] This secure, state-of-the-art facility will provide an appropriate alternative to prison for some of the most vulnerable members of our community. While the Disability Justice Centre will not cater for people whose mental impairment is predominantly caused by mental illness, it does provide a possible model for future service developments and will be closely monitored by the Mental Health Commission.

WHAT THE MODELLING TELLS US

FRAMEWORK

The national modelling tools used to develop the Plan do not include the provision for modelling forensic services. To account for this, the forensic services required for Western Australia were developed jointly by the Mental Health Commission, the former Drug and Alcohol Office, the Department of Health, and the Department of Corrective Services, in extensive consultation with the Forensic Mental Health Planning Group, Forensic Mental Health Expert Reference Group, Consumer, Carer and Family Workshops, and the former Drug and Alcohol Office Treatment and Support Expert Reference Group.

These groups worked collaboratively to determine the services required for the range of forensic settings in Western Australia (see Figure 9 below, and Table 9 on pages 89-91).

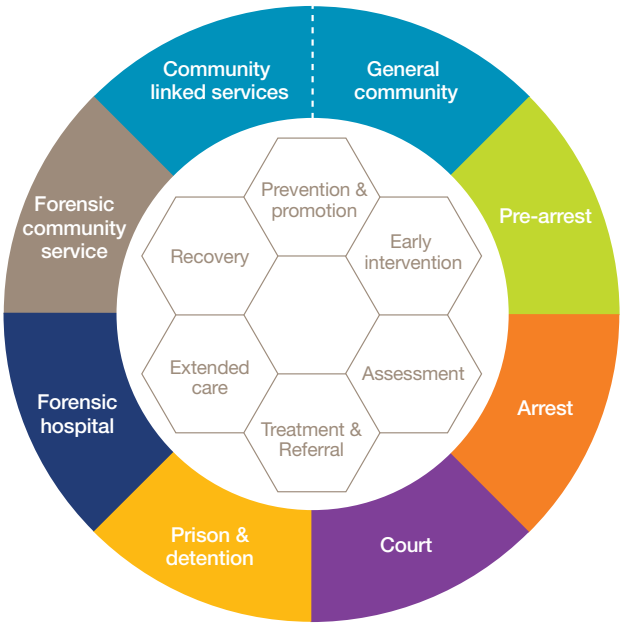


Figure 9: Range of forensic settings

xix Cognitive disability is usually associated with a brain injury or neurological condition. It can be understood as the combination of a range of cognitive impairments that lead to a severe and enduring functional disability.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

AGE COHORTS

Due to the nature of the criminal justice system, the age cohorts differ to the age cohorts proposed for all other service streams within the Plan. The age cohorts in the forensic service stream are as follows:

Table 8: Service streams by age cohort for mental health services

AGE COHORTS	OTHER MENTAL HEALTH SERVICE STREAMS	FORENSIC (COMMUNITY SERVICES)	FORENSIC (IN-PRISON AND INPATIENT* SERVICES)
Infant, Child and Adolescent	0-15 years	10-15 years**	N/A
Juvenile	N/A	N/A	10-17 years**
Youth	16-24 years	16-24 years	N/A
Adult	25-64 years	25-64 years	18-54 years
Older Adult	65+ years	65+ years	55+ years

* note that the viability for the inpatient service age cohorts will be dependent on relevant legislation at the time of establishment of the service.

** note that the statutory minimum age of criminal responsibility is 10 years.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

SERVICE TYPES

Table 9: Forensic services

Early intervention/ prevention	**1. Prevention** **2. General community services**	1. Preventing mental health, alcohol and other drug problems, through the development of the prevention plan (see the *Prevention* section in the Plan). 2. Accessibility to general services throughout the community, including early intervention (refer to all service streams in the Plan).	1. Included in the *Prevention* section modelling. 2. Included in modelling for all sections in the Plan.
Pre-arrest police Liaison/ support	**Police co-response**	A police and mental health co-response program will provide a coordinated response by mental health services and police for people experiencing a mental health crisis in the community (see the *Community Treatment Services* section of the Plan). Once established and running effectively, consideration will be given to how the police co-response program can incorporate appropriate responses to police call-outs relating to alcohol and other drug problems.	Included in *Community Treatment Services* modelling.
Arrest/ police Lock-Up	**1. Police Drug Diversion** **2. Mental health, alcohol and other drug in-reach into police lock-ups**	1. This has an early intervention focus by providing access to education and treatment services. 2. Providing mental health, alcohol and other drug assessment on arrival, and subsequently liaising with family and carers, relevant services, and other elements of the criminal justice system.	Included in forensic community hours of service modelling.
Court Liaison and support	**Court Diversion**	These programs are voluntary and pre-sentence and offer the opportunity to engage in treatment programs prior to sentencing.	Included in forensic community hours of service modelling.

Table 9: Forensic services (continued)

	SERVICE	DESCRIPTION	MODELLING
Prison and Detention	**1. In-prison community treatment** **2. In-prison subacute beds** **3. Declared places**	1. In the general prison areas, staff provide assessment, planning treatment and evaluation for people in a custodial environment with co-occurring mental health, alcohol and other drug problems and offending behaviours. Prison medical and nursing staff support opioid pharmacotherapy to ensure continuing treatment for people prescribed methadone or buprenorphine entering prison and on their release as well as providing methadone maintenance whilst in prison. 2. Staff provide the same services as outlined in point one above, however are located in a dedicated subacute bed service within a prison. People would transition to these beds either from the forensic inpatient unit or from the general beds within a prison (as these people are too unwell to remain within the general prison population). This service would be similar to the community subacute step-up, step-down beds identified in the *Community Bed-Based Services* section of the Plan. 3. Alternatives to prison and hospital for mentally impaired accused persons with a mental illness who are subject to a custody order under the *Criminal Law (Mentally Impaired Accused) Act 1996.* Such services may be similar to the in-prison subacute beds outlined in point two above, but would be situated in the community. Community safety will be a paramount consideration in the development and design of declared places.	Included in forensic in-prison modelling.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

Table 9: Forensic services (continued)

	SERVICE	DESCRIPTION	MODELLING
Specialised forensic mental health inpatient	**1. Forensic mental health acute inpatient beds** **2. Forensic mental health subacute inpatient beds**	1. These beds are authorised to provide secure mental health care for people within the criminal justice system on special orders. These beds provide specialist multidisciplinary forensic mental health care including close observation, assessment, evidence-based treatments, court reports and physical health care. 2. Forensic subacute inpatient beds are for those people who may have been in an acute forensic inpatient bed and are awaiting discharge back into the community or back to prison. People in this service are likely to be there due to a special order.	Included in forensic inpatient modelling.
Specialised forensic mental health community treatment	**Mental health, alcohol and other drug community services**	These services provide acute and recovery focused forensic mental health services delivered in the communities in which people live, including specialist assessment and evidence-based treatments, for people with a mental health problem involved in the criminal justice system. This includes treatments for people who are: out of prison and out of hospital on special orders within the community; transitioning between forensic community services and general community services; or transitioning out of prison and into the community.	Included in forensic community hours of service modelling.
Community Linked Services	**1. Accommod-ation** **2. Community Beds**	1. Appropriate and accessible accommodation and housing options for people with mental health, alcohol and other drug problems who have come into contact with the criminal justice system. See *Community Support Services* section of the Plan. 2. Accessible community beds that are predominantly delivered by general mental health services and can accommodate people who have been in contact with the criminal justice system. This can involve in-reach from forensic community treatment mental health services.	1. Included in *Community Support* modelling. 2. Included in the *Community Bed-Based Services* modelling.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

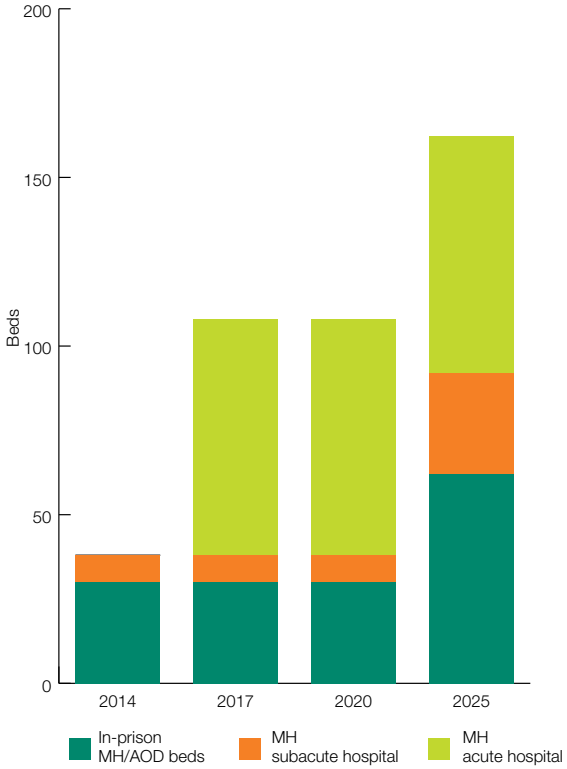
MODELLING

The forensic service modelling across the service spectrum is explained in Table 9 on the previous page.

FORENSIC INPATIENT AND IN-PRISON

This section outlines the modelled requirement for inpatient, and in-prison bed services. In-prison community treatment is required for those prisons that do not have dedicated in-prison subacute beds. The resource requirement for in-prison community treatment will be in addition to those modelled in the *Forensic Services* section of the Plan.

The current number of forensic inpatient beds in the State is less than half what it should be in order to meet demand in 2014. Figure 10 adjacent outlines the beds required to establish a comprehensive forensic service system, both in-prison and in hospital. The current mental health forensic inpatient beds are required to grow from 30 acute and eight subacute, to 62 acute and 30 subacute, by the end of 2025. The in-prison subacute beds are required to grow from a base of zero beds, to 70 beds by the end of 2025.



MH = Mental Health
AOD = Alcohol and Other Drug

Figure 10: Forensic bed-based services

Dedicated inpatient forensic mental health facilities are required urgently, to replace the inadequate conditions and bed numbers currently provided at the Frankland Centre (on the Graylands site).

Declared places are urgently required in the community for mentally impaired accused persons. The number required would be in addition to the in-prison and inpatient beds outlined above. Further modelling work is required to ascertain the current and future demand.

FORENSIC COMMUNITY HOURS OF SERVICE

Forensic community hours of service includes the modelled resource requirement for (as per table three):

- police drug diversion
- mental health, alcohol and other drug in-reach into police lock-ups
- court diversion
- mental health, alcohol and other drug community services.

In relation to forensic community services, the hours of service for alcohol and other drugs are required to grow from 50,000 hours to 163,000 hours, whereas the mental health community hours are required to grow from 33,000 to 140,000 hours, by the end of 2025.

STRATEGIES

BOOST EARLY IDENTIFICATION AND PREVENTION PROGRAMS TARGETING PEOPLE AT RISK OF BECOMING INVOLVED IN THE CRIMINAL JUSTICE SYSTEM

Prevention

It is intended that prevention is undertaken in a two-pronged approach:

1. Enhance general prevention programs, and increasing access to general mental health, alcohol and other drug services
2. Establishing forensic-focused prevention programs, and early identification and intervention.

The first approach refers to increasing general prevention strategies, as well as access to mental health, alcohol and other drug treatment and support services. The aim is to reduce the number of people developing mental health, alcohol and other drug problems; and ensure those who do have a mental health, alcohol and other drug problem have adequate access to appropriate services that can intervene early, enhance health and wellbeing and prevent deterioration of illness, thereby preventing offending behaviours.

The second approach refers to establishing forensic-focused prevention programs aimed at preventing those with a mental health, alcohol and other drug problem from becoming involved in the criminal justice system. Further work to establish an evidence-base for this work is required. This approach also includes the early identification and intervention of people with mental health, alcohol and other drug problems in the criminal justice system.

Early Identification and Intervention

Early identification and intervention is essential to reduce the risk of individuals coming in contact with the criminal justice system. Evidence-based programs can include police diversion programs, the provision of mental health, alcohol and other drug assessment in police lock-ups, and other services where required. A mental health police co-response program is discussed in further detail in the *Community Treatment Services* section. Continued expansion of mental health, alcohol and other drug court diversion and liaison programs is also important.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

Following an initial trial and evaluation in the metropolitan area, we aim to expand the alcohol diversion program to regional areas in Western Australia. The optimal mix includes an increase in referral pathways for young people with other drug problems through the Young People's Opportunity Program. Consultation and planning needs to be undertaken with CALD and Aboriginal communities to improve access to diversion programs.

ESTABLISH DEDICATED FORENSIC SERVICES FOR YOUNG PEOPLE

Dedicated forensic services for young people are a high priority, in particular prevention and early intervention programs, specialised assessment, liaison with mainstream services, in-reach to police lock-ups, community forensic services, forensic inpatient services, in-reach to juvenile detention centres, community correction programs, and transition care (between the detention centre and community).

The provision of forensic best practice interventions, tailored for young people, provides the best chance of reducing future contact with the criminal justice system. We aim to progress these priorities in partnership with the Department of Corrective Services. Please see page 88 for information on forensic service age cohorts.

SIGNIFICANTLY INCREASE THE PROVISION OF CONTEMPORARY MENTAL HEALTH, ALCOHOL AND OTHER DRUG SERVICES FOR PEOPLE IN PRISONS AND DETENTION

As previously mentioned, people in contact with the criminal justice system should receive mental health, alcohol and other drug services equivalent to services available to the community, with due regard to community safety. With this in mind, an increase in contemporary in-prison services is urgently required, including dedicated in-prison mental health, alcohol and other drug subacute beds for men and women, and in-reach community treatment type services.

Consideration may be given to the establishment of a therapeutic community within the prison system for prisoners who have had significant alcohol and other drug problems and commit to their own recovery. If implemented, the program would be provided in a separate area of the prison during the three to six months prior to release. The program could be self-catering and include support to develop life skills, and therapeutic groups such as anger management and impulse control. A discharge plan would build on the program and support transition post release and may be linked to parole conditions.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

The models of service for all in-prison services would be developed in partnership with the Department of Corrective Services, as well as other key stakeholders (including service providers). In addition, transfer of service purchasing responsibility for mental health, alcohol and other drug prison based services will be moved to the Mental Health Commission. It is imperative that the management of the in-prison beds is undertaken in a flexible way, to ensure cultural security, and to cater for the needs of Aboriginal people as required. Progression of in-prison subacute services will be undertaken as an early priority.

EXPAND FORENSIC HOSPITAL SERVICES TO MEET THE NEEDS OF THE GROWING POPULATION

Modelling suggests a significant increase in hospital forensic services is urgently required, however detailed planning and delivery for such a project requires considerable time. The modelling shows that a 92-bed forensic inpatient facility is required by the end of 2025. Of this, 62 beds will be acute and 30 beds will be subacute, containing dedicated places for men, women, young people and Aboriginal people.

Over the next ten years we aim to develop this 92-bed inpatient service, which would replace the current 38 beds at Graylands Hospital. The new services will need to be established before the phased closure of forensic beds at Graylands Hospital. Detailed transition planning will occur to ensure costs of dual site operations are at a minimum. Further work is required regarding the location of this service, with an option being a contemporary service on the Graylands site.

ESTABLISH APPROPRIATE COMMUNITY-BASED SERVICES, AND TRANSITION SERVICES FOR INDIVIDUALS TRANSITIONING FROM PRISON TO THE COMMUNITY

Services such as community treatment and support services, and stable accommodation and housing options are required to be enhanced to provide individuals with the best opportunity to reintegrate successfully into the community. Forensic community services may also provide long-term case management for high risk offenders. Further, these services can help individuals transition from community forensic services to non-forensic (mainstream) services, as required on a case by case basis.

A community-based forensic problem behaviour clinic and programs which target sex offenders, violent extremism, arson, and stalking are also required for the State. Further work is required in determining the quantity of services, types of programs, and models of service. This will be undertaken in collaboration with key stakeholders including service providers, clinicians, consumers, families and carers.

Ensuring effective transition services are in place prior to an individual leaving prison is important for future outcomes. The first six months after release from prison is a particularly vulnerable period of transition, as it is known that mortality and morbidity are very high. Transition services would work with individuals prior to release and onwards in relation to connecting the individuals with the services and accommodation/housing required, coordinating community referrals, developing effective partnerships between prisons and other agencies, and coordinating ongoing peer support.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

It is important that these initiatives are progressed in partnership with the Department of Corrective Services, Department of Health, Department of Housing, other service providers, consumer, families and carers – particularly in the development of models of service.

IMPLEMENT TRAINING INITIATIVES FOR ALL NON-MENTAL HEALTH, ALCOHOL AND OTHER DRUG FRONTLINE STAFF INCLUDING POLICE, CORRECTIONS OFFICERS, COURT OFFICERS, MAGISTRATES AND OTHERS

The need for improved training of non-mental health, alcohol and other drug frontline staff has been identified by a range of stakeholders, including consumers, families and carers. Delivering comprehensive training to frontline staff such as police, corrections officers, court officers, magistrates and others will aid in their understanding of people who have a mental health, alcohol or other drug problem. It will also aid in the delivery of the criminal justice services, developing forensic mental health, alcohol or other drug services, and with regard to mentally impaired accused.

ENCOURAGE INTERSECTORIAL COLLABORATION AND SUPPORT CAPACITY BUILDING TO DEVELOP AND MAINTAIN A WELL-TRAINED AND INFORMED FORENSIC WORKFORCE

Achieving a reduction in mental illness, and alcohol and other drug use and harm is a significant challenge and can only be achieved by collaborative partnerships across government, non-government and community organisations. Services need to be streamlined and provide a cohesive approach that reduces relapse and further re-offending. Development of a high-level agreement between government agencies, including the Department of Corrective Services, the Western Australia Police, the Department of Health and the Mental Health Commission will support intersectorial collaboration and guide strategies, responsibilities, monitoring and evaluation.

The Plan indicates there is a need for positions that have a specialist role in co-occurring mental health, alcohol and other drug treatment and support. These workers can provide consultancy to others in the service system, but more importantly, all the workforce (including the forensic workforce) needs to have the capability to provide services for people with co-occurring problems.

Strategies to secure and support the current forensic workforce include expanding system-wide supports, implementing quality service provision, and articulating clear workforce standards.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

REVIEW THE *CRIMINAL LAW (MENTALLY IMPAIRED ACCUSED) ACT 1996*, AND ESTABLISH A DEDICATED FACILITY IN THE COMMUNITY FOR PEOPLE WITH A MENTAL ILLNESS WHO ARE MENTALLY IMPAIRED ACCUSED

As noted on page 85, the CLMIA Act is currently being reviewed by the Attorney General. The review is considering how the legislation can better support the rights and rehabilitation of mentally impaired accused persons while maintaining community safety. The views of stakeholders from within the mental health sector, including clinicians, consumers, families, carers and service providers, are being actively considered through the review process. It is anticipated that the review will be completed by the end of 2017.

In the absence of declared places, mentally impaired accused persons who are subject to a custody order must be detained in either an authorised hospital or a prison. Neither is satisfactory as a long-term place of detention for people who are mentally impaired accused. The availability of inpatient beds is essential, and is provided for under this Plan, but hospitalisation that is not clinically justified is unconducive to recovery and imposes unnecessary costs on the forensic mental health system. Imprisonment is problematic because it can exacerbate mental ill-health and involves imposing what is effectively a criminal sanction on individuals who, by definition, have not been found guilty of the offence or offences with which they have been charged.

In most Australian states mentally impaired accused persons with mental illness are treated in secure forensic hospitals, however, in Western Australia many are detained in prison. The *United Nations Standard Minimum Rules* for the treatment of prisoners states unequivocally that prisoners found not guilty by reason of unsoundness of mind should not be detained in prison. Very few custody orders are made in Western Australia compared with other States: there has been an average of three per year since 2008.[45] In 2013-14, a total of 39 mentally impaired accused persons were on custody orders: 18 in prison; 10 were in hospital; seven in the community; and four interstate. Twenty seven of these mentally impaired accused persons had a diagnosis of mental illness; seven had intellectual impairment; and five had a dual diagnosis of a combined intellectual impairment and mental illness.[45]

These issues point to the need for alternative options for accommodating mentally impaired accused persons who have a mental illness. The establishment of a dedicated facility (or declared place) in the community for mentally impaired accused with a mental illness is imperative, and should aim to promote the rehabilitation of mentally impaired accused persons while maintaining community safety. The Disability Justice Centre in Caversham provides a model that could potentially be adapted to the needs of persons with a mental illness. The specifications of this type of facility will be partially informed by the outcomes of the review of the CLMIA Act, and will be developed in collaboration with key stakeholders, clinicians, consumers, families and carers.

ACTIONS

The actions regarding forensic services are detailed below. For further information please refer to the *Plan Matrix* on page 105.

IMPLEMENTING EXISTING COMMITMENTS:

- progress the State Government's 2013 election commitment to deliver mental health adult and children court diversion
- complete the evaluation of the Mental Health Court Diversion programs.

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- research an evidence-base and establish forensic focused prevention programs which reduce the risk of individuals coming into contact with the criminal justice system
- increase mental health community forensic treatment services from 33,000 to 84,000 hours of service, with a focus on in-reach services for police lock-ups, police diversion, case management, and transition services for people moving from prison to community
- develop comprehensive training requirements for non-mental health, alcohol and other drug frontline staff including police, corrections officers, court officers, magistrates and others
- commence development of a 70 bed in-prison dedicated mental health, alcohol and other drug service for men and women
- further develop in-prison mental health, alcohol and other drug treatment and support services for men, women and young people
- work with the Department of Corrective Services to develop models of service for in-prison treatment and support services and move service purchasing responsibility to the Mental Health Commission
- complete the review of the *Criminal Law (Mentally Impaired Accused) Act 1996*
- complete the planning of 92-bed secure forensic inpatient unit (including specific places for men, women, young people and Aboriginal people)
- work with the Department of Corrective Services to develop core capabilities and workforce standards for mental health, alcohol and other drug service provision across the forensic system.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- continue to develop in-prison mental health, alcohol and other drug treatment and support services for men, women and young people
- increase mental health community forensic treatment services from 84,000 to 112,000 hours of service
- expand the Mental Health Court Diversion and Liaison program subject to the outcomes of the current evaluation
- expand alcohol and other drug diversion (community) services from 50,000 to 94,000 hours of service
- establish a specialised forensic community-based clinic and programs for people with problem behaviours, targeting sex offenders, violent extremism, arson, and stalking

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

- commission a facility in the community for mentally impaired accused persons with a mental illness, which is an appropriate alternative to prison and hospital
- establish positions that have a specialist role in co-occurring mental health, alcohol and other drug treatment and support to support capacity building across the forensic mental health, alcohol and other drug system.

BY THE END OF 2025, TO CONTINUE THE REFORM, MODELLING IDENTIFIES THE REQUIREMENT TO:

- open 92-bed secure forensic inpatient unit with 62 acute and 30 subacute beds, including specific places for men, women, young people and Aboriginal people
- further expand alcohol and other drug diversion (community) services from 94,000 to 163,000 hours of service
- increase mental health community forensic treatment services from 112,000 to 140,000 hours of service.

Table 10: Summary of the *Plan Matrix*

STATE TOTAL	MEASURE	CURRENT	2017	2020	2025
Forensic Services	Beds (total)	38	38	38	92
	Hours ('000) (total)	83	134	206	302
MH Acute Hospital	Beds	30	30	30	62
MH Subacute Hospital	Beds	8	8	8	30
MH Community	Hours ('000)	33	84	112	140
AOD Community (Diversion)	Hours ('000)	50	50	94	163
Forensic Services (in-prison)	Beds (total)	–	70	70	70
In-prison MH/AOD	Beds	–	70	70	70

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug
– : Service is not available.

ACUTE AND SPECIALISED CARE FOR THOSE WHO NEED IT

Declared places are urgently required in the community for mentally impaired accused persons.

SERVICES BY REGION

SERVICES BY REGION

KEY INFORMATION ABOUT REGIONS

This section provides information on mental health, alcohol and other drug services required for each region of Western Australia. The modelling which underpins the Plan has been undertaken according to the population in given geographical regions, including:

- North Metropolitan
- South Metropolitan
- Northern and Remote comprising of:
  - Goldfields
  - Kimberley
  - Pilbara
  - Midwest
- Southern Country comprising of:
  - Great Southern
  - South West
  - Wheatbelt.

POPULATION FACTS

Overall, the population in all regions is expected to increase between now and 2025, however, the population in the metropolitan area will increase at a higher rate than all regions (with the exception of the South West), in which case the percentage of the population residing in the regions will fall compared to 2014. Population forecasts show that the North Metropolitan area is expected to stay constant at 41.5 per cent of the population, the South Metropolitan area is expected to increase to 38.4 per cent, and the South West is expected to increase to 7.3 per cent. All other regions will have a decline in the percentage of total population residing there.[46]

The Aboriginal population in each region is expected to increase, however the percentage of the total Aboriginal population residing the areas is forecast to change over time. For example, the North Metropolitan, South Metropolitan, Wheatbelt and South West are all expected to have an increased percentage of the total Aboriginal population residing in those regions. The Great Southern and Midwest regions are expected to stay constant, with the Kimberley, Pilbara and Goldfields declining. The South Metropolitan area is forecast to overtake the Kimberley region by 2025 with regards to the geographical area with the highest percentage of the total Aboriginal population (21.0 per cent and 20.7 per cent respectively).[47] It is forecast that by 2025, Aboriginal people will represent 3.76 per cent of Western Australia's total population.[47]

SERVICES BY REGION

During the consultation process for the Plan, people in regional areas raised a range of issues and priorities, including:

- a need for a greater level of detail about services for their particular region
- culturally secure services and programs for Aboriginal people
- the high proportion of children and young people in some areas and the need for early intervention
- challenges regarding transport and geographical distance.

It is forecast that by 2025, Aboriginal people will represent 3.76 per cent of Western Australia's total population.

SERVICES BY REGION

THE *PLAN MATRIX*

Predicated on the national modelling tools (*National Mental Health Service Planning Framework*; and the *National Drug and Alcohol Service Planning Model,* see Appendix D*)*, the *Plan Matrix* details the service types, levels and locations required in Western Australia by the end of 2025, based on population, demand and prevalence. These requirements have been further prioritised across three time horizons: by the end of 2017; by the end of 2020; and by the end of 2025 (further detail on the prioritisation process is included in the: *A Partnership Approach to Implementing Reform* section).

Exact locations and distributions of services will be determined by a combination of consultation processes and the assessment of relative feasibility to deliver the service. For example, if the modelling identifies one bed in a region, consideration will be given as to how that can be adapted or combined with other service types for the practicalities of service delivery in order to successfully and efficiently commission the services required for the region.

The modelling tools' output is provided in hours of service, hours of support or bed numbers; however, these are considered a proxy for the levels of service that will be provided in any given location.

The modelled output does not specify the model of service or the service provider. In consultation with key stakeholders (including consumers, carers and families), models of service will be developed to achieve a degree of standardisation throughout the State. This will enable a consistent standard of service provision, however, this must be balanced with the key aim of personalisation to meet individual needs and adaptability to meet local area characteristics (including service availability, population profile, diversity and cultural factors).

THE PLAN MATRIX

SERVICE TYPE		STATE TOTAL				STATEWIDE SERVICES				GRAYLANDS				NORTH METROPOLITAN				SOUTH METROPOLITAN				NORTHERN AND REMOTE								SOUTHERN COUNTRY						
																						NORTHERN AND REMOTE TOTAL				GOLDFIELDS	KIMBERLEY	PILBARA	MIDWEST	SOUTHERN COUNTRY TOTAL				GREAT SOUTHERN	SOUTH WEST	WHEATBELT
		Current	2017	2020	2025	Current	2017	2020	2025	Current	2017	2020	2025	Current	2017	2020	2025	Current	2017	2020	2025	Current	2017	2020	2025	2025	2025	2025	2025	Current	2017	2020	2025	2025	2025	2025
Prevention	Hours ('000) (total)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	–	3	3	3	–	7	7	7	12	23	38	42	10	12	9	10	2	16	31	33	10	12	10
MH *	Percentage	1%	2%	4%	5%	1%	2%	4%	5%	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
AOD	Hours ('000)	66	108	192	208	52	59	112	122	n/a	n/a	n/a	n/a	–	3	3	3	–	7	7	7	12	23	38	42	10	12	9	10	2	16	31	33	10	12	10
Community Support Services	Hours ('000) (total)	859	1,687	3,438	5,600	2	2	42	60	n/a	n/a	n/a	n/a	n/av	515	1,299	2,120	n/av	485	1,223	1,997	n/av	326	415	672	142	182	157	191	n/av	360	459	751	143	425	182
	Beds (total)	168	178	205	205	–	–	–	–	n/a	n/a	n/a	n/a	14	14	17	17	–	–	12	12	154	164	176	176	18	84	46	28	–	–	–	–	–	–	–
MH	Hours ('000)	842	1,661	3,171	5,286	–	–	–	–	n/a	n/a	n/a	n/a	n/av	505	1,212	2,021	n/av	477	1,145	1,908	n/av	320	384	639	133	173	149	184	n/av	359	431	718	138	406	175
AOD (Harm-reduction and personal support)	Hours ('000)	5	5	225	258	2	2	42	60	n/a	n/a	n/a	n/a	2	2	73	79	2	2	65	71	–	–	23	23	5	6	6	6	–	–	23	24	5	14	6
AOD (Post Residential Rehabilitation)	Hours ('000)	12	21	41	57	–	–	–	–	n/a	n/a	n/a	n/a	4	8	14	21	3	6	13	18	5	6	9	9	4	3	2	1	–	1	5	8	1	6	1
AOD (Safe places for intoxicated people)	Beds	168	178	205	205	–	–	–	–	n/a	n/a	n/a	n/a	14	14	17	17	–	–	12	12	154	164	176	176	18	84	46	28	–	–	–	–	–	–	–
Community Treatment Services	Hours ('000) (total)	2,713	3,302	4,307	5,820	–	–	–	–	n/a	n/a	n/a	n/a	1,235	1,396	1,705	2,241	901	1,142	1,494	2,095	288	359	530	738	153	205	181	199	290	406	578	745	139	427	179
MH Infant, Child and Adolescent	Hours ('000)	373	747	1,170	1,560	–	–	–	–	n/a	n/a	n/a	n/a	149	298	441	588	149	298	422	563	32	65	161	215	45	63	52	55	43	85	145	194	35	112	46
MH Youth	Hours ('000)	339	360	398	453	–	–	–	–	n/a	n/a	n/a	n/a	161	170	178	178	121	124	132	165	26	34	45	56	12	16	14	14	31	32	43	54	10	32	13
MH Adult	Hours ('000)	1,200	1,183	1,183	1,218	–	–	–	–	n/a	n/a	n/a	n/a	495	480	480	480	436	433	433	433	124	124	124	156	32	43	41	40	145	145	145	149	27	86	36
MH Older Adult	Hours ('000)	236	335	422	528	–	–	–	–	n/a	n/a	n/a	n/a	114	131	150	187	97	119	159	199	8	29	39	49	10	11	6	21	17	56	75	93	20	50	23
AOD – All (non-residential treatment)	Hours ('000)	565	677	1,133	2,060	–	–	–	–	n/a	n/a	n/a	n/a	316	316	456	808	97	167	347	735	98	107	161	262	54	72	68	68	54	87	169	255	47	147	61
Community Bed-Based Services	Beds (total)	639	838	1,072	1,733	–	–	–	–	n/a	n/a	n/a	n/a	300	345	408	658	205	255	379	615	98	174	178	225	43	73	51	59	36	64	107	234	45	132	57
MH Community-Based	Beds	281	404	475	909	–	–	–	–	n/a	n/a	n/a	n/a	131	163	177	343	100	120	166	331	14	60	64	102	21	27	22	33	36	61	68	132	26	74	32
AOD – Low Medical Withdrawal	Beds	14	35	39	52	–	–	–	–	n/a	n/a	n/a	n/a	14	17	17	20	–	7	11	17	–	8	8	8	2	2	2	2	–	3	3	7	2	3	2
AOD – Residential Rehabilitation	Beds	344	399	558	772	–	–	–	–	n/a	n/a	n/a	n/a	155	165	214	295	105	128	202	267	84	106	106	115	20	44	27	24	–	–	36	95	17	55	23
Hospital-Based Services	Beds (total)	696	822	956	1,150	26	34	38	40	176	183	163	–	207	241	306	423	223	266	304	401	21	48	68	135	28	35	33	39	43	50	76	151	28	85	37
	Hours ('000) (total)	218	274	292	309	35	36	36	36	n/a	n/a	n/a	n/a	63	85	95	106	117	98	98	98	3	27	30	33	7	9	8	9	–	28	32	36	7	20	9
MH Infant, Child and Adolescent	Beds	26	20	20	27	26	20	20	22	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	3	1	1	1	1	–	–	–	3	–	2	1
MH Youth Acute	Beds	–	18	42	83	–	–	–	–	–	–	–	–	–	–	16	33	–	14	14	30	–	4	8	11	2	3	3	3	–	–	4	10	2	6	2
MH Youth Subacute/Non–acute	Beds	–	14	14	18	–	14	14	14	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2	–	–	1	1	–	–	–	2	–	1	1
MH Adult Acute	Beds	384	386	388	409	–	–	–	–	54	45	45	–	123	132	132	161	143	143	143	145	21	23	25	52	11	15	14	13	43	43	43	50	9	29	12
MH Adult Subacute/Non–acute	Beds	102	102	102	87	–	–	–	–	82	82	62	–	–	–	20	34	20	20	20	31	–	–	–	11	2	3	3	3	–	–	–	11	2	6	3
MH Older Adult Acute	Beds	144	93	95	78	–	–	–	–	32	32	32	–	52	28	28	28	60	29	29	29	–	4	4	7	2	2	1	3	–	–	2	14	3	7	3
MH Older Adult Subacute/Non–acute	Beds	–	55	63	114	–	–	–	–	–	–	–	–	–	24	24	40	–	31	31	43	–	–	4	10	2	2	1	5	–	–	4	20	4	11	5
MH Hospital in the Home (HITH)**	Beds	12	73	121	195	–	–	–	–	8	24	24	–	4	19	37	74	–	17	35	70	–	6	12	24	5	6	6	7	–	7	13	27	5	15	7
Mental Health Observation Area (MHOA)	Beds	6	28	40	40	–	–	4	4	n/a	n/a	n/a	n/a	6	16	16	16	–	12	20	20	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
MH Private ^	Beds	231	231	231	231	–	–	–	–	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
AOD (High/Complex Medical Withdrawal)	Beds	22	33	70	98	–	–	–	–	n/a	n/a	n/a	n/a	22	22	33	36	–	–	12	33	–	11	15	15	3	4	4	4	–	–	10	14	3	8	3
AOD Private ^	Beds	19	19	19	19	–	–	–	–	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
MH/AOD Consultation Liaison	Hours ('000)	218	274	292	309	35	36	36	36	n/a	n/a	n/a	n/a	63	85	95	106	117	98	98	98	3	27	30	33	7	9	8	9	–	28	32	36	7	20	9
Specialised Statewide Services (inpatient) * **	Beds (total)	8	40	54	75	8	40	54	75	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Eating Disorders	Beds	–	24	34	47	–	24	34	47	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Perinatal	Beds	8	16	20	28	8	16	20	28	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Forensic Services	Beds (total)	38	38	38	92	–	–	–	92	38	38	38	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
	Hours ('000) (total)	83	134	206	302	33	84	112	140	n/a	n/a	n/a	n/a	10	10	17	28	21	21	28	40	12	12	33	58	12	17	12	16	7	7	16	37	9	16	12
MH Acute Hospital	Beds	30	30	30	62	–	–	–	62	30	30	30	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
MH Subacute Hospital	Beds	8	8	8	30	–	–	–	30	8	8	8	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
MH Community	Hours ('000)	33	84	112	140	33	84	112	140	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
AOD Community (Diversion)	Hours ('000)	50	50	94	163	–	–	–	–	n/a	n/a	n/a	n/a	10	10	17	28	21	21	28	40	12	12	33	58	12	17	12	16	7	7	16	37	9	16	12
Forensic Services (in–prison)	Beds (total)	–	70	70	70	–	70	70	70	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
In-prison MH/AOD	Beds	–	70	70	70	–	70	70	70	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

NOTES

* Percentage of total Mental Health Commission budget.

** Hospital in the Home beds are a substitution for both acute and Subacute/Non–acute hospital beds.

***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 private beds, unknown whether they will grow.

n/av : Data is not available.

n/a : Data is not applicable.

– : Service is not available.

MH = Mental Health

AOD = Alcohol and Other Drugs

Note: Some total columns may not add up 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'.

Define: Hours of Support: includes face–to–face time only. For example, hours a person spends in respite care, hours spent undertaking an activity, hours of face–to–face support with peer workers, or health, social and welfare support workers etc.

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.

Note: The 2012–13 mental health community treatment actuals (as outlined in the matrix) were supplied by Area Health Services and the Department of Health. 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.

Note: The Mental Health inpatient beds at Royal Perth Hospital have been recorded in the North Metropolitan total in the matrix (due to geographic location). These beds are however part of the South Metropolitan Health Service (Department of Health).

Note: Contemporary, personalised bed-based services will be retained on the Graylands site. Planning is underway and is part of the Graylands divestment planning. See page 70 for more information.

THE PLAN MATRIX CONTINUED

SERVICE TYPE		STATEWIDE SERVICES				GRAYLANDS				NORTH METROPOLITAN									SOUTH METROPOLITAN							
										NORTH METROPOLITAN				CITY	JOONDALUP-WANEROO	LOWER WEST	STIRLING-OSBORNE PARK	SWAN AND HILLS	SOUTH METROPOLITAN				ARMADALE	BENTLEY	FREMANTLE	PEEL AND ROCKINGHAM/KWINANA
		Current	2017	2020	2025	Current	2017	2020	2025	Current	2017	2020	2025	2025	2025	2025	2025	2025	Current	2017	2020	2025	2025	2025	2025	2025
Community Bed-Based Services	Beds (total)	–	–	–	–	n/a	n/a	n/a	n/a	300	345	408	658	111	152	82	117	196	205	255	379	615	182	128	105	200
MH Community-Based	Beds	–	–	–	–	n/a	n/a	n/a	n/a	131	163	177	343	43	90	62	68	80	100	120	166	331	84	92	63	92
AOD – Low Medical Withdrawal	Beds	–	–	–	–	n/a	n/a	n/a	n/a	14	17	17	20	14	3	–	–	3	–	7	11	17	3	3	3	8
AOD – Residential Rehabilitation	Beds	–	–	–	–	n/a	n/a	n/a	n/a	155	165	214	295	54	59	20	49	113	105	128	202	267	95	33	39	100
Hospital-Based Services	Beds (total)	26	34	38	40	176	183	163	–	207	241	306	423	82	94	91	73	82	223	266	304	401	69	112	127	93
MH Infant, Child and Adolescent	Beds	26	20	20	22	n/a	n/a	n/a	n/a	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
MH Youth Acute	Beds	–	–	–	–	–	–	–	–	–	–	16	33	–	17	–	–	16	–	14	14	30	–	–	15	15
MH Youth Subacute/Non-acute	Beds	–	14	14	14	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
MH Adult Acute	Beds	–	–	–	–	54	45	45	–	123	132	132	161	20	42	44	30	25	143	143	143	145	25	50	50	20
MH Adult Subacute/Non-acute	Beds	–	–	–	–	82	82	62	–	–	–	20	34	–	5	20	4	5	20	20	20	31	9	12	–	10
MH Older Adult Acute	Beds	–	–	–	–	32	32	32	–	52	28	28	28	6	2	2	12	6	60	29	29	29	9	10	–	10
MH Older Adult Subacute/Non-acute	Beds	–	–	–	–	–	–	–	–	–	24	24	40	6	6	6	12	10	–	31	31	43	5	16	16	6
MH Hospital in the Home (HITH)**	Beds	–	–	–	–	8	24	24	–	4	19	37	74	15	15	15	15	14	–	17	35	70	17	18	17	18
Mental Health Observation Area (MHOA)	Beds	–	–	4	4	n/a	n/a	n/a	n/a	6	16	16	16	4	4	4	–	4	–	12	20	20	4	4	8	4
AOD (High/Complex Medical Withdrawal)	Beds	–	–	–	–	n/a	n/a	n/a	n/a	22	22	33	36	31	3	–	–	2	–	–	12	33	–	2	21	10
Specialised Statewide Services (inpatient)* **	Beds (total)	8	40	54	75																					
Eating Disorders	Beds	–	24	34	47																					
Perinatal	Beds	8	16	20	28																					
Forensic Services	Beds (total)	38	38	38	92																					
MH Acute Hospital	Beds	30	30	30	62																					
MH Subacute Hospital	Beds	8	8	8	30																					
Forensic Services (in-prison)	Beds (total)	–	70	70	70																					
In-prison MH/AOD	Beds	–	70	70	70																					

NOTES

** Hospital in the Home beds are a substitution for both acute and Subacute/Non–acute hospital beds.

***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).

n/a : Data is not applicable.

– : Service is not available.

MH = Mental Health

AOD = Alcohol and Other Drugs

Note: Some total columns may not add up 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'.

Define: Hours of Support: includes face-to-face time only. For example, hours a person spends in respite care, hours spent undertaking an activity, hours of face-to-face support with peer workers, or health, social and welfare support workers etc.

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.

Note: The 2012-13 mental health community treatment actuals (as outlined in the matrix) were supplied by Area Health Services and the Department of Health. 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.

Note: The Mental Health inpatient beds at Royal Perth Hospital have been recorded in the North Metropolitan total in the matrix (due to geographic location). These beds are however part of the South Metropolitan Health Service (Department of Health).

Note: Contemporary, personalised bed-based services will be retained on the Graylands site. Planning is underway and is part of the Graylands divestment planning. See page 70 for more information.

SERVICES BY REGION

STATEWIDE SERVICES

OVERVIEW

Western Australia is the largest state in Australia with a total land area of 2.5 million square kilometres. This equals 33 per cent of the country's total land area and makes our State more than three times bigger than Texas.[48] Western Australia's population represents 11 per cent of Australia's total population, however, Western Australia is sparsely populated, with a rate of 1.0 person per square kilometre (the second-lowest of all States and Territories following the Northern Territory, and compares with 3.1 people per square kilometre for the nation).

The total Western Australian population in 2014 was 2.57 million, and this is expected to grow to 3.19 million by 2025.[46] The population is heavily concentrated in the metropolitan area, in which 78.6 per cent of the State's total population reside.[46]

There are currently three tertiary publicly funded hospitals which are classified as statewide: Graylands Hospital, King Edward Memorial Hospital and Perth Children's Hospital.

SERVICES BY REGION

ABORIGINAL POPULATION

In 2011, the Aboriginal population in Western Australia was approximately 76,000 people, and is forecast to grow to 120,000 by 2025.[47] The Aboriginal population is spread throughout the state, and by 2025 it is forecast that 18.1 per cent will live in the North Metropolitan area, 21.0 per cent in the South Metropolitan area, 48.4 per cent in the Northern and Remote region, and 12.5 per cent in the Southern Country region.[47]

SERVICES FOR THE STATE

Statewide services are those services that can be accessed by, or are modelled for, the entire population of the state. Statewide services often provide an additional level of expertise or service response for people with particular clinical conditions or complex and high-level needs. Many of these services provide expert advice, consultation and support to general services (including services in regional areas). They are usually delivered at a smaller scale as demand for the service is lower than demand for general services.

Mental health prevention and promotion resources outlined in the *Plan Matrix* are currently modelled at the state level. Following the development of the prevention plan (see page 30), mental health prevention resource distribution for regional areas will be determined. Alcohol and other drug prevention resources have been allocated at a regional level.

Certain inpatient beds are outlined in the Plan as statewide due to the relatively small number of people that will require access to such services. There are inherent feasibility challenges running and staffing multiple small units across the State, (e.g. infant, child and adolescent inpatient beds, youth subacute inpatient beds perinatal inpatient beds), therefore some services will need to be combined with other services or provided from a single location.

The closure of Graylands Hospital by the end of 2025 is a major milestone in the Plan. Graylands is the last statewide mental health inpatient hospital. New services will be established across the State before any beds at Graylands Hospital close. The location of the new services will be determined during the implementation of the Plan, as this will be dependent on the need for services in the regions.

Specialised statewide services are outlined on pages 75–82. Only some of these services have been outlined in the *Plan Matrix*: dedicated eating disorder and perinatal inpatient beds. All services outlined in the *Specialised Statewide Services* section will be delivered as statewide services.

Many of the forensic mental health services are also classified as statewide services, due to the specialist nature of the inpatient facility proposed in the Plan, and the dedicated in-prison beds. There is greater flexibility with community-based forensic mental health, with geographical locations of services to be established during the implementation of the Plan. The alcohol and other drug forensic community services are modelled for specific regional areas across the State.

SERVICES BY REGION

Considerable feedback was received during consultation, outlining the importance of having true 'statewide' services, which are accessible to all regions. In developing the models of service (during implementation of the Plan), key stakeholders from different regions will be involved to ensure that the statewide services are configured to provide adequate access to all regions.

Further consideration needs to be given to how consumers, carers and families can be supported to travel from regional areas to access services located in the metropolitan area and how Statewide services can provide outreach to regional areas.

Table 11: Summary of the *Plan Matrix* – Statewide

Below is an excerpt from the *Plan Matrix* showing Statewide services.

SERVICE TYPE	MEASURE	STATEWIDE SERVICES			
		CURRENT	2017	2020	2025
Prevention	Hours ('000) (total)	n/a	n/a	n/a	n/a
MH*	Percentage	1%	2%	4%	5%
AOD	Hours ('000)	52	59	112	122
Community Support Services	Hours ('000) (total)	2	2	42	60
AOD (Harm-reduction and personal support)	Hours ('000)	2	2	42	60
Hospital-Based Services	Beds (total)	26	34	38	40
	Hours ('000) (total)	35	36	36	36
MH Infant, Child and Adolescent	Beds	26	20	20	22
MH Youth Subacute/Non-acute	Beds	–	14	14	14
Mental Health Observation Area (MHOA)	Beds	–	–	4	4
MH/AOD Consultation Liaison	Hours ('000)	35	36	36	36
Specialised Statewide Services (inpatient)	Beds (total)	8	40	54	75
Eating Disorders	Beds	–	24	34	47
Perinatal	Beds	8	16	20	28
Forensic Services	Beds (total)	–	–	–	92
	Hours ('000) (total)	33	84	112	140
MH Acute Hospital	Beds	–	–	–	62
MH Subacute Hospital	Beds	–	–	–	30
MH Community	Hours ('000)	33	84	112	140
Forensic Services (in-prison)	Beds (total)	–	70	70	70
In-prison MH/AOD	Beds	–	70	70	70

* Percentage of total Mental Health Commission budget.
n/a : Data is not applicable.
– : Service is not available.
Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

SERVICES BY REGION

NORTH METROPOLITAN

OVERVIEW

The North Metropolitan area has a 3,000 square kilometre catchment area,[49] which constitutes 0.1 per cent of the total Western Australian land mass. In 2014, 1.06 million people (41.5 per cent of the State's population) lived in the North Metropolitan catchment area.[46] By 2025, the population is expected to reach 1.33 million people (41.5 per cent of the State's population).[46]

There are a total of six publicly funded hospitals in this area, including three tertiary (King Edward Memorial Hospital, Royal Perth Hospital, and Sir Charles Gairdner Hospital), and three other hospitals (Osborne Park Hospital, Kalamunda Hospital, and Swan District Hospital). Joondalup Health Campus also falls within this catchment area, as a publicly contracted service.

SERVICES BY REGION

ABORIGINAL POPULATION

The Aboriginal population in the North Metropolitan area totalled almost 13,400 people in 2011, which represented 17.6 per cent of the total Aboriginal population. This is expected to grow to almost 21,000 people by 2025, with the percentage increasing slightly to 18.1 per cent of the total Aboriginal population residing in the North Metropolitan area.[47]

SERVICES FOR THE NORTH METROPOLITAN AREA

People living in the North Metropolitan area require access to services across the service spectrum, including statewide services (as described on pages 75–82)

Modelling shows mental health, alcohol and other drug **community support** services are required to increase dramatically from the current level by the end of 2025. In particular, two million hours of support per annum for mental health and about 99,000 hours of service for alcohol and other drugs are required to meet the needs of the population in this area. Alcohol and other drug safe places for intoxicated people are not required to increase substantially. Current services are already delivering 14 beds in the North Metropolitan area, with the modelling indicating a total need of 17 beds by the end of 2025.

Youth and adult mental health **community treatment** services are not required to increase substantially. A challenge for this area will be the reconfiguration of current services to meet the needs of the new age cohorts (see page 24). Infant, child and adolescent mental health community treatment hours are required to increase significantly.

Alcohol and other drug community treatment hours of service are required to more than double from the current base by the end of 2025. More access to services is required in the outer metropolitan areas of the region.

Mental health **community beds** and alcohol and other drug residential rehabilitation beds are required to increase by 212 and 140 beds respectively between now and the end of 2025 to meet the needs of the population in this area. Alcohol and other drug low medical withdrawal beds need to increase from the current 14 beds to 20 beds. Metropolitan regions are serviced to some extent by home-based withdrawal services.

The notable changes required for the North Metropolitan area for **hospital-based services** include the introduction of dedicated mental health youth inpatient beds, the reconfiguration of older adult acute and subacute mental health inpatient beds, the substantial increase in HITH beds (from four beds to 74 beds), an increase in MHOA beds, an increase of 14 beds for alcohol and other drug high and complex medical withdrawal, and the growth of mental health inpatient beds to 297 beds by the end of 2025 (some of this growth would be sourced from the closure of Graylands Hospital).

As with all regions, resources dedicated to alcohol and other drug **prevention**, and alcohol and other drug community diversion programs (**forensic**) need to steadily increase over the next ten years.

Feedback received during the consultation process for the Plan indicated King Edward Memorial Hospital (KEMH) does not need MHOA beds. These beds are therefore no longer planned.

SERVICES BY REGION

Table 12: Summary of the *Plan Matrix* – North Metropolitan

Below is an excerpt from the *Plan Matrix*.

SERVICE TYPE	MEASURE	NORTH METROPOLITAN			
		CURRENT	2017	2020	2025
Prevention	Hours ('000) (total)	–	3	3	3
AOD	Hours ('000)	–	3	3	3
Community Support Services	Hours ('000) (total) Beds (total)	n/av 14	515 14	1,299 17	2,120 17
MH	Hours ('000)	n/av	505	1,212	2,021
AOD (Harm-reduction and personal support)	Hours ('000)	2	2	73	79
AOD (Post Residential Rehabilitation)	Hours ('000)	4	8	14	21
AOD (Safe places for intoxicated people)	Beds	14	14	17	17
Community Treatment Services	Hours ('000) (total)	1,235	1,396	1,705	2,241
MH Infant, Child and Adolescent	Hours ('000)	149	298	441	588
MH Youth	Hours ('000)	161	170	178	178
MH Adult	Hours ('000)	495	480	480	480
MH Older Adult	Hours ('000)	114	131	150	187
AOD – All (non-residential treatment)	Hours ('000)	316	316	456	808
Community Bed-Based Services	Beds (total)	300	345	408	658
MH Community-Based Beds	Beds	131	163	177	343
AOD – Low Medical Withdrawal	Beds	14	17	17	20
AOD – Residential Rehabilitation	Beds	155	165	214	295
Hospital-Based Services	Beds (total) Hours ('000) (total)	207 63	241 85	306 95	423 106
MH Inpatient (Acute and Subacute/ Non-acute)	Beds	175	184	220	297
MH Hospital in the Home (HITH)	Beds	4	19	37	74
Mental Health Observation Area (MHOA)	Beds	6	16	16	16
AOD (High/Complex Medical Withdrawal)	Beds	22	22	33	36
MH/AOD Consultation Liaison	Hours ('000)	63	85	95	106
Forensic Services	Hours ('000) (total)	10	10	17	28
AOD Community (Diversion)	Hours ('000)	10	10	17	28

n/av : Data is not available.
– : Service is not available.
Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

SERVICES BY REGION

SOUTH METROPOLITAN

OVERVIEW

The South Metropolitan has a catchment area of 4,000 square kilometres[49] which constitutes 0.2 per cent of the total Western Australian land mass. In 2014 the population of the area was 955,000 (representing 37.2 per cent of the State's population).[46] By 2025, the population is expected to reach 1.23 million people (38.4 per cent of the State's population).[46]

There are a total of seven publicly funded hospitals in this area, including one tertiary (Fiona Stanley Hospital), and six other hospitals (Fremantle Hospital, Bentley Hospital, Armadale Hospital, Rockingham Hospital, Peel Health Campus, and Murray District Hospital).

SERVICES BY REGION

ABORIGINAL POPULATION

The Aboriginal population in the South Metropolitan area was approximately 15,500 people in 2011, which represented 20.4 per cent of the total Aboriginal population. This is expected to grow to 25,200 people by 2025, with the percentage increasing slightly to 21.0 per cent of the total Aboriginal population. By 2025, there will be more Aboriginal people living in the South Metropolitan area compared to the Kimberley area.[47]

SERVICES FOR THE SOUTH METROPOLITAN AREA

People living in the South Metropolitan area require access to services across the service spectrum, including statewide services (see page 75–82).

Modelling shows mental health, alcohol and other drug **community support** services are required to substantially increase over the next ten years. In particular, by the end of 2025, 1.9 million hours of support per annum for mental health and about 89,000 hours of service for alcohol and other drugs are required to meet the needs of the population in this area. Currently, there are no beds in the South Metropolitan area for alcohol and other drug safe places for intoxicated people. The modelling indicates that 12 beds are required for this region by the end of 2025.

Adult mental health **community treatment** services are not required to change substantially but require reconfiguration to meet the needs of the new age cohorts. Infant, child and adolescent as well as older adult mental health community treatment hours are required to increase significantly.

Alcohol and other drug community treatment service availability in the South Metropolitan region is currently much lower compared to the North Metropolitan area. Services are therefore required to increase more than seven-fold over the next ten years in the South Metropolitan, particularly in the outer metropolitan areas of the region.

Mental health **community beds** and alcohol and other drug residential rehabilitation beds are required to increase by 231 and 162 beds respectively between now and the end of 2025 to meet demand. Currently, there are no alcohol and other drug low medical withdrawal beds in this region; however the modelling shows a requirement of 17 beds by the end of 2025. The metropolitan regions are serviced to some extent by home-based withdrawal services.

The notable changes to **hospital-based services** in the South Metropolitan area include the introduction of dedicated mental health youth inpatient beds, the reconfiguration of older adult acute and subacute mental health inpatient beds, the establishment of HITH beds (to a total of 70 beds by the end of 2025), the establishment of MHOA beds, an increase of 33 beds for alcohol and other drug high and complex medical withdrawal (from a current base of zero beds), and the growth of mental health inpatient beds to 279 beds by the end of 2025.

As with all regions, resources dedicated to alcohol and other drug **prevention**, and alcohol and other drug community diversion programs (**forensic**) need to steadily increase over the next ten years.

SERVICES BY REGION

Feedback received during the Plan consultation period (including from consumers, carers and service providers) indicated a need for MHOA beds in the Rockingham and Peel areas. Following further data analysis, the cost effectiveness of MHOA beds and in response to strong public opinion, MHOA beds have now been included for both the Rockingham and Peel areas (see pages 73-74).

Table 13: Summary of the *Plan Matrix* – South Metropolitan

Below is an excerpt from the *Plan Matrix*.

SERVICE TYPE		SOUTH METROPOLITAN			
	MEASURE	CURRENT	2017	2020	2025
Prevention	Hours ('000) (total)	–	7	7	7
AOD	Hours ('000)	–	7	7	7
Community Support Services	Hours ('000) (total) Beds (total)	n/av –	485 –	1,223 12	1,997 12
MH	Hours ('000)	n/av	477	1,145	1,908
AOD (Harm-reduction and personal support)	Hours ('000)	2	2	65	71
AOD (Post Residential Rehabilitation)	Hours ('000)	3	6	13	18
AOD (Safe places for intoxicated people)	Beds	–	–	12	12
Community Treatment Services	Hours ('000) (total)	901	1,142	1,494	2,095
MH Infant, Child and Adolescent	Hours ('000)	149	298	422	563
MH Youth	Hours ('000)	121	124	132	165
MH Adult	Hours ('000)	436	433	433	433
MH Older Adult	Hours ('000)	97	119	159	199
AOD – All (non-residential treatment)	Hours ('000)	97	167	347	735
Community Bed-Based Services	Beds (total)	205	255	379	615
MH Community-Based	Beds	100	120	166	331
AOD – Low Medical Withdrawal	Beds	–	7	11	17
AOD – Residential Rehabilitation	Beds	105	128	202	267
Hospital-Based Services	Beds (total) Hours ('000) (total)	223 117	266 98	304 98	401 98
MH Inpatient (Acute and Subacute/ Non-acute)	Beds	223	237	237	279
MH Hospital in the Home (HITH)	Beds	–	17	35	70
Mental Health Observation Area (MHOA)	Beds	–	12	20	20
AOD (High/Complex Medical Withdrawal)	Beds	–	–	12	33
MH/AOD Consultation Liaison	Hours ('000)	117	98	98	98
Forensic Services	Hours ('000) (total)	21	21	28	40
AOD Community (Diversion)	Hours ('000)	21	21	28	40

n/av : Data is not available.
– : Service is not available.
Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

SERVICES BY REGION

GOLDFIELDS

OVERVIEW

The Goldfields region is located in the south eastern corner of the State and covers 754,000 square kilometres[49] which constitutes 30.3 per cent of the total Western Australian land mass. It is the largest of the State's nine regions and more than three times the size of the State of Victoria. The region supports a wide range of industry, including mining, agriculture, aquaculture and tourism. Mining is the predominant sector in the central and northern parts of the region, with a well-established agricultural sector in the south.

The Goldfields region had a population of 58,300 people in 2014 (representing 2.3 per cent of the State's population). By 2025, the population is expected to reach almost 60,000 people. However, although the population will increase, the percentage of the State's population residing in the Goldfields will decrease to 1.9 per cent.[46] According to the Australian Bureau of Statistics (ABS), between 2013 and 2014 the population of the Goldfields declined by 1.8 per cent (or 800 people), with the largest decline in Kalgoorlie (270 people).[50]

SERVICES BY REGION

ABORIGINAL POPULATION

The Aboriginal population in the Goldfields was approximately 6,000 people in 2011, which represented 7.8 per cent of the total Aboriginal population of Western Australia. This is expected to grow to almost 9,300 by 2025. However, although the population will increase, the percentage of the State's Aboriginal population residing in the Goldfields will slightly decrease to 7.7 per cent.[47]

SERVICES FOR THE GOLDFIELDS REGION

People living in the Goldfields region require access to services across the service spectrum, including statewide services (see pages 75–82). It is important to note that the exact locations and distributions of services will be determined by a combination of consultation process and the assessment of relative feasibility to deliver the service.

By the end of 2025, 133,000 hours of support per annum for mental health **community support** and about 9,000 hours of service for alcohol and other drugs are required to meet the needs of the population in this area. There is no need to expand alcohol and other drug safe places for intoxicated people in the Goldfields, as the current bed numbers are in line with the modelled demand for the end of 2025 (18 beds).

The modelling indicates that by the end of 2025, 99,000 mental health and 54,000 alcohol and other drug **community treatment** hours of service need to be delivered per annum. The increase in alcohol and other drug community treatment service resources would allow an expansion of service hubs in the Goldfields and increased outreach services to more outlying areas of the region.

Currently, there are no mental health **community beds** in the Goldfields, and modelling shows that to meet demand, a total of 21 beds are required for the region by the end of 2025. The State Government has announced the establishment of six community beds in Kalgoorlie/Boulder, which will contribute to the 21-bed requirement. Alcohol and other drug residential rehabilitation beds are required to double between now and the end of 2025 (from 10 beds to 20 beds). Currently, there are no alcohol and other drug low medical withdrawal beds in the region; however the modelling shows a requirement of two beds by the end of 2025.

The delivery of **hospital-based services**, including inpatient beds, MHOAs and HITH beds, will need to be informed by consultation and assessment of feasibility to deliver the service, during the implementation of the Plan. Mental health inpatient beds and HITH beds are required to grow to 20 beds and five beds, respectively, by the end of 2025. There may be a requirement for inpatient mental health beds to be flexible in relation to age cohorts, due to the limited number of beds required. Other modelled requirements for the Goldfields region include the establishment of three beds for alcohol and other drug high and complex medical withdrawal (from a current base of zero beds) and the expansion of consultation and liaison services to 7,000 hours of service per annum.

As with all regions, resources dedicated to alcohol and other drug **prevention**, and alcohol and other drug community diversion programs (**forensic**) need to steadily increase over the next ten years.

SERVICES BY REGION

During the Plan consultation period, feedback from the Goldfields region indicated that stakeholders in the area want to see the *Criminal Law (Mentally Impaired Accused) Act 1996* (CLMIA Act) repealed.

The MHC has included an additional strategy and action in the *Forensic Services* section of the Plan, outlining that the CLMIA Act will be reviewed by the end of 2017 (see pages 97-98).

Table 14: Summary of the *Plan Matrix* – Goldfields

Below is an excerpt from the *Plan Matrix*.

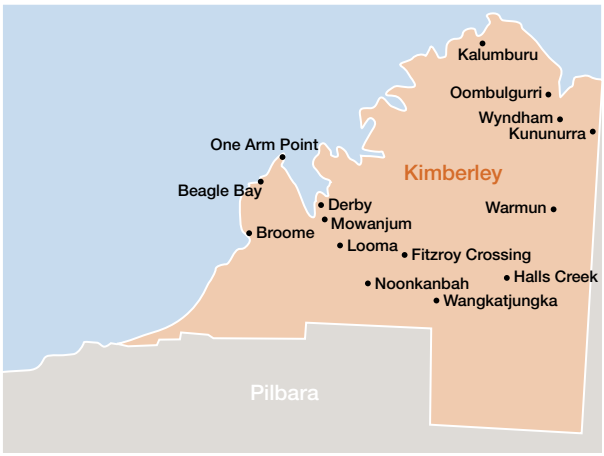
SERVICE TYPE	MEASURE	NORTHERN AND REMOTE GOLDFIELDS 2025
Prevention	Hours ('000) (total)	10
AOD	Hours ('000)	10
Community Support Services	Hours ('000) (total) Beds (total)	142 18
MH	Hours ('000)	133
AOD (Harm-reduction and personal support)	Hours ('000)	5
AOD (Post Residential Rehabilitation)	Hours ('000)	4
AOD (Safe places for intoxicated people)	Beds	18
Community Treatment Services	Hours ('000) (total)	153
MH Infant, Child and Adolescent	Hours ('000)	45
MH Youth	Hours ('000)	12
MH Adult	Hours ('000)	32
MH Older Adult	Hours ('000)	10
AOD – All (non-residential treatment)	Hours ('000)	54
Community Bed-Based Services	Beds (total)	43
MH Community-Based	Beds	21
AOD – Low Medical Withdrawal	Beds	2
AOD – Residential Rehabilitation	Beds	20
Hospital-Based Services	Beds (total) Hours ('000) (total)	28 7
MH Inpatient (Acute and Subacute/Non-acute)	Beds	20
MH Hospital in the Home (HITH)	Beds	5
AOD (High/Complex Medical Withdrawal)	Beds	3
MH/AOD Consultation Liaison	Hours ('000)	7
Forensic Services	Hours ('000) (total)	12
AOD Community (Diversion)	Hours ('000)	12

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

SERVICES BY REGION

KIMBERLEY

OVERVIEW



The Kimberley region is Western Australia's most northern region encompassing an area of 420,000 square kilometres[49] (almost twice the size of the State of Victoria, and three times that of the United Kingdom). The region constitutes 16.9 per cent of the total Western Australian land mass.

The Kimberley has a diverse economy, with mining, tourism, agriculture, and pearling all major contributors to the economic output of the area. Geographically, this region features arid desert areas, gorges and river valleys, beaches, pockets of rainforest and extensive cave systems.

The Kimberley region had a population of 38,500 people in 2014 (representing 1.5 per cent of the State's population).[46] By 2025, the population is expected to reach almost 43,000 people. However, although the population will increase, the percentage of the State's population living in the Kimberley region will decrease to 1.3 per cent.[46] According to the ABS, between 2013 and 2014 the population of the Kimberley region declined by 1.0 per cent (or 390 people).[50] The age distribution of the Kimberley population is younger than the State average, with more than 30 per cent under 15 years.

SERVICES BY REGION

ABORIGINAL POPULATION

In 2011, the Kimberley region had the highest number of Aboriginal people living there: approximately 16,400 people, representing 21.5 per cent of all Aboriginal people in the State. It is forecast that the Aboriginal population in the Kimberley region will reach 24,800 people by 2025. However, although the population will increase, the percentage of the State's Aboriginal population residing in the Kimberley region will decrease to 20.7 per cent. By 2025, it is forecast that more Aboriginal people will live in the South Metropolitan area compared to the Kimberley region.[47]

There are more than 100 Aboriginal communities of various population sizes, scattered throughout the Kimberley region.[51] Aboriginal people will represent 46 per cent of the total population in the Kimberley by 2025, which is the highest proportion of Aboriginal people compared to non-Aboriginal people in any other region in the State.[51]

SERVICES FOR THE KIMBERLEY REGION

People living in the Kimberley region require access to services across the service spectrum, including statewide services (see pages 75–82). It is important to note that the exact locations and distributions of services will be determined by a combination of consultation process and the assessment of relative feasibility to deliver the service.

By the end of 2025, 173,000 hours of support per annum of mental health **community support** and about 9,000 hours of service for alcohol and other drugs are required to meet the needs of the population in this area.

There is no need to expand alcohol and other drug safe places for intoxicated people in the Kimberley region, as the current bed numbers are in line with the modelled demand for the end of 2025 (84 beds).

The modelling indicates that by the end of 2025, 133,000 mental health and 72,000 alcohol and other drug **community treatment** hours of service need to be delivered per annum. The increase in resources would allow an expansion of alcohol and other drug treatment service hubs in the Kimberley and increased outreach services to more outlying areas of the region.

Currently, there are no mental health **community beds** in the Kimberley, and modelling shows that to meet demand, a total of 27 beds are required for the region by the end of 2025. The State Government has announced the establishment of six community beds in Broome which will contribute to meeting the 27 bed requirement. Alcohol and other drug residential rehabilitation beds are not required to grow, as the current beds equal that of the modelled requirement for the end of 2025 (44 beds). Currently, there are no alcohol and other drug low medical withdrawal beds in the region; however the modelling shows a requirement of two beds by the end of 2025.

The delivery of **hospital-based services**, including inpatient beds, MHOAs and HITH beds, will need to be informed by consultation and assessment of feasibility to deliver the service, during the implementation of the Plan. Mental health inpatient beds and HITH beds are required to grow to 25 beds and six beds, respectively, by the end of 2025.

SERVICES BY REGION

There may be a requirement for inpatient mental health beds to be flexible in relation to age cohorts, due to the limited number of beds required in the region. Other modelled requirements for the Kimberley region include the establishment of four beds for alcohol and other drug high and complex medical withdrawal (from a current base of zero beds) and the expansion of consultation and liaison services to 9,000 hours of service per annum.

As with all regions, resources dedicated to alcohol and other drug **prevention**, and alcohol and other drug community diversion programs (**forensic**) need to steadily increase over the next ten years.

The Kimberley region provided feedback on a number of gaps in the Plan. One of these was the required training of court officials and magistrates in relation to mental health, alcohol and other drug problems. The Mental Health Commission has included an additional strategy and action in the *Forensic Services* section of the Plan: *Develop comprehensive training requirements for all non-mental health, alcohol and other drug frontline staff including police, corrections officers, court officers, magistrates and others* (see page 98), with this to occur by the end of 2017. The Kimberley region also identified the need for hospital-based withdrawal beds in the region, which has also been addressed in the Plan.

SERVICES BY REGION

Table 15: Summary of the *Plan Matrix* – Kimberley

Below is an excerpt from the *Plan Matrix*.

SERVICE TYPE	MEASURE	NORTHERN AND REMOTE KIMBERLEY 2025
Prevention	Hours ('000) (total)	12
AOD	Hours ('000)	12
Community Support Services	Hours ('000) (total) Beds (total)	182 84
MH	Hours ('000)	173
AOD (Harm-reduction and personal support)	Hours ('000)	6
AOD (Post Residential Rehabilitation)	Hours ('000)	3
AOD (Safe places for intoxicated people)	Beds	84
Community Treatment Services	Hours ('000) (total)	205
MH Infant, Child and Adolescent	Hours ('000)	63
MH Youth	Hours ('000)	16
MH Adult	Hours ('000)	43
MH Older Adult	Hours ('000)	11
AOD – All (non-residential treatment)	Hours ('000)	72
Community Bed-Based Services	Beds (total)	73
MH Community-Based	Beds	27
AOD – Low Medical Withdrawal	Beds	2
AOD – Residential Rehabilitation	Beds	44
Hospital-Based Services	Beds (total) Hours ('000) (total)	35 9
MH Inpatient (Acute and Subacute/Non-acute)	Beds	25
MH Hospital in the Home (HITH)	Beds	6
AOD (High/Complex Medical Withdrawal)	Beds	4
MH/AOD Consultation Liaison	Hours ('000)	9
Forensic Services	Hours ('000) (total)	17
AOD Community (Diversion)	Hours ('000)	17

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

SERVICES BY REGION

PILBARA

OVERVIEW

The Pilbara region covers a total area of 498,000 square kilometres[49] which constitutes 20 per cent of the total Western Australian land mass. The Pilbara economy is crucial to the State, providing two of its largest export revenue earners – iron ore and liquefied natural gas. Most of the region's inhabitants are located in the western third, whereas the eastern third is largely desert with few inhabitants.

The Pilbara region had a population of 62,000 in 2014 (representing 2.4 per cent of the State's population).[46] By 2025, the population is expected to reach 66,000 persons. However, although the population will increase, the percentage of the State's population residing in the Pilbara will decrease to 2.1 per cent.[46] According to the ABS, between 2013 and 2014 Karratha had one of the largest population growth rates in the State of four per cent (or 750 people).[50]

SERVICES BY REGION

ABORIGINAL POPULATION

The Aboriginal population in the Pilbara totalled almost 8,000 persons in 2011, which represented 10.4 per cent of the total Aboriginal population in Western Australia. This is expected to grow to 12,000 persons by 2025. However, although the population will increase, the percentage of the State's Aboriginal population residing in the Pilbara will fall slightly to 10.1 per cent.[47]

SERVICES FOR THE PILBARA REGION

People living in the Pilbara region require access to services across the service spectrum, including statewide services (see pages 75–82). It is important to note that the exact locations and distributions of services will be determined by a combination of consultation process and the assessment of relative feasibility to deliver the service.

By the end of 2025, 149,000 hours of support per annum for mental health **community support** and about 8,000 hours of service for alcohol and other drugs are required to meet the needs of the population in this area. There is a need to expand alcohol and other drug safe places for intoxicated people from the current 34 beds to 46 beds in the Pilbara by the end of 2025.

The modelling indicates that by the end of 2025, 113,000 mental health and 68,000 alcohol and other drug **community treatment** hours of service need to be delivered per annum. The increase in resources for alcohol and other drug community treatment would allow an expansion of service hubs in the Pilbara and increased outreach services to more outlying areas of the region.

Currently, there are no mental health **community beds** in the Pilbara, and modelling shows that to meet demand, a total of 22 beds are required for the region by the end of 2025. The State Government has announced the establishment of six community beds in Karratha which will contribute to the total requirement of 22 beds. Alcohol and other drug residential rehabilitation beds are required to grow from the current 18 beds to 27 beds by the end of 2025. Currently, there are no alcohol and other drug low medical withdrawal beds in this region; however modelling shows a requirement of two beds by the end of 2025.

The delivery of **hospital-based services**, including inpatient beds, MHOAs and HITH beds, will need to be informed by consultation and assessment of feasibility to deliver the service, during the implementation of the Plan. Mental health inpatient beds and HITH beds are required to grow to 23 beds and six beds, respectively, by the end of 2025. There may be a requirement for inpatient mental health beds to be flexible in relation to age cohorts, due to the limited number of beds. Other requirements for the Pilbara region include four beds for alcohol and other drug high and complex medical withdrawal (both from a current base of zero beds), and the expansion of consultation and liaison services to 8,000 hours of service per annum by the end of 2025.

As with all regions, resources dedicated to alcohol and other drug **prevention**, and alcohol and other drug community diversion programs (**forensic**) need to steadily increase over the next ten years.

SERVICES BY REGION

Feedback from the Pilbara outlined that school-based education and intervention should be a priority. The Plan identifies this as a key action: *identify opportunities to enhance existing prevention initiatives targeting children, young people, families and the broader community including (but not limited to) school-based programs which incorporate mental health, alcohol and other drug education, and resilience building* (see page 32).

Further, due to the feedback received, the below action has been moved from the end of 2025 time horizon, to the end of 2020 time horizon: *complete the rollout of school-based education programs on mental health, alcohol and other drugs, and resilience building until available to all schools* (see page 33).

Table 16: Summary of the *Plan Matrix* – Pilbara

Below is an excerpt from the *Plan Matrix*.

SERVICE TYPE	MEASURE	NORTHERN AND REMOTE PILBARA 2025
Prevention	Hours ('000) (total)	9
AOD	Hours ('000)	9
Community Support Services	Hours ('000) (total) Beds (total)	157 46
MH	Hours ('000)	149
AOD (Harm-reduction and personal support)	Hours ('000)	6
AOD (Post Residential Rehabilitation)	Hours ('000)	2
AOD (Safe places for intoxicated people)	Beds	46
Community Treatment Services	Hours ('000) (total)	181
MH Infant, Child and Adolescent	Hours ('000)	52
MH Youth	Hours ('000)	14
MH Adult	Hours ('000)	41
MH Older Adult	Hours ('000)	6
AOD – All (non-residential treatment)	Hours ('000)	68
Community Bed-Based Services	Beds (total)	51
MH Community-Based	Beds	22
AOD – Low Medical Withdrawal	Beds	2
AOD – Residential Rehabilitation	Beds	27
Hospital-Based Services	Beds (total) Hours ('000) (total)	33 8
MH Inpatient (Acute and Subacute/Non-acute)	Beds	23
MH Hospital in the Home (HITH)	Beds	6
AOD (High/Complex Medical Withdrawal)	Beds	4
MH/AOD Consultation Liaison	Hours ('000)	8
Forensic Services	Hours ('000) (total)	12
AOD Community (Diversion)	Hours ('000)	12

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

SERVICES BY REGION

MIDWEST

OVERVIEW

The Midwest region of Western Australia covers more than 470,000 square kilometres, nearly one fifth of the State.[49] The Midwest region has a diverse economy built around mining, agriculture, fishing and tourism. The population is concentrated along the coast with more than 70 per cent living around Geraldton-Greenough. The area has a high Aboriginal population and an increasing proportion of aged people. Whilst the population is growing along the coast, the inland population has been declining slightly.[52]

The Midwest region had a population of 69,600 in 2014 (representing 2.7 per cent of the State's population).[46] By 2025, the population is expected to reach almost 80,000 persons. However, although the population will increase, the percentage of the State's population residing in the Midwest will decrease to 2.5 per cent.[46]

SERVICES BY REGION

ABORIGINAL POPULATION

The Aboriginal population in the Midwest totalled almost 7,600 persons in 2011, which represented 10.0 per cent of the total Aboriginal population of Western Australia. This is expected to grow to almost 12,000 persons by 2025, with the percentage remaining constant at 10.0 per cent.[47]

SERVICES FOR THE MIDWEST REGION

People living in the Midwest region require access to services across the service spectrum, including statewide services (see pages 75–82). It is important to note that the exact locations and distributions of services will be determined by a combination of consultation process and the assessment of relative feasibility to deliver the service.

By the end of 2025, 184,000 hours of support per annum for mental health **community support** and about 7,000 hours of service for alcohol and other drugs are required to meet the needs of the population in this area. There is no need to expand alcohol and other drug safe places for intoxicated people, as the current services reflect the modelled requirement for the end of 2025 (28 beds).

The modelling shows mental health **community treatment** hours of service need to be delivered at 130,000 hours, whereas alcohol and other drug hours need to total 68,000 per annum by the end of 2025. The increase in resources for alcohol and other drug community treatment would allow an expansion of service hubs in the Midwest and increased outreach services to more outlying areas of the region.

Currently, there are 14 mental health **community beds** in the Midwest, and modelling shows a need for this to grow to 33 beds by the end of 2025. Alcohol and other drug residential rehabilitation beds are required to double by the end of 2025, to a total of 24 beds. Currently, there are no alcohol and other drug low medical withdrawal beds in this region; however the modelling shows a requirement of two beds by the end of 2025.

The delivery of **hospital-based services**, including inpatient beds, MHOAs and HITH beds will need to be informed by consultation and assessment of feasibility to deliver the service, during the implementation of the Plan. Mental health inpatient beds and HITH beds are required to grow to 28 beds and seven beds, respectively, by the end of 2025. There may be a requirement for inpatient mental health beds to be flexible in relation to age cohorts, due to the limited number of beds. Other requirements for the Midwest region includes four beds for alcohol and other drug high and complex medical withdrawal (both from a current base of zero beds), and the expansion of consultation and liaison services to 9,000 hours of service per annum by the end of 2025.

As with all regions, resources dedicated to alcohol and other drug **prevention**, and alcohol and other drug community diversion programs (**forensic**) need to steadily increase over the next ten years.

The Midwest provided feedback outlining that the establishment of a 24-hour crisis response line, which would improve access to regional Western Australia was vital.

SERVICES BY REGION

The Plan outlines a strategy and action in the *Community Treatment Services* section: *establish an effective 'one stop shop' service that provides 24-hour mental health crisis and emergency services, system navigation assistance and frontline staff training (see page 53)*, by the end of 2017. It is envisaged that this service will also play a role in system navigation.

Table 17: Summary of the *Plan Matrix* – Midwest

Below is an excerpt from the *Plan Matrix*.

SERVICE TYPE	MEASURE	NORTHERN AND REMOTE MIDWEST 2025
Prevention	Hours ('000) (total)	10
AOD	Hours ('000)	10
Community Support Services	Hours ('000) (total) Beds (total)	191 28
MH	Hours ('000)	184
AOD (Harm-reduction and personal support)	Hours ('000)	6
AOD (Post Residential Rehabilitation)	Hours ('000)	1
AOD (Safe places for intoxicated people)	Beds	28
Community Treatment Services	Hours ('000) (total)	199
MH Infant, Child and Adolescent	Hours ('000)	55
MH Youth	Hours ('000)	14
MH Adult	Hours ('000)	40
MH Older Adult	Hours ('000)	21
AOD – All (non-residential treatment)	Hours ('000)	68
Community Bed-Based Services	Beds (total)	59
MH Community-Based	Beds	33
AOD – Low Medical Withdrawal	Beds	2
AOD – Residential Rehabilitation	Beds	24
Hospital-Based Services	Beds (total) Hours ('000) (total)	39 9
MH Inpatient (Acute and Subacute/Non-acute)	Beds	28
MH Hospital in the Home (HITH)	Beds	7
AOD (High/Complex Medical Withdrawal)	Beds	4
MH/AOD Consultation Liaison	Hours ('000)	9
Forensic Services	Hours ('000) (total)	16
AOD Community (Diversion)	Hours ('000)	16

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

SERVICES BY REGION

GREAT SOUTHERN

OVERVIEW

The Great Southern region has a total land area of 38,000 square kilometres,[49] representing approximately 1.5 per cent of the State's total land mass. The historic port town of Albany is the region's administrative centre and home to around 57 per cent of the region's population,[53] and is also the transport hub from where most of region's crops and livestock are shipped. The main industries in the region are agriculture, fishing, forestry, mining, tourism and viticulture.

The Great Southern region had a population of 62,700 in 2014 (representing 2.4 per cent of the State's population).[46] By 2025, the population is expected to reach almost 72,000 persons. However, although the population will increase, the percentage of the State's population residing in the Great Southern will decrease to 2.3 per cent.[46]

SERVICES BY REGION

ABORIGINAL POPULATION

The Aboriginal population in the Great Southern was approximately 2,200 people in 2011, which represented 2.9 per cent of the total Aboriginal population of Western Australia. This is expected to grow to 3,500 by 2025, with the percentage remaining constant at 2.9 per cent.[47]

SERVICES FOR THE GREAT SOUTHERN REGION

People living in the Great Southern region require access to services across the service spectrum, including statewide services (see pages 75–82). It is important to note that the exact locations and distributions of services will be determined by a combination of consultation process and the assessment of relative feasibility to deliver the service.

The Plan outlines the **community support** services requirement of 138,000 hours of support for mental health and 6,000 hours of service for alcohol and other drugs in the Great Southern region by the end of 2025. Modelling indicates no requirement for alcohol and other drug safe places for intoxicated people in the Great Southern region.

The modelling shows mental health **community treatment** hours of service need to be delivered at 92,000 hours, whereas alcohol and other drug hours need to total 47,000 per annum by the end of 2025.

The increase in alcohol and other drug resources would allow an expansion of service hubs in the Great Southern and increased outreach services to more areas within the region.

Currently, there are 11 mental health **community beds** in the Great Southern, and modelling shows that this needs to grow by a further 15 beds by the end of 2025. There are currently no alcohol and other drug residential rehabilitation beds and low medical withdrawal beds, and by the end of 2025 there needs to be a total of 17 beds and two beds respectively to meet demand.

The delivery of **hospital-based services**, including inpatient beds, MHOAs and HITH beds will need to be informed by consultation and assessment of feasibility to deliver the service, during the implementation of the Plan. Mental health inpatient beds and HITH beds are required to grow to 20 beds and five beds, respectively, by the end of 2025. There may be a requirement for inpatient mental health beds to be flexible in relation to age cohorts, due to the limited number of beds required. Other requirements for the Great Southern region include the establishment of three beds for alcohol and other drug high and complex medical withdrawal (from a current base of zero beds) and the expansion of consultation and liaison services to 7,000 hours of service per annum.

As with all regions, resources dedicated to alcohol and other drug **prevention**, and alcohol and other drug community diversion programs (**forensic**) need to steadily increase over the next ten years.

The Great Southern consultation provided feedback regarding the delivery of community support services to areas of low population. It is important to note that the modelled demand is for the whole region; therefore consultation needs to occur in relation to how service providers are able to cater for the entire region.

SERVICES BY REGION

Table 18: Summary of the *Plan Matrix* – Great Southern

Below is an excerpt from the *Plan Matrix*.

SERVICE TYPE	MEASURE	SOUTHERN COUNTRY GREAT SOUTHERN 2025
Prevention	Hours ('000) (total)	10
AOD	Hours ('000)	10
Community Support Services	Hours ('000) (total)	143
MH	Hours ('000)	138
AOD (Harm-reduction and personal support)	Hours ('000)	5
AOD (Post Residential Rehabilitation)	Hours ('000)	1
Community Treatment Services	Hours ('000) (total)	139
MH Infant, Child and Adolescent	Hours ('000)	35
MH Youth	Hours ('000)	10
MH Adult	Hours ('000)	27
MH Older Adult	Hours ('000)	20
AOD – All (non-residential treatment)	Hours ('000)	47
Community Bed-Based Services	Beds (total)	45
MH Community-Based	Beds	26
AOD – Low Medical Withdrawal	Beds	2
AOD – Residential Rehabilitation	Beds	17
Hospital-Based Services	Beds (total) Hours ('000) (total)	28 7
MH Inpatient (Acute and Subacute/Non-acute)	Beds	20
MH Hospital in the Home (HITH)	Beds	5
AOD (High/Complex Medical Withdrawal)	Beds	3
MH/AOD Consultation Liaison	Hours ('000)	7
Forensic Services	Hours ('000) (total)	9
AOD Community (Diversion)	Hours ('000)	9

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

SERVICES BY REGION

SOUTH WEST

OVERVIEW

The South West region covers an area of 24,000 square kilometres, representing around 1.0 per cent of the landmass of Western Australia.[49] The region's main economic activities include agriculture and horticulture, timber and forest products, mineral extraction, processing and manufacturing, tourism, construction, manufacturing, and fishing and aquaculture.

The South West region had a population of almost 180,000 in 2014 (representing 7.0 per cent of the State's population).[46] By 2025, the population is expected to reach almost 233,000 persons (7.3 per cent of the State's population).[46] The ABS reported that between 2013 and 2014, some of the fastest population increases were in the South West, including: Gelorup/Dalyellup/Stratham/Busselton region (4.5 per cent), Margaret River (4.0 per cent), and Bunbury (2.5 per cent).[49]

SERVICES BY REGION

ABORIGINAL POPULATION

The Aboriginal population in the South West was approximately 3,300 people in 2011, which represented 4.4 per cent of the total Aboriginal population in Western Australia. This is expected to grow to almost 5,500 by 2025, with the percentage increasing slightly to 4.5 per cent.[47]

SERVICES FOR THE SOUTH WEST REGION

People living in the South West region require access to services across the service spectrum, including statewide services (see pages 75–82). It is important to note that the exact locations and distributions of services will be determined by a combination of consultation process and the assessment of relative feasibility to deliver the service.

By the end of 2025, 406,000 hours of support per annum of mental health **community support** and about 20,000 hours of service for alcohol and other drugs are required to meet the needs of the population in this area. There is no modelled requirement for alcohol and other drug safe places for intoxicated people in the South West region.

The modelling shows mental health **community treatment** hours of service need to be delivered at 280,000 hours, whereas alcohol and other drug hours need to total 147,000 per annum by the end of 2025. The increase in resources for alcohol and other drug community treatment would allow an expansion of service hubs and increased outreach services to more areas within the region.

Currently, there are 25 mental health **community beds** in the South West, and modelling shows that this needs to grow by a further 49 beds by the end of 2025. There are currently zero alcohol and other drug residential rehabilitation beds and low medical withdrawal beds, and by the end of 2025 there needs to be a total of 55 beds and three beds respectively to meet demand.

The delivery of **hospital-based services**, including inpatient beds, MHOAs and HITH beds will need to be informed by consultation and assessment of feasibility to deliver the service, during the implementation of the Plan. Mental health inpatient beds and HITH beds are required to grow to 62 beds and 15 beds, respectively, by the end of 2025. There may be a requirement for inpatient mental health beds to be flexible in relation to age cohorts, due to the limited number of beds required. Other requirements for the South West region include the establishment of eight beds for alcohol and other drug high and complex medical withdrawal (from a current base of zero beds) and the expansion of consultation and liaison services to 20,000 hours of service per annum.

As with all regions, resources dedicated to alcohol and other drug **prevention**, and alcohol and other drug community diversion programs (**forensic**) need to steadily increase over the next ten years.

Feedback received from the South West consultation included the need for alcohol and other drug services to be included in the *Community Treatment Services* strategy: *Establish a police co-response program* (see page 51). The Mental Health Commission gave this suggestion consideration and also undertook further consultation on the issue.

SERVICES BY REGION

Following this feedback, consideration will be given as to how alcohol and other drug services can be included in the Mental Health and Police Co-Response program after its establishment.

Table 19: Summary of the *Plan Matrix* – South West

Below is an excerpt from the *Plan Matrix*.

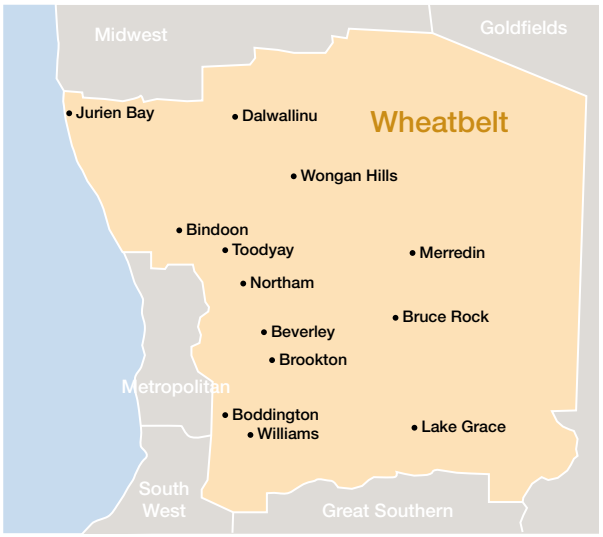
SERVICE TYPE	MEASURE	SOUTHERN COUNTRY SOUTH WEST 2025
Prevention	Hours ('000) (total)	12
AOD	Hours ('000)	12
Community Support Services	Hours ('000) (total)	425
MH	Hours ('000)	406
AOD (Harm-reduction and personal support)	Hours ('000)	14
AOD (Post Residential Rehabilitation)	Hours ('000)	6
Community Treatment Services	Hours ('000) (total)	427
MH Infant, Child and Adolescent	Hours ('000)	112
MH Youth	Hours ('000)	32
MH Adult	Hours ('000)	86
MH Older Adult	Hours ('000)	50
AOD – All (non-residential treatment)	Hours ('000)	147
Community Bed-Based Services	Beds (total)	132
MH Community-Based	Beds	74
AOD – Low Medical Withdrawal	Beds	3
AOD – Residential Rehabilitation	Beds	55
Hospital-Based Services	Beds (total) Hours ('000) (total)	85 20
MH Inpatient (Acute and Subacute/Non-acute)	Beds	62
MH Hospital in the Home (HITH)	Beds	15
AOD (High/Complex Medical Withdrawal)	Beds	8
MH/AOD Consultation Liaison	Hours ('000)	20
Forensic Services	Hours ('000) (total)	16
AOD Community (Diversion)	Hours ('000)	16

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

SERVICES BY REGION

WHEATBELT

OVERVIEW



The Wheatbelt region covers 157,000 square kilometres,[49] which constitutes 6.3 per cent of the total Western Australian land mass and contains the majority of the State's grain growing areas.[54] The Wheatbelt's economy has historically been based on agriculture, particularly cropping – which remains the most dominant industry in the region – but it is also supported by mining, commerce, manufacturing, fishing and tourism.

The Wheatbelt region had a population of almost 80,000 in 2014 (representing 3.1 per cent of the State's population).[46] By 2025, the population is expected to reach almost 88,000 persons. However, although the population will increase, the percentage of the State's population residing in the Wheatbelt will decrease to 2.8 per cent.[46] The ABS reported that between 2013 and 2014, the Wheatbelt experienced a slight drop in population (0.3 per cent).[50]

SERVICES BY REGION

ABORIGINAL POPULATION

The Aboriginal population in the Wheatbelt totalled almost 3,800 people in 2011, which represented 5.0 per cent of the total Aboriginal population of Western Australia. This is expected to grow to 6,000 by 2025, with the percentage increasing slightly to 5.1 per cent.[47]

SERVICES FOR THE WHEATBELT REGION

People living in the Wheatbelt region require access to services across the service spectrum, including statewide services (see pages 75–82). It is important to note that the exact locations and distributions of services will be determined by a combination of consultation process and the assessment of relative feasibility to deliver the service.

By the end of 2025, 175,000 hours of support per annum for mental health **community support** and about 7,000 hours of service for alcohol and other drugs are required to meet the needs of the population in this area. There is no modelled requirement for alcohol and other drug safe places for intoxicated people in the Wheatbelt region.

The modelling shows mental health **community treatment** hours of service need to be delivered at 118,000 hours, whereas alcohol and other drug hours need to total 61,000 per annum by the end of 2025. The increase in resources would allow an expansion of service hubs in the Wheatbelt and increased outreach services to more areas within the region.

Currently, there are zero mental health **community beds**, alcohol and other drug residential rehabilitation beds and low medical withdrawal beds in the Wheatbelt, and modelling shows that there needs to be 32 beds, 23 beds and two beds respectively to meet demand by the end of 2025.

The delivery of **hospital-based services**, including inpatient beds, MHOAs and HITH beds, will need to be informed by consultation and assessment of feasibility to deliver the service, during the implementation of the Plan. Mental health inpatient beds and HITH beds are required to grow to 27 beds and seven beds, respectively, by the end of 2025. There may be a requirement for inpatient mental health beds to be flexible in relation to age cohorts, due to the limited number of beds required. Other requirements for the Wheatbelt region include three beds for alcohol and other drug high and complex medical withdrawal (both from a current base of zero beds) and the expansion of consultation and liaison services to 9,000 hours of service per annum by the end of 2025.

As with all regions, resources dedicated to alcohol and other drug **prevention**, and alcohol and other drug community diversion programs (**forensic**) need to steadily increase over the next ten years.

Feedback from the Wheatbelt included that declared places need to be established for mentally impaired accused. The Mental Health Commission has included a new strategy and action in the *Forensic Services* section of the Plan: *commission a facility in the community for mentally impaired accused persons with a mental illness, which is an appropriate alternative to prison and hospital*, by the end of 2020 (see page 99).

SERVICES BY REGION

Table 20: Summary of the *Plan Matrix* – Wheatbelt

Below is an excerpt from the *Plan Matrix*.

SERVICE TYPE	MEASURE	SOUTHERN COUNTRY WHEATBELT 2025
Prevention	Hours ('000) (total)	10
AOD	Hours ('000)	10
Community Support Services	Hours ('000) (total)	182
MH	Hours ('000)	175
AOD (Harm-reduction and personal support)	Hours ('000)	6
AOD (Post Residential Rehabilitation)	Hours ('000)	1
Community Treatment Services	Hours ('000) (total)	179
MH Infant, Child and Adolescent	Hours ('000)	46
MH Youth	Hours ('000)	13
MH Adult	Hours ('000)	36
MH Older Adult	Hours ('000)	23
AOD – All (non-residential treatment)	Hours ('000)	61
Community Bed-Based Services	Beds (total)	57
MH Community-Based	Beds	32
AOD – Low Medical Withdrawal	Beds	2
AOD – Residential Rehabilitation	Beds	23
Hospital-Based Services	Beds (total) Hours ('000) (total)	37 9
MH Inpatient (Acute and Subacute/Non-acute)	Beds	27
MH Hospital in the Home (HITH)	Beds	7
AOD (High/Complex Medical Withdrawal)	Beds	3
MH/AOD Consultation Liaison	Hours ('000)	9
Forensic Services	Hours ('000) (total)	12
AOD Community (Diversion)	Hours ('000)	12

Note: Some totals may not add up due to rounding.
MH = Mental Health
AOD = Alcohol and Other Drug

SERVICES BY REGION

In consultation with key stakeholders (including consumers, carers and families), models of service will be developed to achieve a degree of standardisation throughout the State. This will enable a consistent standard of service provision, however, this must be balanced with the key aim of personalisation to meet individual needs and adaptability to meet local area characteristics (including service availability, population profile, diversity and cultural factors).

SYSTEM-WIDE REFORM

SYSTEM-WIDE REFORM

Progression of significant system improvements and new initiatives are required to support the achievement of our vision. This section of the Plan outlines in greater detail what system-wide reform areas of work need to be undertaken over the next ten years to support the Plan's implementation. In summary, areas of work focus on:

- promoting personal **recovery-oriented practice**
- supporting **consumer and carer voice**
- promoting effective system and individual **advocacy**
- exploring the expansion of **individualised funding** programs
- culturally secure service delivery for **Aboriginal people**
- **cultural and social diversity**
- improving **integration and system navigation**
- continuing the work already underway to improve **organisational effectiveness and efficiency**
- supporting **research and evaluation**
- **workforce development** to ensure the required, suitably skilled workforce is available to deliver the services, programs and initiatives identified within the Plan
- **information and communication technology** improvements and changes
- **capital infrastructure**.

AIM

Together with key stakeholders (including clinicians, consumers, families and carers), implement a range of system-wide reform initiatives to support the transformation of the mental health, alcohol and other drug service system.

RECOVERY-ORIENTED PRACTICE

It is recognised that recovery outcomes are personal and unique for each individual (see page 11 for more information on a definition of recovery). The overarching principle of personal recovery will continue to be promoted across the mental health service continuum and further investigation into how this concept applies to the alcohol and other drug sector will be progressed.

The principles of the *National Mental Health Recovery Framework* are embedded in the Plan and will continue to inform the Plan implementation. Development of the future system needs to support:

- autonomy, self-determination and choice
- co-designing of individualised plans
- the involvement of those with lived experience (such as through the employment of peer workers), families, friends, culture and community
- social inclusion, and the challenging of stigmatising attitudes and discrimination
- the provision of family inclusive practice.

TRAUMA INFORMED CARE AND PRACTICE

Many people who access mental health and community sector services have undergone many overwhelming life experiences, interpersonal violence, abuse and adversity. This includes victims of war and persecution, victims of crime and people who have experienced family violence and/or child sexual abuse.

There are more than four million survivors of childhood trauma in Australia. Abuse and trauma history has been reported by 90 per cent of people who use public mental health services.[55]

Trauma-informed practice recognises that past trauma experiences affect a person's present perspectives and responses. Therefore, it is imperative that the workforce is trained to respond appropriately, including minimising the potential for re-traumatisation. Key trauma-informed principles that guide the consumer-staff interactions are safety, trustworthiness, choice, collaboration and empowerment.[56]

Complex trauma programs are resource-intensive, however they can be delivered in the community and encompass recovery, harm minimisation and de-diagnosis paradigms. They are designed to assist people to find other ways of managing distress without resorting to familiar self-harm techniques. These programs have potential to take pressure off acute hospital-based services and also reduce the suicide rate.

Commissioning of mental health community treatment will require services to be able to offer evidence-based support and treatment for people with a history of trauma. Organisations will need to invest in the training and development of their workforce in trauma-informed practice.

ACTIONS

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- investigate international best practice recovery culture change programs
- incorporate recovery principles in the design of service models and associated practices, procedures, protocols, and commissioning practices
- explore how the concept of recovery applies to the alcohol and other drug sector and how the principles of recovery-oriented practice can be embedded in service delivery where appropriate.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- progress the implementation of recovery-oriented culture change programs as appropriate
- monitor the incorporation of recovery principles in the design of service models and associated practices, procedures, protocols and commissioning practices.

CO-PRODUCTION AND CO-DESIGN WITH CONSUMERS, FAMILIES AND CARERS

Supporting consumers, families and carers to actively participate in decision-making including co-production and co-design of policy, planning, service delivery, evaluation and research is important.

Meaningful engagement can enable services to be developed and delivered in a way that will meet consumer, family and carer needs. It can also improve communication, information flow, linkages and coordination, ultimately resulting in better outcomes for consumers, family and carers.

Consumers, families and carers can participate in working groups, forums, advisory councils, boards; and in the co-production and co-design of new policies, programs, initiatives and legislation. Appropriate training and support is essential to enable consumers, families and carers to feel confident in their role and feel supported to contribute. In addition, particular emphasis needs to be given to innovative and effective ways to engage with marginalised groups, including Aboriginal people and CALD people, to ensure they are supported to fully and actively participate.

Many organisations responsible for commissioning and/or service delivery already have a range of mechanisms in place to involve consumers, families and carers in a meaningful way, whereas others need to significantly enhance consumer, family and carer involvement.

ACTIONS

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- develop a statewide mental health, alcohol and other drug consumer, family and carer involvement framework that will outline best practice principles and practices in relation to consumer and carer involvement, co-production and co-design
- incorporate a range of mechanisms in commissioning and service provision practices to enable the involvement of consumers, families and carers in co-production and co-design of policy, planning, service delivery, evaluation and research, with a particular focus on enabling the involvement of marginalised groups (including Aboriginal people)
- consider the establishment of an alcohol and other drug consumer peak body
- provide consumers, families and carers with access to appropriate training to support them in their role as a consumer/carer representative
- include consumer experience and satisfaction indicators in the Plan evaluation process and ongoing contract monitoring.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- monitor the involvement of consumers, families and carers in co-production and co-design of policy, planning, service delivery, evaluation and research and continue to provide access to training to support consumers, families and carers.

SUPPORTING THE VOICE OF CLINICIANS AND HEALTH WORKERS

In addition to supporting the voices of consumers, families and carers, the views of clinicians and health workers also need to be heard by commissioning agencies, service managers, policy makers and all levels of Government. The Mental Health Network is a recently established group of clinicians and health workers that have an interest in mental health, alcohol and other drugs. Members come from primary, secondary and tertiary services.

It is anticipated through the Mental Health Network, clinicians and health workers will be supported to contribute to service development and reform, alongside consumers, families and carers. This will be further supported by the systemic advocacy undertaken by peak bodies such as the Western Australian Association for Mental Health (WAAMH) and the Western Australian Network of Alcohol and Drug Agencies (WANADA).

ADVOCACY

Advocacy can be individual or systemic. Individual advocacy is the process of standing alongside an individual to ensure they are able to speak out, to express their views and uphold their rights.[57] Systemic advocacy is usually carried out by an organisation who aims to influence public policy. Systemic advocacy organisations draw on the expertise, and represent the collective views of their members, the broader community, consumers, families and carers. Both systemic and individual advocacy are essential elements of the mental health, alcohol and other drug system. Effective, transparent complaints mechanisms are also required to further support system and quality improvement.

At present individual advocacy services are available, predominantly for people who require assistance under the *Mental Health Act 2014*. Individual, independent advocacy must be accessible to all mental health, alcohol and other drug service consumers, families and carers. It is therefore the intention to further explore the availability of individual advocacy and where appropriate expand access (further information is available in the *Community Support Services* section, page 40).

Systemic advocacy is currently undertaken by a range of mental health, alcohol and other drug organisations and the aim is to continue to support these activities. State Government departments (e.g. Mental Health Commission, Department of Health) also have a role to play working with other non-health sectors and levels of Government to ensure people with, or at risk of, mental health, alcohol and other drug problems are considered in public policy decisions. Other non-health sector agencies include (but are not limited to) housing, police, child protection, disability services, education, employment agencies, Local and Commonwealth Governments.

ACTIONS

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- continue to support effective systemic advocacy organisations
- further improve access to transparent and effective complaints mechanisms across the mental health, alcohol and other drug system.

Actions on page 42 relate to the expansion of access to individual advocacy.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- monitor access to individual advocacy services and the effectiveness of complaints mechanisms.

INDIVIDUALISED FUNDING

Individualised funding refers to a portable package of funds allocated to a person who is supported to choose how to spend the funds to purchase personalised supports and services.

The introduction of individualised funding programs has been progressing internationally, as well as locally in Western Australia: the National Disability Insurance Scheme (NDIS – see page 41 for more information) and the Individualised Community Living Strategy (ICLS – see page 40 for more information) are two examples. Individualised funding programs, when operating effectively, have the potential to greatly increase access to personalised service provision.

The potential expansion of individualised funding programs will be explored further during the Plan implementation. Expansion of such programs will be informed by international best practice as well as evaluations of local programs such as the NDIS and ICLS.

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- monitor evidence emerging from existing individualised funding programs and further explore the potential to expand access to a range of individualised funding programs across the service system.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- continue to monitor the implementation of individualised funding programs.

ABORIGINAL PEOPLE

In Western Australia, Aboriginal people are hospitalised six times more often than non-Aboriginal people for alcohol related causes,[58] and 2.5 times more often for illicit drugs.[58] According to the Australian Bureau of Statistics, Aboriginal and Torres Strait Islander people aged 18 years and over were 2.5 times more likely than non-Indigenous people to have experienced high/very high-levels of psychological distress.[59]

This requires mental health, alcohol and other drug services to understand the role of culture, provide non-discriminatory care and respond to the cultural requirements of Aboriginal people.

The recently released *Western Australian Aboriginal Health and Wellbeing Framework 2015-2030* will be used to guide the appropriate implementation of the Plan with Aboriginal communities.

The *Looking Forward project* aims to design, develop, and pilot a culturally-safe mental health service framework that will benefit the community, and provide a benchmark for organisations to provide more effective mental health services to Aboriginal people. The project is a partnership between public and non-government service providers, GPs, and other health professions.

The outcomes of the project will be used to inform future service development in the mental health, alcohol and other drug sector.

SYSTEM-WIDE REFORM

Strategies to improve the health and wellbeing of Aboriginal people needs to be developed by and with Aboriginal people, communities and elders, taking into account the Aboriginal definition of health and wellbeing. The continued funding of the Statewide Specialist Aboriginal Mental Health Service (see page 52) is one element of the service system which supports the health and wellbeing of Aboriginal people. Other dedicated Aboriginal programs and services will be developed across the service system as appropriate, particularly in regional areas. This will involve cultural rehabilitation and healing programs where appropriate.

Increasing the Aboriginal workforce across the service spectrum is also a key priority. However, it should be noted, the delivery of culturally secure services is the responsibility of all staff working across the mental health, alcohol and other drug service system. Workforce planning and workforce development initiatives are discussed on page 161.

TRADITIONAL ABORIGINAL HEALERS

The role of traditional healers is recognised in the *Mental Health Act 2014* (Act). The Act defines a traditional healer as a person of Aboriginal descent who uses traditional (including spiritual) methods of healing, and is recognised by the community as a traditional healer. The Act requires assessment and examination of a person of Aboriginal descent to be conducted in collaboration with Aboriginal mental health workers and significant members of the person's community, including elders and traditional healers. The same collaboration is required in relation to the provision of treatment.

SYSTEM-WIDE REFORM

ACTIONS:

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- incorporate culturally secure and respectful, non-discriminatory principles in the design of service models and associated practices, procedures, protocols, and commissioning practices.

Additional actions relating to services for Aboriginal people and communities are included throughout the Plan.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- monitor the extent to which services have incorporated culturally secure and respectful, non-discriminatory principles in the design of service models and associated practices, procedures, protocols, and commissioning practices.

CULTURAL AND SOCIAL DIVERSITY

CULTURALLY AND LINGUISTICALLY DIVERSE PEOPLE

In Western Australia, people from CALD backgrounds can be under-represented in mental health, alcohol and other drug services, due to barriers of language, lack of awareness of services, and factors such as fear of stigmatisation. People from CALD backgrounds may have also experienced a range of stressors including trauma and discrimination.

The expansion of transcultural specialised statewide services (see page 80) is one component of the service system. All mental health, alcohol and other drug services need to be competent at providing culturally competent services that also respect an individual's spiritual and religious beliefs.

Cultural competence will be improved across the system through robust and consistent training and education programs, by advocating seamless and timely access to appropriately qualified interpreters, and by increasing the CALD workforce. Dedicated CALD programs and services will be developed across the service system as appropriate.

ACTIONS:

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- incorporate culturally competent principles in the design of service models and associated practices, procedures, protocols, and commissioning practices.

See page 81 for additional actions relating to services for CALD people.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- monitor the extent to which services have incorporated culturally competent principles in the design of service models and associated practices, procedures, protocols, and commissioning practices.

LESBIAN, GAY, BISEXUAL, TRANSGENDER, INTERSEX COMMUNITY

A greater proportion of people who identify as homosexual/bisexual have experience mental health problems compared to people who identify as heterosexual. For example, approximately 36 per cent of transgender and approximately 24.0 per cent of gay, lesbian and bisexual Australians met the criteria for experiencing a major depressive episode in 2005, compared with 6.8 per cent of the general population.[60]

All services need to be able to provide services that are accessible and sensitive to the needs of Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) people. A dedicated service has been identified in the *Specialised Statewide Services* section (see page 78). This service will provide for people requiring support with their gender identity. It will also provide support, training, education and consultancy to mainstream services, as all mental health, alcohol and other drug services need to ensure they are sensitively meeting the needs of LGBTI people.

SYSTEM INTEGRATION AND NAVIGATION

MODELS OF SERVICE

A model of service broadly defines the preferred way services are to be delivered using international, national and local evidence-based best practice principles. When implemented, models of service positively impact standardisation, quality, organisational effectiveness, efficiency and every individual's experience of services.

Models of service will be centred on a personal-recovery approach to service delivery in the mental health sector. Models of service outline what a particular service type could offer (based on best practice), how the service could be configured, eligibility, length and frequency of treatment, roles and responsibilities of staff, consumers and carers. Where relevant, models of service also include expectations and standards regarding:

- recovery-oriented (particularly for mental health service)
- trauma informed care and practice
- physical health assessment and treatment
- requirements to support people with co-occurring problems (e.g. mental health, alcohol and other drug use problems; disability)
- family inclusive and where appropriate child-centred and/or child-aware practice
- non-discriminatory and de-stigmatising service provision
- culturally secure and/or Aboriginal ways of working
- culturally competent practice
- service navigation, integration, referral pathways and transition
- communication between and within services
- quality and safety
- reporting and evaluation.

The Mental Health Commission will work with key partners, including consumers, families, carers, clinicians, primary care, service providers and the Office of the Chief Psychiatrist, to progress the development of standardised models of service for service streams including community support services, community treatment services, community bed-based services, hospital-based services, specific specialised statewide services, and forensic services. Where relevant, mechanisms to monitor the implementation of models of service will be established.

The models of service would be informed by, and complement, the standards currently under development by the Office of the Chief Psychiatrist as part of the implementation of the *Mental Health Act 2014*.

SYSTEM-WIDE REFORM

SYSTEM INTEGRATION

Mental health, and alcohol and other drug problems, more often than not occur together and with other health and/or social issues (e.g. trauma, cognitive impairment, physical health problems, housing problems). It is essential that mental health, alcohol and other drug services work together across primary care, community and hospital-based services and across health and human service sectors in an integrated, coordinated way to improve consumer, family and carer service experience and outcomes.

System integration ensures service delivery is comprehensive, cohesive, accessible, responsive, and optimises the use of limited resources. 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.

Figure 11 shows the prevalence of mental health, alcohol and other drug problems, subdivided into grades of severity and distress (labelled severe, moderate and mild). It is estimated that 17.2 per cent of the population will experience mental illness and 2.7 per cent of people will experience alcohol and other drug-related problems, with different levels of severity and distress.[61,62]

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

People with alcohol and other drug 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. For more information, refer to Appendix D.

SYSTEM-WIDE REFORM

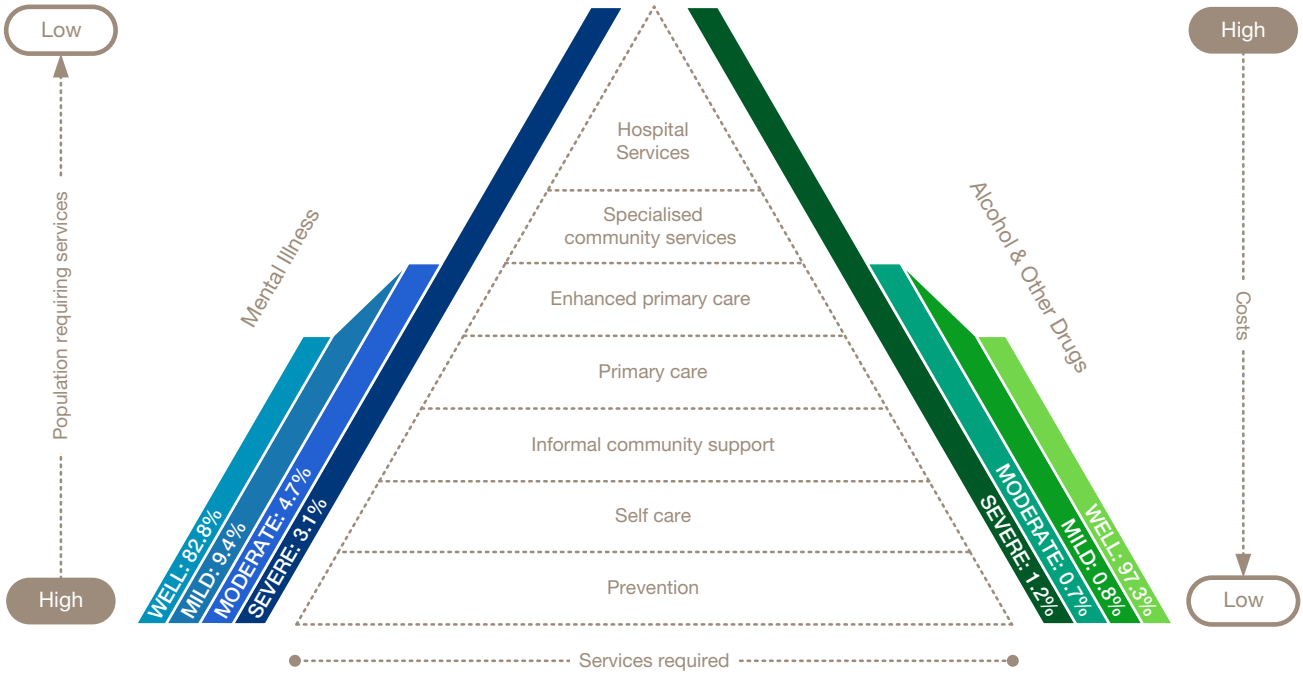


Figure 11: Optimal service mix and severity continuum [61,62]

While there are some excellent examples of collaborative or integrated work occurring in the mental health, alcohol and other drug sectors, there is more often limited joint planning and communication between services. 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.

An integrated system requires new and effective ways of working together within and across traditional boundaries so that services are coordinated. Critical to the success of working in shared ways are:

- making available nominated people that assist people to navigate the system of services
- clarity about shared roles and responsibilities
- clarity around accountability
- clear and established decision-making processes and agreed conflict resolution mechanisms
- minimising bureaucracy and avoiding duplication of administration
- having compatible information technology and sharing information appropriately
- resolving service gaps and policy issues at the earliest opportunity
- flexibility around service outcomes, including shared outcomes and reporting arrangements
- recognition that staff involved in working in an integrated fashion need to understand how they fit within their own organisation and within the larger system.

SYSTEM-WIDE REFORM

CO-OCCURRING MENTAL HEALTH, ALCOHOL AND OTHER DRUG PROBLEMS

The level of co-occurrence of mental health, alcohol and other drug problems is such that some services would be more efficient and produce better consumer outcomes if services supported people with both conditions holistically. The amalgamation of the Mental Health Commission and the former Drug and Alcohol Office will assist collaboration, integration, planning, and the commissioning of services.

Commissioning and service delivery will require collaborative and, where appropriate, integrated provision of treatment for mental health, alcohol and other drug problems. This will involve a more consistent approach to collaboration, joint protocols, clearly defined treatment and support protocols, and care pathways. It may also involve workers who are specialised in co-occurring mental health, alcohol and other drug treatments providing expert consultancy and support to mainstream services. It may also include the transfer of mental health workers into alcohol and other drug services, and vice versa. Additional training will further support staff from each sector to ensure competent delivery of services for people with co-occurring problems.

CO-OCCURRING MENTAL HEALTH AND INTELLECTUAL OR COGNITIVE DISABILITY

According to a 2008 Western Australia population level data linkage study,[63] 31.7 per cent of people with an intellectual disability have a mental health problem and 1.8 per cent of people with a mental health problem have an intellectual disability. These figures are thought to be an underestimate and prevalence varies between studies. Generally, staff are trained in one area and or the other (i.e. mental health or disability, not both), which can lead to a lack of coordinated and integrated care for people with co-occurring mental health problems and intellectual/cognitive disability. Additional training, consultancy across sectors and where appropriate the transfer of workers will be explored with the disability services sector to ensure people receive seamless treatment and care.

IMPROVING THE PHYSICAL HEALTH OF PEOPLE WITH MENTAL HEALTH, ALCOHOL AND OTHER DRUG PROBLEMS

The poor physical health status of many people with mental illness is a concern shared across Australian jurisdictions. People with alcohol and other drug problems also experience poorer health outcomes than the general population. For example, Hepatitis C is a blood-borne virus and approximately 90 per cent of newly acquired Hepatitis C infections and 80 per cent of prevalent cases in Australia are a result of unsafe injecting use practices.[64] Alarmingly, 70 per cent of people with a serious mental illness die from cardiovascular disease compared with 18 per cent of the general population and approximately 60 per cent of people with a serious mental illness smoke compared to 17 per cent of the general population.[65] Many of these physical illnesses are preventable.

SYSTEM-WIDE REFORM

We aim to build on existing programs and strategies that improve the physical (including oral) health of individuals with mental health, alcohol and other drug problems. This would include:

- monitoring the implementation of the physical health strategies currently being progressed by the Office of the Chief Psychiatrist and Office of Mental Health (including operational directives)
- collaborating with existing health promotion agencies to promote good health and wellbeing across the service system
- engaging the primary healthcare sector and ensuring clinicians working in mental health, alcohol and other drug services (e.g. psychiatrists) are supported to assess and monitor the physical health of consumers
- increasing access to Hepatitis C treatment for those with Hepatitis C.

Much work already occurs in the area of tobacco control, managed by the Chronic Disease Prevention Directorate of the Department of Health. This work is guided by the *Western Australian Health Promotion Strategic Framework 2012–2016*.

SYSTEM NAVIGATION

The mental health, alcohol and other drug system is a complex arrangement of public sector, not-for-profit and private sector services and supports. Whilst there are some initiatives currently in place that assist with navigating the complex system, continued difficulty in accessing information and navigating the system exists. The following initiatives can aid individuals in navigating the system.

HELP LINES

Evidence-based telephone helplines assist people to navigate the system as well as provide assistance in the following areas:

- the provision of specific information and advice targeted to members of the public, individuals seeking advice reassurance and guidance on behalf of others, and people self-identifying their particular issues
- the provision of screening, assessment, triage and brief intervention
- offering referral to specialist treatment services and the provision of information and advice to health professionals
- provision of direct clinical services.

There are a range of telephone-based helplines in Western Australia including Mental Health Emergency Response Line (MHERL), Rural Link, Alcohol and other Drug Information Service (ADIS), Healthdirect, SANE, Men's Helpline Australia, Lifeline and others. The establishment of a single point of access is essential to reduce confusion. The establishment of a 'one stop shop' that will provide a single point of access is discussed further on page 47.

SYSTEM-WIDE REFORM

ONLINE SERVICES

Many people prefer to access information and assistance through online support. Information about accessing treatment is available through service directories and some websites provide access to online counselling.

The *Green Book* is a collaborative project between the Western Australian Network of Alcohol and Other Drug Agencies (WANADA) and the Western Australian Association of Mental Health (WAAMH). It contains a listing of organisations providing mental health, alcohol and other drug services to the Western Australian community. It is available in print, online and there is a smartphone application which can be downloaded. The *Green Book* is widely distributed and is provided extensively to GPs.

Following the amalgamation of the Mental Health Commission and the former Drug and Alcohol Office, online services will be reviewed to ensure they are streamlined, comprehensive and easy to use. Whilst telephone and online services are important they are of limited value unless widely publicised and effective in meeting the needs of people who access them. Both community information campaigns as well as targeted training and advice to groups such as GPs and other health practitioners is needed to improve knowledge about where to seek assistance. The 'one stop shop' (see page 47) will play an integral role in ensuring online services are streamlined and easy to use.

PEER SUPPORT WORKERS

Peer support workers are able to assist with advocacy and provide social, emotional and practical support (such as helping someone get to appointments or helping them to identify the supports and services they need). Often, peer workers share lived experiences with the participants, and have been shown to reduce hospital readmission and increase discharge rates.[66,67] Peer workers can also include parents, families and friends who provide support to each other through formal and informal mechanisms.

Peer workers have an important role in driving person-centred approaches within services. Research shows that individuals have improved recovery from mental health, alcohol and other drug problems as well as a reduction in recidivism where peer support workers are engaged.

Peer support workers can also offer follow-up phone calls to ensure that people are settling back into the community and connecting with relevant services, and they can deliver health promotion, education and training. Peer workers can be employed in services including outreach services, inpatient units, day programs, and telephone services.[68,69]

The optimal mix shows a requirement for the peer support workforce to be substantially increased and embedded in not only the clinical areas but also in community support programs. These workers are an important component in helping people to navigate the system and to access the range of services they need to achieve the outcomes they are seeking in their personal recovery journey.

COMMUNITY COORDINATION

The emerging role of coordination empowers individuals to navigate the system and access services and supports that will meet their holistic needs, such as housing, connection to their community, employment, and other important needs. The Mental Health Commission proposes to pilot a community coordinator program that will complement (not duplicate) existing coordination programs (e.g. Partners in Recovery). Key functions would include:

- *Individual coordination*: facilitating access to culturally secure, inclusive and regionally appropriate supports and services, and empowering individuals and their families to achieve a better quality of life through full community participation and the development of reciprocal relationships
- *Planning*: working with individuals and their families to identify whole-of-life goals and identify the steps and actions required to achieve them
- *Advocacy*: supporting individuals to have their voice heard and their point of view duly considered, or standing alongside and advocating where required
- *Information*: ensuring that members of the community have timely access to the information they need
- *Community building:* working to build an inclusive and supportive community that values the contribution of people with mental health, alcohol and other drug problems
- *Individualised funding*: facilitating access to flexible funding that individuals can use to purchase goods, supports and services
- *Building partnerships:* working across services and within community (government, private and community funded sector) to enhance outcomes for individuals
- *Future systemic planning:* Contributing to the Mental Health Commission's future planning and purchasing by informing and advising on local needs from the perspective of individuals, carers, families and local community.

ACTIONS

IMPLEMENT EXISTING COMMITMENTS:

- implement the provisions of the *Mental Health Act 2014* and monitor the extent of improved integration of care.

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- require commissioned services to develop coordination and communication strategies to ensure relevant services[xx] are integrated and people are supported to transition effectively between services, programs and regions. This may include:
  - the establishment of integration, coordination and transition initiatives and policies such as the reciprocal transfer of staff between services
  - the establishment of protocols for informing consumers, carers, families and GPs (throughout treatment and upon discharge) as to treatment plans and how to re-access services if required

xx Relevant services can include private sector, government, non-government and primary care services across a range of sectors including mental health, alcohol and drug, disability, housing and so on.

  - the development of communication and information flow protocols for accessing patient records and treatment plans, other communication and reporting between non-government organisations, public sector, and private sector, and across community, primary, secondary and tertiary services
- where relevant, standardise, establish and monitor key performance indicators for follow-up and other communication during treatment and post-discharge
- continue to build upon programs to address the physical health gap including partnering with existing healthy lifestyle and injury prevention health promotion programs
- together with key stakeholders, 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
- develop and commence a pilot community coordination program to assist people to navigate the mental health, alcohol and other drug service system (complementing current programs such as Partners in Recovery)
- progress the expansion of the peer workforce across the service spectrum.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- continue to monitor service integration and navigation initiatives and models of service implementation, progressing improvements as necessary
- finalise an evaluation of the pilot community coordination program and, depending on the evaluation outcomes, expand its reach to areas of greatest need.

ORGANISATIONAL EFFECTIVENESS AND EFFICIENCY

Organisational effectiveness and efficiency can be improved through a range of strategies to standardise and improve the safety and quality of the system. Commissioning services would require providers to demonstrate:

- safety and quality assurance mechanisms, including safeguarding practices for vulnerable people
- appropriate benchmarks of quality and responsiveness
- evidence-based models of service that are effective, efficient and are capable of delivering quality care in a financially constrained environment
- acceptable outcomes in terms of length of stay, treatment episodes completed as planned, readmission rates, and continuing care following discharge
- the use of standardised documentation (both non-electronic and electronic) across the system to improve efficiency and access to key information.

Both the Department of Health and the Mental Health Commission are implementing a range of strategies to support system development and growth. The Mental Health Commission would largely do this through its policy setting and commissioning role as well as through sponsoring sector development and information/knowledge sharing initiatives.

RESEARCH AND EVALUATION

Research and evaluation is important for promoting innovation, service development and continual improvement. Although new services are required to be evidence-based and/or evidence informed, research and evaluation can build on the evidence base and provide opportunities to expand knowledge around what works in prevention, treatment and support.

Research and evaluation initiatives are already underway, with the Mental Health Commission and Department of Health funding a range of projects and pilots. The development of an evaluation plan is a key priority for all relevant new projects and initiatives and is considered in the context of the Department of Treasury's *Program Evaluation: Sunset Clause* requirements.[xxi] Research also continues through tertiary institutions and other research agencies and is critically important for translating international research findings into a Western Australian context.

Resources for research and evaluation over the next ten years have been included in the costings relating to the Plan. Funding is subject to the State's fiscal capacity and the distribution of any funds will be determined during the Plan implementation phase.

Further information on the evaluation framework that will be used to monitor and inform improvements to the Plan implementation is provided in Appendix B.

ACTIONS

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- in collaboration with key stakeholders, identify research priorities and allocate resources according to identified priorities
- continue to make evaluation a requirement of funding and service agreements where applicable.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- progress the commissioning and undertaking of research projects in line with identified priorities.

xxi http://www.treasury.wa.gov.au/uploadedFiles/Treasury/Program_Evaluation/program_evaluation_sunset_clause_agency_guide.pdf.

WORKFORCE

The implementation of the Plan over the next ten years will involve substantial service development and expansion. There is a corresponding need for substantial growth in existing and new/emerging work roles in the mental health, alcohol and other drug workforce.

Currently, the mental health, alcohol and other drug sectors do not have the workforce capacity to deliver on all of the services and programs outlined in the Plan. Further to this, there is a need to develop the capability of the broader health and human service workforce to contribute to preventing mental illness, reducing harm from alcohol and other drug use and to meet the needs of people with mental health, alcohol and other drug problems (e.g. general health services, police, education, corrections, primary care, emergency services).

Detailed planning and the implementation of a range of workforce initiatives and programs is required to ensure that there is the right number and mix of suitably qualified and skilled staff to effectively deliver the services and programs outlined in the Plan. This includes aligning with, and building upon, existing State and national workforce strategies, for example:

- *The National Mental Health Workforce Strategy and Plan.*
- *Western Australian Public Sector Commission's Aboriginal Employment Strategy 2011–2015.*

Priorities for workforce development over the next ten years will include working with key stakeholders to:

- increase the number and appropriate mix of skilled workers across the mental health, alcohol and other drug sector
- identify mechanisms to expand and build the capacity and skill of the new and emerging mental health, alcohol and other drug workforce (e.g. prevention workers, peer workers, community coordinators). This may include the development of career pathways, certification and training.
- increase the capability across the specialist mental health, alcohol and other drug sector to address complex problems and meet the needs of priority target groups (e.g. co-occurring mental health, alcohol and other drug problems; physical health problems; trauma; disability; older adults). This may involve consultancy and the transfer of workers between different sectors, where appropriate.
- implement a range of initiatives to improve the capability of mental health services to deliver evidence-based prevention and recovery-focused programs and services
- implement a range of initiatives to increase the capability of the alcohol and other drug workforce to deliver evidence-based programs and services for prevention through to treatment
- ensure staff have access to supervision and support to increase staff retention
- explore the need to set minimum qualification requirements across the sectors

- build capability across the broader health and human service sectors (e.g. general health services, police, education, corrections, primary care, emergency services) to appropriately prevent mental illness, reduce the harm of alcohol and other drug use and meet the needs of people with mental health, alcohol and other drug problems
- build on existing programs[xxii] to increase the Aboriginal workforce and implement strategies to build the cultural security of the mental health, alcohol and other drug workforce
- build on existing programs to increase the CALD workforce and implement strategies to build the cultural awareness of the mental health, alcohol and other drug workforce to ensure services are respectful of cultural diversity
- explore innovative options to increase the number, and support the sustainability, of an appropriately qualified and skilled regional workforce
- if required, expand upon strategies to attract skilled migrants
- develop and strengthen partnerships with the tertiary education sector to introduce or increase mental health, alcohol and other drug content into curricula for relevant courses.

xxii For example the Strong Spirit Strong Mind cultural awareness training and Certificate III and IV Aboriginal Alcohol and Other Drug Worker training program.

ACTIONS

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- develop and commence implementation of a comprehensive mental health, alcohol and other drug workforce planning and workforce development strategy that includes key priorities and strategies to build the right number and appropriately skilled mix of staff, and clarifies roles and responsibilities of commissioning agencies and service providers
- maintain Registered Training Organisation registration and continue to deliver nationally recognised training programs, currently Certificate III Community Services Work, and Certificate IV in Alcohol and Other Drugs for the Aboriginal Alcohol and Other Drug Workforce in Western Australia.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- continue the implementation of evidence-based strategies to establish and maintain the optimal number and mix of suitably qualified and skilled staff to effectively deliver the services and programs outlined in the Plan
- monitor and evaluate the effectiveness of the workforce planning and workforce development strategies employed and adapt strategies as appropriate.

BY THE END OF 2025, TO CONTINUE THE REFORM, MODELLING IDENTIFIES THE REQUIREMENT TO:

- continue to monitor and evaluate the effectiveness of the workforce planning and workforce development strategies and adapt strategies as appropriate.

INFORMATION AND COMMUNICATION TECHNOLOGY

There are currently multiple Information and Communication Technology (ICT) systems used across the mental health, alcohol and other drug service system. More consistency is seen in the alcohol and other drug sector where Service Information Management System (SIMS) is used by most alcohol and other drug agencies. In regards to the mental health sector, a variety of ICT systems are used which can have a detrimental impact on the provision of seamless, coordinated treatment and support.

The Stokes Review identified the following areas for improvement:

- ensuring information is available and accessible to all clinicians involved in a person's care
- developing and implementing standardised documentation in all public mental health services in Western Australia
- improving intra- and interdisciplinary communication within and between services.

There are two core components in relation to ICT:

- managing information across the system
- delivering treatment and support services through technology.

MANAGING INFORMATION ACROSS THE SYSTEM

A centralised approach to information that translates across all care streams and all service providers. ICT systems must:

- enable improved access to authoritative and accurate information related to individuals' care throughout the system, where and when its needed – including clinical and community
- support the need for information to move with the individual
- enable information and record sharing across services where appropriate
- embrace innovation and standards
- facilitate easier organisational reporting.

In developing the required specifications for the new ICT system, examination will be undertaken with regard to electronic forms (including those under the *Mental Health Act 2014*), and automated notifications where possible. This would ensure minimal administrative burden on staff.

DELIVERING TREATMENT AND SUPPORT SERVICES THROUGH TECHNOLOGY

Technology can provide, and support the delivery of mental health, alcohol and other drug services across the system. Delivering services using ICT (telehealth) allows for:

- improved access to mental health, alcohol and other drug information, training and promotion to anyone, anytime and anywhere
- accessible diagnostic/assessment and consultation/treatment services including telepsychiatry, regardless of geographical location, including regional areas
- individuals, support networks and clinicians having control and choice of when, where and how services are delivered – complementing rather than replacing traditional service delivery mechanisms.

ACTIONS

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

- progress updates and essential development of current ICT systems (e.g. uploading new forms) to ensure current work practices are supported during the development of a new ICT system
- develop a mental health, alcohol and other drug service ten year ICT plan that will encompass improved systems, telehealth and telepsychiatry services, and communications within and between services that supports:
  - the maintenance of existing clinical information systems, ongoing training and auditing of system use
  - development of a business case for new clinical information system(s) to support the delivery of best practice and efficient mental health, alcohol and other drug services
  - implementation of innovative eHealth and telehealth for specialised mental health, alcohol and other drug services across regional Western Australia
  - the implementation of information sharing protocols across the sector.

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

- commission an effective ICT system across the mental health, alcohol and other drug system.

BY THE END OF 2025, TO CONTINUE THE REFORM, MODELLING IDENTIFIES THE REQUIREMENT TO:

- implement an ongoing program of ICT maintenance and enhancement, in line with the long-term strategy.

CAPITAL INFRASTRUCTURE

The optimal place to provide services is close to home so that individuals can maintain connection with family, friends, and their community. Services need to be reconfigured so that beds and community services are distributed geographically in accordance with population need. In recognition of this need, clinical and infrastructure change has already begun. In the next two years, four new hospital services with dedicated mental health beds will open:

- Perth Children's Hospital – 20 beds
- QEII – 30 beds
- Midland – 56 beds
- Fiona Stanley Hospital – 30 beds.

To meet population demand, the optimal mix identifies that the Mental Health Commission needs to commission a combination of new builds, redesign of existing services, and increased leasing of suitable properties. Expansion of services closer to where people live includes a substantial investment across the regions, which aligns to population projections.

The expansion in regions refers to both community and hospital services (as shown in the *Plan Matrix on page 105*).

Further consultation, research, market evaluation and business cases will be developed over the next ten years for Government decision.

Supporting consumers, families and carers to actively participate in decision-making including co-production and co-design of policy, planning, service delivery, evaluation and research is important.

A PARTNERSHIP APPROACH TO IMPLEMENTING REFORM

A PARTNERSHIP APPROACH TO IMPLEMENTING REFORM

The Plan is highly ambitious in the extent it recommends service expansion and systemic change. Achieving such widespread reform requires commitment from all levels of Government, the private and non-government sector, other health and social services, and most importantly consumers, carers and their families. It also necessitates a phased approach over the next ten years which allows for effective implementation, evaluation and adjustments to the Plan.

The Plan is provider and funder neutral, that is, the Plan articulates what services are required in the system but not who should fund or provide such services. Importantly, the Plan is not prescriptive about *how* the programs and services will be delivered, but rather proposes the level of service required and some priority areas for development going forward.

The Mental Health Commission will, in partnership with key stakeholders, lead the Plan implementation. The Plan's vision, principles and areas for achievement will guide implementation over the next ten years. Models of service and operational aspects of the services will be decided in partnership with clinicians, service providers, consumers, carers and their families. Management of risk will be the responsibility of the Mental Health Commission, funding agencies and service providers.

Implementation processes must consider the particular challenges of delivering services in regional areas and work with local stakeholders to develop services that enable equitable access for the community.

A PARTNERSHIP APPROACH TO IMPLEMENTING REFORM

PRIORITISING AND PROGRESSING ACTION

The following factors will influence the prioritisation and progression of the Plan:

- prioritisation of investment will be focused on the areas and services of greatest need first
- clinical safety and human rights will remain the highest priority
- sufficient planning time will be allocated for all projects, including sufficient time for ongoing meaningful involvement of consumers and carers and thorough options analysis
- achievable timeframes will be established for all initiatives
- interdependencies between actions will be considered
- where practical, remodelling and improvement of existing services will be undertaken prior to focusing on additional investment
- economies of scale will be considered when implementing small programs and programs in areas of small populations
- transparency and accountability is vital in relation to decision-making, and the delivery of the actions and outcomes of the Plan.

A PHASED APPROACH

Implementation of the Plan and investment in reform is dependent on Government's fiscal capacity and is subject to normal Government approval through budgetary processes. Business cases are required to be developed for each initiative, and be submitted for Government approval. Business cases will include detailed analysis of evidence, costings, as well as a range of delivery and procurement options to consider.

The quantum and locations of services may be subject to change, and specifics will be evaluated and confirmed during the business case development and options analysis process. Development of business cases will continue over the life of the Plan, for the implementation of all initiatives.

Revised activity targets, population and resource estimates will be produced by the modelling estimator tools every two years to guide investment to the end of 2025 and keep the Plan current and relevant. This will confirm whether the planned changes for the end of 2025 remain appropriate and achievable.

A PARTNERSHIP APPROACH TO IMPLEMENTING REFORM

PREPARE FOR THE FUTURE – *From now until the end of 2017, we need to prepare for the future by:*

- engaging with consumers, families, carers and the service system to prepare for reform
- implementing the initiatives that have already been committed
- progress high priority actions that will make a real difference, by developing business cases for Government approval
- developing standardised models of service
- evaluating, redesigning, remodelling and reconfiguring existing services – including specifying logistics in relation to facilities, workforce/recruitment, and patient transfers.

REBALANCE THE SYSTEM – *From the end of 2017 to the end of 2020, we need to rebalance the system by:*

- continuing service redesign
- finalising the standardised models of service
- implementing Government approved projects
- business case development (focus on community), and seek Government approval
- the provision of a progress report to Government in 2020.

A PARTNERSHIP APPROACH TO IMPLEMENTING REFORM

CONTINUE THE REFORM – *From the end of 2020 to the end of 2025, we need to continue the reform by:*

- implementing improvements which arise during the progress report to Government in 2020
- further implementing approved projects
- developing more business cases to grow all elements of the system, and seek Government approval
- the provision of a progress report to Government in 2025.

FACTORS INFLUENCING PLAN IMPLEMENTATION

SHARED PLANNING BETWEEN COMMONWEALTH AND STATE GOVERNMENTS

There is currently no consistent mechanism for shared planning of mental health, alcohol and other drug services and investment between the Commonwealth and State Governments. Whilst there is dialogue about policies and agreements at the national level through the Council of Australian Governments and other national organisations, there is no significant planning of investment between the jurisdictions. This issue has been recognised in the recently released National Mental Health Commission *Report of the National Review of Mental Health Programmes and Services*.[30]

Significant planning of investment between the State and Commonwealth Governments is an important step going forward. Close working with the new Primary Health Networks is also required.

The Plan provides an opportunity to use a common platform on which to base decisions for the future.

The Commonwealth financed the development of the National Mental Health Services Planning Framework (NMHSPF) and the Estimator Tool. In addition, all jurisdictions assisted in developing this planning mechanism. An agreement to adopt the Plan as a framework for collaborative future planning in Western Australia would benefit the mental health, alcohol and other drug system as a whole.

Given the Mental Health Commission is uniquely placed as a purchasing commission, there is a further opportunity for the Commonwealth to invest through the Mental Health Commission and in so doing, achieve coordinated allocation of both Commonwealth and State funding.

ESTABLISHING MULTI-AGENCY PARTNERSHIPS AND LEAD AGENCIES

There is a widely held view that the delivery of mental health, alcohol and other drug services is fragmented and that there is duplication and service gaps. Local partnerships between government agencies and non-government organisations will drive continuous improvement at the local level through joint planning, action and review between sectors.

Western Australia has already implemented important measures to facilitate partnerships between Government agencies and non-government organisations. In 2011, Western Australia introduced the *Delivering Community Services in Partnership* (DCSP) policy, which aims to put the individual at the centre of the relationship between the public and not-for-profit community sectors by requiring a joint approach to contracting between government agencies and not-for profit organisations.

A PARTNERSHIP APPROACH TO IMPLEMENTING REFORM

To further reduce fragmentation, commissioning practices can also involve the commissioning of a lead agency to deliver a variety of services across the spectrum. In these cases, the lead agency could then bring together a consortia of providers to deliver a variety of seamless services across spectrum.

OTHER FACTORS INFLUENCING THE IMPLEMENTATION OF THE PLAN

Mental Health Act 2014

The new *Mental Health Act 2014* (Act) provides new rights and protections for people experiencing mental illness and promotes recovery-oriented practice within mental health services. It recognises the important roles of families and carers by providing rights to information and involvement. The Act also provides increased certainty and clarity for clinicians and builds on existing best clinical practice.

The Act and the Plan are largely separate initiatives, however, where relevant such as in the models of service in the *System-Wide Reform s*ection, reference to the applicability of the Act is made.

Stokes Review

The State Government made a firm commitment to implement 115 of the 117 recommendations of the Stokes Review. Many of the strategies and actions within the Plan address other key recommendations of the Stokes Review. The Stokes Review made a range of operational improvement recommendations which are progressively being implemented alongside the implementation of the Plan.

Commonwealth initiatives

The Commonwealth Government established the National Mental Health Commission in 2012. It also initiated: the Partners in Recovery program; mental health and family support programs; the establishment of Medicare Locals; funding of headspace and enhanced headspace across Australia; and programs for suicide prevention and bereavement support. More recently, the Commonwealth Government has also focused on the mental health of veterans. The Commonwealth also contributes to the funding of mental health services through the *National Health Reform Agreement*, (NHRA) Medicare Benefits Schedule items, and the Better Access program.

Shared State and Commonwealth Commitments

Shared State and Commonwealth Government commitment to mental health initiatives include:

- the *Roadmap for National Mental Health Reform 2012-2022*: a policy document that provides a vision and national framework for mental health and wellbeing of all Australians
- activities through the *Fourth National Mental Health Plan* – a strategic document that sets an agenda for collaborative Commonwealth, State and Territory Governments action in mental health for five years from 2009
- the NHRA, which was signed in 2011 by the Commonwealth and all States and Territories, to drive major reforms to the organisation, funding and delivery of health and aged care.

SUMMARY AND CONCLUSION

There is a need for substantial transformation and ongoing investment in Western Australia's mental health, alcohol and other drug system. The system as a whole requires reconfiguration in order to achieve the optimal service mix and best outcomes for individuals.

According to the modelling, the hours of service/support across the mental health, alcohol and other drug sector is required to increase almost threefold. Ultimately, bed numbers are required to double over the ten years, with the majority being community-based beds.

This Plan provides us with a roadmap for the change, development and growth of Western Australia's mental health, alcohol and other drug system. The system is out of balance, in that the absence of some services has led to strain on other parts of the service continuum. Improvement can be achieved through a strategic, balanced and targeted approach to investment over a number of years.

The changes outlined in the Plan require a phased approach to enable careful design of service models and facilities, and to ensure the new system is sustainable, more efficient and importantly, enables better outcomes for people, their families and carers.

The Plan articulates the requirements and optimal service mix by the end of 2025. It is acknowledged we cannot implement all changes in the short term; hence actions are phased up until the end of 2025. Achievement of outcomes is based on numerous factors including the labour market; the property market; population changes (including in regions); stakeholder input and collaboration; and investment decisions by the State and Commonwealth Governments, and the private and non-government sectors.

The Plan is an important first step along the pathway to change and improve the mental health, alcohol and other drug system. This will achieve the best outcomes for people with mental health, alcohol and other drug problems, and establish a sustainable system for future populations.

Table 21: Overall results: Hours of service/support and bed numbers

	2012-13 ACTUALS	2013-14 REQUIRED	2024-25 FORECAST	ADDITIONAL REQUIREMENT
Hours of Service/Support ('000)*	4,007	9,820	12,349	8,343
Beds**	1,381	2,509	3,119	1,738

* Excludes hours of service for Prevention; includes hours of service for Alcohol and Other Drug safe places for intoxicated people, and in-prison forensic.

** Excludes Alcohol and Other Drug safe places for intoxicated people beds.

APPENDICES

APPENDIX A – SUMMARY OF ACTIONS

IMPLEMENTING EXISTING COMMITMENTS:

PREVENTION

1. complete the development, and commence implementation of a new suicide prevention strategy
2. implement legislation and associated strategies to respond to the rapid emergence of new psychoactive substances.

COMMUNITY SUPPORT SERVICES

3. complete the evaluation of the Individualised Community Living Strategy and implement improvements and, if appropriate, commence expansion of the program
4. continue to provide alcohol and other drug support services[xxiii] for residents within existing Transitional Housing and Support Program houses in North Metropolitan, South Metropolitan, the Goldfields, the Midwest, and the Kimberley.

COMMUNITY TREATMENT SERVICES

5. continue the implementation of the Statewide Specialised Aboriginal Mental Health Services including specific strategies to enhance access for Aboriginal children, families and people with co-occurring alcohol and other drug problems
6. establish a new integrated alcohol and other drug treatment service in Joondalup
7. complete an evaluation of the Royalties for Regions funded North West Drug and Alcohol Support Program expansion (Kimberley, Pilbara and Gascoyne regions) to inform future funding decisions
8. implement an Alcohol Interlock Assessment and Treatment Service in support of the *Road Traffic Amendment (Alcohol Interlocks and other Matters) Act 2015*.

COMMUNITY BED-BASED SERVICES

9. open new mental health community bed-based services approved by Government:
   a. Rockingham (Peel – 10 beds)
   b. Broome (Kimberley – six beds)
   c. Kalgoorlie/Boulder (Goldfields – six beds)
   d. Karratha (Pilbara – six beds)
   e. Bunbury (South West – 10 beds).

HOSPITAL-BASED SERVICES

10. open 36 new and 100 replacement mental health inpatient services at:
    a. Perth Children's Hospital – 20 bed acute mental health unit for children up to 16 years (six new beds, and 14 replacement beds (six Bentley Hospital, eight Princess Margaret Hospital))

xxiii Referred to in the *Plan Matrix* as 'post residential rehabilitation' (Page 105).

b. QEII – 30 bed adult acute mental health unit (30 replacement beds)
c. Midland – 56 bed acute mental health unit, including 41 replacement beds from Swan (16 Older Adult, 25 Adult), nine replacement beds from Graylands Hospital and six replacement beds from Sir Charles Gairdner Hospital
d. Fiona Stanley Hospital – 30 bed acute mental health unit, including eight new mother and baby (perinatal) beds, 14 new youth beds, and eight new mental health assessment beds (short-stay)

11. complete the evaluation of the pilot transport service and continue to commission an effective and safe transfer service for people who require transport under the *Mental Health Act 2014*.

SPECIALISED STATEWIDE SERVICES

12. continue to develop specialised statewide inpatient services for perinatal (eight beds) at the Fiona Stanley Hospital.

FORENSIC SERVICES

13. progress the State Government's 2013 election commitment to deliver mental health adult and children court diversion
14. complete the evaluation of the Mental Health Court Diversion programs.

SYSTEM INTEGRATION AND NAVIGATION

15. implement the provisions of the *Mental Health Act 2014* and monitor the extent of improved integration of care.

BY THE END OF 2017, TO PREPARE FOR THE FUTURE WE AIM TO:

PREVENTION

16. develop a comprehensive prevention plan for mental health, alcohol and other drugs which will include a range of evidence-based strategies across the life course (including targeted programs for at risk groups)
17. commence the implementation of the prevention plan, including identifying opportunities to partner with existing relevant health promotion programs delivered by the government and non-government sector
18. identify opportunities to enhance existing prevention initiatives targeting children, young people, families and the broader community including (but not limited to) school-based programs which incorporate mental health, alcohol and other drug education, and resilience building
19. increase the proportion of the Mental Health Commission budget spent on prevention (dedicated to mental health) from one per cent to two per cent; increase the hours of service dedicated to alcohol and other drug prevention from 66,000 to 108,000 hours; and provide the optimal level of resource identified for associated alcohol and other drug prevention programs
20. ensure resourcing of existing public education campaigns is sufficient to optimise effectiveness.

APPENDICES

COMMUNITY SUPPORT SERVICES

21. increase mental health community support services by 432,000 hours of support, with a particular focus on regional areas, children and youth
22. develop and expand local recovery services that offer assistance and support to individuals to maintain personal recovery and live well in the community. This may involve the delivery of education and training programs and telehealth.
23. review existing consumer and carer access to individual, independent advocacy and where appropriate identify opportunities to expand access
24. in collaboration with key stakeholders, develop a housing strategy to address the housing needs of people with mental health, alcohol and other drug problems whilst also increasing access to community support services that will assist with daily living tasks and maintaining tenancy. This includes (as a priority) appropriate housing and support for people who have mental health, alcohol and other drug problems and are homeless.
25. in consultation with housing providers, establish new Transitional Housing and Support Program houses and commission alcohol and other drug support services (expand the total by approximately 9,400 hours of support) across the North Metropolitan (4,000 hours), South Metropolitan (2,900 hours), Goldfields (400 hours), Pilbara (600 hours), Great Southern (400 hours), South West (600 hours), and the Wheatbelt (400 hours) regions
26. explore with the Department of Child Protection and Family Support and key stakeholders, how youth-friendly safe places for those with alcohol and other drug (including volatile substances) use issues in identified regional and remote areas can be established.

COMMUNITY TREATMENT SERVICES

27. boost infant, children and adolescent mental health community treatment services across the State by 374,000 hours of service, which includes early intervention services and services for families
28. build on current youth services and commission new youth services to establish a dedicated youth community treatment service stream
29. establish a new integrated alcohol and other drug treatment service in the South Metropolitan area (70,000 hours)
30. further develop community alcohol and other drug services in the Midwest (9,000 additional hours) and South West (33,000 additional hours)
31. work with the Western Australian Police to develop and commission a mental health police co-response program
32. establish an effective ‘one stop shop’ service that provides 24-hour mental health crisis and emergency services, system navigation assistance and frontline staff training
33. work with the Commonwealth Government to ensure the State has equitable access to Medicare funded services

APPENDICES

34. further progress the development of partnerships, where appropriate, between community treatment, primary care services and existing health promotion programs to optimise the health and wellbeing of people with mental health, alcohol and other drug problems
35. expand training and engagement of GPs and other primary care providers to increase screening, brief interventions, early interventions, and referrals for mental health, alcohol and other drug problems in all regions
36. work with peak bodies representing pharmacies in Western Australia to determine how pharmacists can become more involved in the dispensing of medications and monitoring of people receiving medications for mental health, alcohol and other drug problems
37. commence the development of a real time Schedule 8 (drugs of addiction) medicine dispensing tracing system.

COMMUNITY BED-BASED SERVICES

38. increase the subsidy provided for non-acute long-stay (nursing home) places for older adults with mental illness by 63 places, (32 places in the North Metropolitan region, 10 places in South Metropolitan region, six places in Northern and Remote, and 15 places in Southern Country)
39. work with regional stakeholders to deliver approximately 10 community beds in the Midwest area, which will be supported by comprehensive community and inpatient services
40. expand low medical alcohol and other drug withdrawal services in the metropolitan area by 10 beds, Northern and Remote by eight beds and Southern Country by three beds
41. expand existing alcohol and other drug residential treatment and rehabilitation services by 55 beds (10 beds in North Metropolitan, 23 beds in South Metropolitan, 12 beds in Geraldton and 10 beds in Kalgoorlie)
42. commence the development and implementation of a residential alcohol and other drug treatment and rehabilitation service (30 beds) for Aboriginal people and their families in the south of the State
43. commence the development and implementation of a new alcohol and other drug residential treatment and rehabilitation service in the South West (36 beds)
44. commence planning for a trial compulsory treatment facility to respond to the increased harm seen in communities as a result of alcohol and other drug use including severe methamphetamine dependency. This will involve the development of relevant legislation.

HOSPITAL-BASED SERVICES

45. commence the process of divestment of services on the Graylands and Selby hospital campuses
46. convert the Bentley Adolescent Unit into a statewide 14 bed subacute inpatient service for youth

APPENDICES

47. work with regional stakeholders to deliver approximately 16 inpatient beds in the Midwest area (which may include MHOA, inpatient and HITH beds), which will be supported by a comprehensive community-based service (including community beds)
48. expand MHOAs across the State (Royal Perth Hospital, Rockingham Hospital, Midland Hospital, Joondalup Health Campus)
49. further explore the requirement for MHOAs (or equivalent model) in regional hospitals across the State
50. increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 218,000 to 274,000 hours of service
51. expand the capacity of country hospitals by 11 beds across the Goldfields, Midwest and Pilbara to provide high medical alcohol and other drug withdrawal
52. increase capacity for Telehealth links (i.e. telepsychiatry and specialised services) into small hospitals in regional areas
53. expand HITH beds by 5 per cent and further investigate the appropriateness of this model for infants, children and adolescents.

SPECIALISED STATEWIDE SERVICES

54. establish specialised statewide inpatient services for:
    a. Eating disorders (24 beds)
    b. Neuropsychiatry and Neurosciences disorders.[xxiv]
55. commence establishment or enhance community-based specialised statewide services including:
    a. Eating disorder services
    b. Perinatal services
    c. Neuropsychiatry and Neurosciences
    d. Attention Deficit Hyperactivity Disorder (ADHD)
    e. Co-occurring mental illness and intellectual, cognitive or developmental disability (including autism spectrum) service
    f. Hearing and vision impaired.
56. commence planning of community-based specialised statewide services including:
    a. Sexuality, Sex and Gender Diversity service
    b. Children in Care program
    c. Transcultural services
    d. Homelessness program.
57. build on and improve programs such as Young People with Exceptionally Challenging Needs (YPECN) and People with Exceptionally Challenging Needs (PECN) to ensure people with multiple, high-level needs receive seamless, comprehensive treatment and support.

FORENSIC SERVICES

58. research an evidence-base and establish forensic focused prevention programs which reduce the risk of individuals coming into contact with the criminal justice system

xxiv Bed number to be confirmed during business case development.

APPENDICES

59. increase mental health community forensic treatment services from 33,000 to 84,000 hours of service, with a focus on in-reach services for police lock-ups, police diversion, case management, and transition services for people moving from prison to community
60. develop comprehensive training requirements for non-mental health, alcohol and other drug frontline staff including police, corrections officers, court officers, magistrates and others
61. commence development of a 70 bed in-prison dedicated mental health, alcohol and other drug service for men and women
62. further develop in-prison mental health, alcohol and other drug treatment and support services for men, women and young people
63. work with the Department of Corrective Services to develop models of service for in-prison treatment and support services and move service purchasing responsibility to the Mental Health Commission
64. complete the review of the *Criminal Law (Mentally Impaired Accused) Act 1996*
65. complete the planning of 92-bed secure forensic inpatient unit (including specific places for men, women, young people and Aboriginal people)
66. work with the Department of Corrective Services to develop core capabilities and workforce standards for mental health, alcohol and other drug service provision across the forensic system.

RECOVERY-ORIENTED PRACTICE

67. investigate international best practice recovery culture change programs
68. incorporate recovery principles in the design of service models and associated practices, procedures, protocols, and commissioning practices
69. explore how the concept of recovery applies to the alcohol and other drug sector and how the principles of recovery-oriented practice can be embedded in service delivery where appropriate.

CO-PRODUCTION AND CO-DESIGN WITH CONSUMERS, FAMILIES AND CARERS

70. develop a statewide mental health, alcohol and other drug consumer, family and carer involvement framework that will outline best practice principles and practices in relation to consumer and carer involvement, co-production and co-design
71. incorporate a range of mechanisms in commissioning and service provision practices to enable the involvement of consumers, families and carers in co-production and co-design of policy, planning, service delivery, evaluation and research, with a particular focus on enabling the involvement of marginalised groups (including Aboriginal people)
72. consider the establishment of an alcohol and other drug consumer peak body
73. provide consumers, families and carers with access to appropriate training to support them in their role as a consumer/carer representative

APPENDICES

74. include consumer experience and satisfaction indicators in the Plan evaluation process and ongoing contract monitoring.

ADVOCACY

75. continue to support effective systemic advocacy organisations
76. further improve access to transparent and effective complaints mechanisms across the mental health, alcohol and other drug system.

INDIVIDUALISED FUNDING

77. monitor evidence emerging from existing individualised funding programs and further explore the potential to expand access to a range of individualised funding programs across the service system.

ABORIGINAL PEOPLE

78. incorporate culturally secure and respectful, non-discriminatory principles in the design of service models and associated practices, procedures, protocols, and commissioning practices.

CULTURAL AND SOCIAL DIVERSITY

79. incorporate culturally competent principles in the design of service models and associated practices, procedures, protocols, and commissioning practices.

SYSTEM INTEGRATION AND NAVIGATION

80. require commissioned services to develop coordination and communication strategies to ensure relevant services[xxv] are integrated and people are supported to transition effectively between services, programs and regions. This may include:
    a. the establishment of integration, coordination and transition initiatives and policies such as the reciprocal transfer of staff between services
    b. the establishment of protocols for informing consumers, carers, families and GPs (throughout treatment and upon discharge) as to treatment plans and how to re-access services if required
    c. the development of communication and information flow protocols for accessing patient records and treatment plans, other communication and reporting between non-government organisations, public sector, and private sector, and across community, primary, secondary and tertiary services
81. where relevant, standardise, establish and monitor key performance indicators for follow-up and other communication during treatment and post-discharge
82. continue to build upon programs to address the physical health gap including partnering with existing healthy lifestyle and injury prevention health promotion programs

xxv Relevant services can include private sector, government, non-government and primary care services across a range of sectors including mental health, alcohol and drug, disability, housing and so on.

APPENDICES

83. together with key stakeholders, 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
84. develop and commence a pilot community coordination program to assist people to navigate the mental health, alcohol and other drug service system (complementing current programs such as Partners in Recovery)
85. progress the expansion of the peer workforce across the service spectrum.

RESEARCH AND EVALUATION

86. in collaboration with key stakeholders, identify research priorities and allocate resources according to identified priorities
87. continue to make evaluation a requirement of funding and service agreements where applicable.

WORKFORCE

88. develop and commence implementation of a comprehensive mental health, alcohol and other drug workforce planning and workforce development strategy that includes key priorities and strategies to build the right number and appropriately skilled mix of staff, and clarifies roles and responsibilities of commissioning agencies and service providers
89. maintain Registered Training Organisation registration and continue to deliver nationally recognised training programs, currently Certificate III Community Services Work, and Certificate IV in Alcohol and Other Drugs for the Aboriginal Alcohol and Other Drug Workforce in Western Australia.

INFORMATION AND COMMUNICATION TECHNOLOGY

90. progress updates and essential development of current ICT systems (e.g. uploading new forms) to ensure current work practices are supported during the development of a new ICT system
91. develop a mental health, alcohol and other drug service ten year ICT plan that will encompass improved systems, telehealth and telepsychiatry services, and communications within and between services that supports:
    a. the maintenance of existing clinical information systems, ongoing training and auditing of system use
    b. development of a business case for new clinical information system(s) to support the delivery of best practice and efficient mental health, alcohol and other drug services
    c. implementation of innovative eHealth and telehealth for specialised mental health, alcohol and other drug services across regional Western Australia
    d. the implementation of information sharing protocols across the sector.

APPENDICES

BY THE END OF 2020, TO REBALANCE THE SYSTEM THERE IS A NEED TO:

PREVENTION

92. continue the implementation and monitoring of the prevention plan
93. increase the proportion of the Mental Health Commission budget spent on prevention (dedicated to mental health) from two per cent to four per cent; increase the hours of service dedicated to alcohol and other drug prevention from 108,000 to 192,000 hours; and provide the optimal level of resource identified for associated alcohol and other drug prevention programs
94. complete the rollout of school-based education programs on mental health, alcohol and other drugs, and resilience building until available in all schools
95. expand current public education campaigns targeting harmful alcohol and other drug use
96. promote the adoption of evidence-based mental health 'first aid' training throughout the community.

COMMUNITY SUPPORT SERVICES

97. increase safe places for intoxicated people (also known as sobering up centres) in Fremantle, the Pilbara and for young people in the metropolitan area by a total of 27 beds
98. develop and commission personalised support and harm-reduction services for people with alcohol and other drug problems (approximately 225,000 hours of support), which would include peer workers and the commissioning of in-reach and outreach support in the metropolitan area for people in crisis accommodation
99. in collaboration with key stakeholders, progress implementation and monitoring of the housing strategy and associated community support services
100. in consultation with housing providers, continue to expand the number of Transitional Housing and Support Program houses and commission alcohol and other drug support services (expand the total by approximately 19,600 hours of support) across the North Metropolitan (6,600 hours), South Metropolitan (6,900 hours), Pilbara (600 hours), South West (3,000 hours), Wheatbelt (600 hours) and Goldfields (1,900 hours) regions
101. expand mental health community support services across the state from 1.7 million hours of support to 3.2 million hours of support including expanding services for family and carers through information, support, education and skill development opportunities.

APPENDICES

COMMUNITY TREATMENT SERVICES

102. increase the total mental health community treatment hours of service across the State from 2.6 million hours to 3.2 million hours with a priority on developing telehealth, after hours services and expanded clinical services for the South West
103. expand metropolitan alcohol and other drugs treatment services to provide an additional 320,000 hours of outpatient withdrawal, pharmacotherapy maintenance and specialist counselling and support in the metropolitan area
104. expand the number of alcohol and other drug service hubs in the Northern and Remote, and Southern Country through an additional increase of 136,000 hours of community treatment. This will increase the capacity to provide additional services such as outreach. The focus will initially be on the South West, Great Southern, Wheatbelt, Midwest, and Goldfields areas.
105. continue to engage with the primary care sector across the State to increase screening, brief intervention and early intervention to assist people with mental health, alcohol and other drug problems as early as possible
106. expand the Community Program for Opioid Pharmacotherapy across the State, particularly regional areas.

COMMUNITY BED-BASED SERVICES

107. increase the total number of mental health community beds by 71 beds, including 41 subsidised beds for non-acute long-stay (nursing home) places (North Metropolitan (14 beds), South Metropolitan (16 beds), Northern and Remote (four beds), and Southern Country (seven beds))
108. deliver a new service specifically designed for youth alcohol and other drug treatment and rehabilitation (23 beds) in the metropolitan area
109. pending relevant legislation approval, trial a compulsory treatment facility to respond to the increased harm seen in communities as a result of alcohol and other drug use including severe methamphetamine dependency
110. expand low medical alcohol and other drug withdrawal services in the metropolitan area by a further four beds
111. expand alcohol and other drug residential treatment and rehabilitation services by a further 70 beds (21 beds in South Metropolitan, 49 beds in North Metropolitan).

HOSPITAL-BASED SERVICES

112. work with regional stakeholders to determine how best to provide 16 inpatient beds for the Pilbara area (which may include MHOA, inpatient and HITH beds)
113. work with regional stakeholders to determine how best to provide 16 inpatient beds for the Wheatbelt area (which may include MHOA, inpatient and HITH beds)

APPENDICES

114. expand high medical withdrawal capacity in the North Metropolitan area (increase from 22 to 33 beds)
115. expand the capacity of hospitals by 26 beds across the Great Southern, Kimberley, South West, Wheatbelt and South Metropolitan area to provide high medical alcohol and other drugs withdrawal
116. increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 274,000 to 292,000 hours of service
117. continue to expand MHOAs across the State (Armadale Hospital, Peel Health Campus, and Perth Children's Hospital)
118. continue the closure of Graylands wards in a staged process as HITH and new hospital wards become operational across the State
119. expand HITH beds to meet the target of approximately 10 per cent of inpatient mental health beds to be delivered as HITH.

SPECIALISED STATEWIDE SERVICES

120. continue to develop specialised Statewide inpatient services for:
    a. Eating disorders (10 additional beds)
    b. Perinatal (four additional beds)
    c. Neuropsychiatry and Neurosciences disorders.[xxvi]

FORENSIC SERVICES

121. continue to develop in-prison mental health, alcohol and other drug treatment and support services for men, women and young people
122. increase mental health community forensic treatment services from 84,000 to 112,000 hours of service
123. expand the Mental Health Court Diversion and Liaison program subject to the outcomes of the current evaluation
124. expand alcohol and other drug diversion (community) services from 50,000 to 94,000 hours of service
125. establish a specialised forensic community-based clinic and programs for people with problem behaviours, targeting sex offenders, violent extremism, arson, and stalking
126. commission a facility in the community for mentally impaired accused persons with a mental illness, which is an appropriate alternative to prison and hospital
127. establish positions that have a specialist role in co-occurring mental health, alcohol and other drug treatment and support to support capacity building across the forensic mental health, alcohol and other drug system.

xxvi Bed number to be confirmed during business case development.

APPENDICES

RECOVERY-ORIENTED PRACTICE

128. progress the implementation of recovery-oriented culture change programs as appropriate
129. monitor the incorporation of recovery principles in the design of service models and associated practices, procedures, protocols and commissioning practices.

CO-PRODUCTION AND CO-DESIGN WITH CONSUMERS, FAMILIES AND CARERS

130. monitor the involvement of consumers, families and carers in co-production and co-design of policy, planning, service delivery, evaluation and research and continue to provide access to training to support consumers, families and carers.

ADVOCACY

131. monitor access to individual advocacy services and the effectiveness of complaints mechanisms.

INDIVIDUALISED FUNDING

132. continue to monitor the implementation of individualised funding programs.

ABORIGINAL PEOPLE

133. monitor the extent to which services have incorporated culturally secure and respectful, non-discriminatory principles in the design of service models and associated practices, procedures, protocols, and commissioning practices.

CULTURAL AND SOCIAL DIVERSITY

134. monitor the extent to which services have incorporated culturally competent principles in the design of service models and associated practices, procedures, protocols, and commissioning practices.

SYSTEM INTEGRATION AND NAVIGATION

135. continue to monitor service integration and navigation initiatives and models of service implementation, progressing improvements as necessary
136. finalise an evaluation of the pilot community coordination program and, depending on the evaluation outcomes, expand its reach to areas of greatest need.

RESEARCH AND EVALUATION

137. progress the commissioning and undertaking of research projects in line with identified priorities.

APPENDICES

WORKFORCE

138. continue the implementation of evidence-based strategies to establish and maintain the optimal number and mix of suitably qualified and skilled staff to effectively deliver the services and programs outlined in the Plan
139. monitor and evaluate the effectiveness of the workforce planning and workforce development strategies employed and adapt strategies as appropriate.

INFORMATION AND COMMUNICATION TECHNOLOGY

140. commission an effective ICT system across the mental health, alcohol and other drug system.

BY THE END OF 2025, TO CONTINUE THE REFORM, MODELLING IDENTIFIES THE REQUIREMENT TO:

PREVENTION

141. continue the implementation and monitoring of the prevention plan and commence development of a new prevention plan
142. improve access to web-based/ on-line strategies and interventions
143. have established a comprehensive suite of universal and targeted mass reach campaigns that promote mental health, prevent mental illness and reduce harmful alcohol and other drug use
144. reach the target of five per cent of the Mental Health Commission budget allocated to prevention (dedicated to mental health); 208,000 hours of service dedicated to alcohol and other drug prevention; as well as provide the optimal level of resource identified for associated alcohol and other drug prevention programs.

COMMUNITY SUPPORT SERVICES

145. expand community mental health support services across the State from 3.2 million hours of support to 5.3 million hours of support
146. in collaboration with key stakeholders, continue to progress implementation and monitoring of the housing strategy and associated community support services
147. in consultation with housing providers complete delivery of alcohol and other drug transitional support services, with a further 16,000 hours of support.

COMMUNITY TREATMENT SERVICES

148. continue the expansion of community mental health, alcohol and other drug services (co-located where possible) through:
    a. expanding the metropolitan and regional community alcohol and drug hours of service by a further 926,000 hours (including establishing smaller hub sites)
    b. increasing the total mental health community treatment hours of service across the State from 3.2 million hours to 3.8 million hours.

APPENDICES

COMMUNITY BED-BASED SERVICES

149. further expand alcohol and other drug residential treatment and rehabilitation in the North Metropolitan (81 beds), Southern Metropolitan (65 beds), Northern and Remote (nine beds) and Southern Country (59 beds)
150. complete delivery of low medical withdrawal beds in the metropolitan area (nine beds) and Southern Country (four beds)
151. increase the number of mental health community beds across the State (all metropolitan and regional areas) from 475 beds to deliver the modelled target of 909 beds.

HOSPITAL-BASED SERVICES

152. increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 292,000 to 309,000 hours of service
153. continue the expansion of high medical withdrawal beds by 28 beds (South Metropolitan, North Metropolitan and the South West)
154. complete the closure of the existing Graylands facilities, with final transition by the end of 2025
155. expand HITH beds to meet the target of approximately 20 per cent of inpatient mental health beds to be delivered as HITH.

SPECIALISED STATEWIDE SERVICES

156. continue to develop specialised statewide inpatient services for:
    a. Eating disorders (13 additional beds)
    b. Perinatal (eight additional beds)
    c. Neuropsychiatry and Neurosciences disorders. [xxvii]

FORENSIC SERVICES

157. open 92-bed secure forensic inpatient unit with 62 acute and 30 subacute beds, including specific places for men, women, young people and Aboriginal people
158. further expand alcohol and other drug diversion (community) services from 94,000 to 163,000 hours of service
159. increase mental health community forensic treatment services from 112,000 to 140,000 hours of service.

WORKFORCE

160. continue to monitor and evaluate the effectiveness of the workforce planning and workforce development strategies and adapt strategies as appropriate.

INFORMATION AND COMMUNICATION TECHNOLOGY

161. implement an ongoing program of ICT maintenance and enhancement, in line with the long-term strategy.

xxvii Bed number to be confirmed during business case development.

APPENDIX B – EVALUATION, REPORTING AND ACCOUNTABILITY

Evaluation is an essential part of ensuring that the vision outlined in the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025* (Plan) is realised. The vision is to:

Build a Western Australian mental health, alcohol and other drug service system that:

- prevents and reduces mental health problems and promotes positive mental health
- prevents and reduces the adverse impacts of alcohol and other drugs
- 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 a satisfying, hopeful and contributing life.

Critical to the success of the Plan will be delivering benefits related to the key aims that underpin the Plan (refer to pages 10–12).

OBJECTIVES

The Plan Evaluation Framework has the following objectives:

- evaluate the success of the Plan against the expected key achievements outlined in the *What we hope to achieve* section on pages 10-11, ensuring that success is measured across system, stream and service element levels
- assess the investment that has been and will be made in the mental health, alcohol and other drug sector and system-wide reforms – (measuring inputs, efficiency and cost-effectiveness)
- assess the impact of key client related deliverables (measuring outcomes and effectiveness)
- monitor the implementation of the Plan, including system-wide reform initiatives (measuring outputs and quality)
- make the mental health, alcohol and other drug sector more transparent (ensuring accountability)
- contribute to future mental health, alcohol and other drug service planning, policy development and research (ensuring evidence-based best practice).

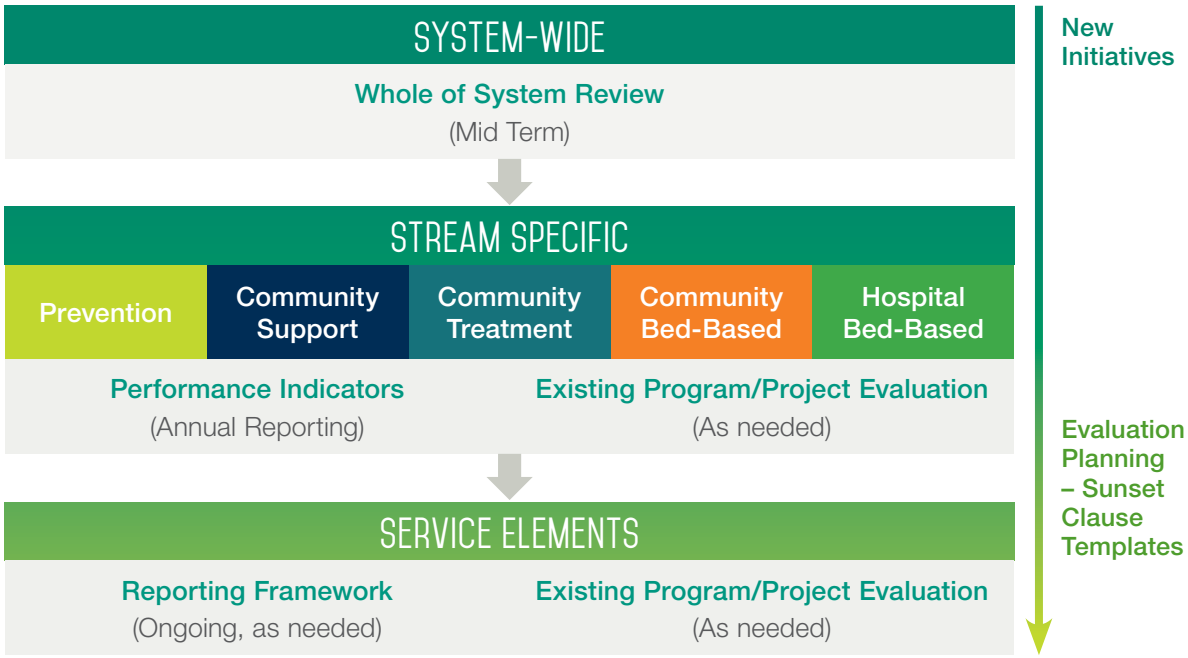
EVALUATION ACTIVITIES

The Mental Health Commission will lead a continuing cycle of implementation and review of progress in realising the intended benefits of the Plan. Evaluation will take place through a range of activities conducted at differing levels of depth and frequency. Appendix B – Figure 1 outlines the key activities that will be delivered as part of the Plan Evaluation Framework.

As much as possible, existing data will be used to inform the development of evaluation methods in order to maximise opportunities for benchmarking with existing sources and collections. This will allow data to be compared over time, with other jurisdictions, for particular target groups and at a regional level. Where data are not currently available, development work will be undertaken to ensure priority areas are addressed.

APPENDICES

Appendix B – Figure 1: Summary of evaluation activities for the Plan



APPENDICES

WHOLE OF SYSTEM REVIEW

Determining how to appropriately frame and quantify the benefits that the mental health, alcohol and other drug system will deliver presents a challenge, as measurement has traditionally been separate and focused on inputs and outputs. A priority will be to ensure all of the evaluation objectives outlined in the Plan Evaluation Framework are addressed for the whole system. Further to this, a comprehensive mid-term review will be conducted addressing every evaluation objective, after five years of the Plan's implementation. A key focus of this review will be whether system reforms led to better outcomes for consumers.

PERFORMANCE INDICATORS

The Plan Evaluation Framework outlines key indicators for the key service streams covering inputs, outputs and outcomes and their alignment with intended benefits (refer to Appendix B – Table 1). Reporting of indicators will occur on an annual basis, with a selection presented in the Mental Health Commission Annual Report.

The indicators have been selected on the basis that:

- they meet the SMART criteria outlined by the Department of Treasury[xxviii]
- they align with existing plans and reporting requirements
- where possible, the data are currently available
- where possible, the indicators are able to be benchmarked.

A number of these indicators are collected through qualitative methodologies such as consumer and community perception surveying, even though some are reported quantitatively.

xxviii Department of Treasury (2014) Program Evaluation: Sunset Clauses Agency Guide. Government of Western Australia.

APPENDICES

Appendix B – Table 1: Key indicators by service stream

	PREVENTION	COMMUNITY SUPPORT	COMMUNITY TREATMENT	COMMUNITY BED-BASED SERVICES	HOSPITAL BED-BASED SERVICES
INPUT INDICATORS (WHAT RESOURCES ARE USED?)	– Proportion of total Mental Health Commission budget spent on mental health, alcohol and other drug prevention and mental health promotion activities (including physical health). – Progress in expenditure of allocation to initiatives to reduce suicide risk within the community.	– Proportion of total Mental Health Commission budget spent on mental health, alcohol and other drug community support services. – Peer workers full time equivalent (FTE) per 1,000 mental health care providers (FTE) in community support services.	– Proportion of total Mental Health Commission budget spent on mental health, alcohol and other drug community treatment services. – Community treatment mental health (Mental Health Commission purchased) and non-residential drug and alcohol treatment FTE per 100,000 population. – Peer workers full time equivalent (FTE) per 1,000 mental health care provider (FTE) in community treatment services.	– Proportion of total Mental Health Commission budget spent on community bed-based services by service element type. – Community beds per 10,000 population (mental health/ drug and alcohol).	– Proportion of total Mental Health Commission budget spent on hospital bed-based services. – Hospital bed-based FTE per 100,000 population. – Hospital inpatient beds per 10,000 population by bed type.

APPENDICES

Appendix B – Table 1: Key indicators by service stream (continued)

	PREVENTION	COMMUNITY SUPPORT	COMMUNITY TREATMENT	COMMUNITY BED-BASED SERVICES	HOSPITAL BED-BASED SERVICES
OUTPUT INDICATORS (WHAT IS DELIVERED?)	– Cost per capita for activities to enhance mental health and wellbeing and prevent suicide (illness prevention, promotion and protection activities). – Correct take out messages from alcohol and other drug campaigns among target population. – Cost per capita of the Western Australian population 14 years and above for initiatives that delay the uptake and reduce the harm, associated with alcohol and other drugs. – Cost per person of alcohol and other drug campaign target group who are aware of and correctly recall the main campaign messages. – Number of eligible cannabis offenders diverted by police to a cannabis intervention session in Western Australia.	– Types of support utilised by persons with a psychiatric disability. – Average cost per hour of community support provided to people with mental health problems. – Average cost per episode of community support provided for alcohol and other drug services. – Average cost per package of care for individualised care. – Cost per episode of care in safe places for intoxicated people. – Percentage of non-government organisations contracted to provide mental health services that met the National Standards for Mental Health Services (2010) through independent evaluation.	– Average treatment days per episode of ambulatory care provided by Mental Health Commission-purchased clinical mental health services. – Average cost per purchased treatment day of ambulatory care provided by Mental Health Commission-purchased clinical mental health services. – Cost per treatment episode in community-based alcohol and other drug services completed as planned or client still in treatment.	– Average cost per bedday by bed type. – Average length of stay in community bed-based services by service element type. – Cost per treatment episode in alcohol and other drug residential rehabilitation services completed as planned or client still in treatment.	– Average length of stay by bed type. – Average cost per Mental Health Commission-purchased bedday by bed type. – Number of weighted activity units delivered in Mental Health Commission-purchased mental health specialised inpatient services.

APPENDICES

Appendix B – Table 1: Key indicators by service stream (continued)

	PREVENTION	COMMUNITY SUPPORT	COMMUNITY TREATMENT	COMMUNITY BED-BASED SERVICES	HOSPITAL BED-BASED SERVICES
OUTCOME INDICATORS (WHAT IS ACHIEVED?)	– Prevalence of mental illness. – Rates of stigmatising attitudes within the community. – Proportion of people with a mental illness who are exposed to physical health risk factors. – Rates of understanding of mental health and alcohol and drug problems in the community. – Percentage of the Western Australian population with high or very high-levels of psychological distress compared to the percentage reported nationally. – Rate of intentional self-harm hospitalisations. – Rate of suicide in the community. – Percentage of the population aged 14 years and over reporting recent use of illicit drugs. – Percentage of the population aged 14 years and over reporting use of alcohol at risky levels. – Average per capita alcohol consumption. – Percentage of the population receiving public clinical mental health care.	– Participation rates by people with mental illness of working age (16-64 years) in employment. – Participation rates by young people aged 16-30 with mental illness in education and employment. – Rates of experience of care in mental health community support services. – Participation rates by people with mental illness in the community. – Proportion of mental health consumers living in stable housing. – Level of consumer satisfaction with quality of service in alcohol and other drug community support services.	– Rate of preadmission community care in specialised mental health services. – Percentage of contacts with community-based public mental health non-admitted services within seven days post discharge from Mental Health Commission-purchased mental health inpatient units. – Proportion of the population receiving mental health community treatment services. – Change in consumer clinical and treatment outcomes. – Rates of experience of care in mental health community treatment services. – Percentage of closed alcohol and other drug treatment episodes completed as planned for community treatment. – Levels of client satisfaction with quality of service in alcohol and other drug community treatment services.	– Proportion of the population receiving care in community bed-based services. – Rates of experience of care in mental health community bed-based services. – Percentage of closed alcohol and other drug treatment episodes completed as planned for community bed-based services. – Level of consumer satisfaction with quality of service in residential rehabilitation services.	– Readmission to hospital within 28 days of discharge from acute specialised mental health inpatient units. – Change in consumer clinical and treatment outcomes. – Proportion of the population receiving care in hospital bed-based services. – Rate of seclusion and restraint in mental health units. – Rates of experience of care in mental health hospital bed-based services. – Proportion of people who could have been discharged from mental health hospital bed-based services if appropriate accommodation and supports were available. – Percentage of closed alcohol and other drug treatment episodes completed as planned for hospital bed-based services. – Level of consumer satisfaction with quality of service in alcohol and other drug hospital bed-based services.

APPENDICES

Appendix B – Table 1: Key indicators by service stream (continued)

	PREVENTION	COMMUNITY SUPPORT	COMMUNITY TREATMENT	COMMUNITY BED-BASED SERVICES	HOSPITAL BED-BASED SERVICES
BENEFITS					
	Fewer people will experience stigma and discrimination. Fewer people will experience high-levels of distress. Fewer people will experience alcohol and other drug-related harm. Fewer people will be readmitted to hospital inappropriately. There will be little or no need for seclusion and restraint. People with poor mental health, alcohol and other drug problems will have better physical health and live longer.			More people will have preadmission and post discharge community care. More people will be discharged from hospital to appropriate levels of accommodation and support in the community. More people will experience improved clinical outcomes. More people will have a positive experience of care in mental health, alcohol and other drug services. More people will have good mental health and wellbeing. More people will experience improvement in wellbeing, engagement and life circumstances. More people with mental health, alcohol and other drug problems will recover. More people with poor mental health and alcohol and drug problems will live in stable housing. More people with mental health, alcohol and other drug problems will participate in employment, education and in the community.	

There are various challenges associated with measuring indicators as it is not always possible to establish a direct relationship between the action undertaken and the achievement of an intended benefit. Changes to the mental health, alcohol and other drug system could be due to a range of other factors, some of which are unforseen, complex and difficult to measure. Given these limitations, program wide and project level evaluations will provide the necessary breadth and depth to properly assess the full effect of the mental health, alcohol and other drug system in Western Australia.

EVALUATION OF EXISTING PROGRAMS/ PROJECTS

A range of comprehensive evaluations will be developed and implemented for existing initiatives across the continuum of prevention, support, treatment, community beds and hospital-based services to evaluate the extent to which they realise their intended benefits. These would include the involvement of consumers, families and carers and should include qualitative and quantitative measures of inputs, outputs and outcomes.

Evaluations may also address efficiency, effectiveness, cost-effectiveness and best practice objectives, particularly where the program or project is of strategic priority. An ongoing schedule of program/project evaluations will be identified as part of annual planning.

APPENDICES

NEW INITIATIVES

All new business cases submitted to the Department of Treasury for the purposes of implementing new elements of the Plan will include a program evaluation proposal if subject to a Department of Treasury's *Program Evaluation: Sunset Clause*. This will adhere to the guidelines in the *Program Evaluation: Sunset Clauses Agency Guide* released by the Department of Treasury. Programs not subject to a Sunset Clause will also have measurement and reporting frameworks developed where applicable as part of service agreement and contractual processes.

All service agreements for future mental health services (public, private and non-government) will include compliance with the *National Standards for Mental Health Services 2010* (NSMHS) as a minimum requirement. In particular to the non-government sector, services are also required to demonstrate continuous improvement towards the achievement of the six Mental Health Outcome Statements. The Mental Health Outcome Statements were developed by people with mental illness, carers and their families (in conjunction with the Mental Health Commission and the Western Australian Association for Mental Health), and relate to a key principle of the *Mental Health 2020: Making it personal and everybody's business* – 'Quality of Life'.

The six Mental Health Outcome Statements are:

1. **Health, Wellbeing and Recovery:** People enjoy good physical, social, mental, emotional and spiritual health and wellbeing and are optimistic and hopeful about their recovery.
2. **A home and financial security:** People have a safe home and a stable and adequate source of income.
3. **Relationships:** People have enriching relationships with others that are important to them such as family, friends and peers.
4. **Recovery, learning and growth:** People develop life skills and abilities, and learn ways to recover that builds their confidence, self-esteem and resilience for the future.
5. **Rights, respect, choice and control:** People are treated with dignity and respect across all aspects of their life and their rights and choices are acknowledged and respected. They have control over their lives and direct their services and supports.
6. **Community belonging:** People are welcomed and have the opportunity to participate and contribute to community life.

APPENDICES

Eligible service agreements for alcohol and drug services are required to demonstrate continuous improvement towards the achievement of community and service specific outcomes. The outcomes were developed through consultation with the alcohol and other drug sector, key stakeholders and the broader community as part of the response to the State Government's *Delivering Community Services in Partnership* (DCSP) policy. The community outcome and service-specific outcomes are:

1. **Community outcome**

   The adverse impacts of alcohol and other drug use in the Western Australian community are prevented and reduced.

2. **Service-specific outcomes**

   Services will have an impact upon the individual, their family or significant others, and community through:

   i. reduction of alcohol and other drug use and related harm
   ii. improvement in wellbeing including physical, mental, emotional and social wellbeing
   iii. improvement in attitude, knowledge, skills and understanding of strategies to reduce the adverse effects of alcohol and other drug use
   iv. improvement in relationships, appropriate interactions and engagement in the broader community
   v. improvement in circumstances and life condition in areas such as housing, education and employment.

REPORTING FRAMEWORK

The newly amalgamated Mental Health Commission has an extensive range of reporting requirements, which align with existing state and national processes. A combined Outcome-Based Management Framework (the framework) for the amalgamated organisation has been developed and implemented.

The Framework reflects activities relating to the: *Financial Management Act 2006* (s.61), *National Mental Health Performance Framework, Fourth National Mental Health Plan, Key Performance Indicators for Public Mental Health Services* (Third Edition), *Mental Health 2020: Making it Personal and Everybody's Business, National Drug Strategy 2010-2015* and *Drug and Alcohol Interagency Strategic Framework for Western Australian 2010-2015 (DAS).*

Implementation of reform activities will be monitored as part of ongoing organisational business planning and reporting and will also include ongoing contract performance monitoring. Regular organisational reports will be provided using establishment and treatment data collections, corporate data collections (e.g. human resources and finance) and other external data sources as needed (e.g. crime-related, hospitalisation data, Coroner's data etc).

Data collection relating to establishments and treatment is guided by mandatory reporting requirements coordinated by the Australian Institute of Health and Welfare, including the *Mental Health Establishments National Minimum Data Set* and the *Alcohol and Other Drug Treatment Services National Minimum Data Set.*

APPENDICES

CONSUMER, CARER AND FAMILY INVOLVEMENT IN SERVICE EVALUATION

A number of service specific evaluations for mental health, alcohol and other drug services are conducted every year which actively involves consumers, carers and family members by seeking qualitative and quantitative feedback on features, quality and outcomes of service delivery. Independent evaluations are conducted for some services and pilot projects. The majority of alcohol and other drug treatment services (funded by the newly amalgamated Mental Health Commission) are also required to survey consumers in relation to quality of service, drug use and treatment outcomes. Almost 70 per cent of all consumers complete a survey at least once and almost half are surveyed a second time.

In relation to prevention strategies, the Western Australian community, young people and school student population is regularly surveyed in relation to the reach of prevention campaigns, drug use and drug-related harms. Regional communities are also regularly surveyed to monitor alcohol related beliefs and changes in behaviour.

Evaluation of service quality for Community Managed Organisations (CMO) compliance with the NSMHS and delivery on the Mental Health Outcome Statements, is undertaken once every three years (or as required) by a team of independent evaluators external to the CMO and the Mental Health Commission.

As part of the evaluation process, any individual using the services being evaluated, and/or their families and carers, can contact the evaluator directly to provide their feedback about the quality of services provided by the CMO.

In 2011, the Australian Health Ministers endorsed the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme established by the Australian Commission on Safety and Quality in Health Care (ACSQHC). Since January 2013, there has been a requirement for all Australian public and private hospitals and health services to be accredited against the National Safety and Quality Health Service Standards (NSQHS). In addition, the ACSQHC has now developed resources to assist public and private mental health services to ensure accreditation against both the NSQHS and the NSMHS (which were developed independently of the NSQHS and endorsed by Australian Health Ministers in 2010).

In Western Australia (as part of their service agreements with the Mental Health Commission), public mental health hospitals and community treatment services are expected to pursue recognised accreditation against the NSQHS via their Organisation Wide Survey (EQuIP5) plus all the criteria in the NSMHS, in accordance with the requirements of the ACSQHC. Compliance with the NSMHS for both CMOs and public mental health services includes assessment against *Standard 3: Consumer and Carer Participation,* to ensure there is active involvement of consumers and carers in the development, planning, delivery and evaluation of services at both the individual and organisational level.

APPENDIX C – GOVERNANCE

The following governance roles and responsibilities will oversee the whole of sector implementation of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025* (Plan).

A representative oversight committee will be established and report directly to the Mental Health Commissioner.
The committee will:

- provide strategic advice and direction in relation to the implementation of the Plan, including advice on risk management
- monitor the annual progress and the implementation of all proposals
- review the Plan as required.

A number of working groups will also be established, with documented terms of reference and reporting responsibilities. The working groups will focus on the implementation and report to the oversight committee where appropriate.

The working groups will:

- identify how to translate the demand modelling and resource predictions into the most appropriate service mix at the local level including how best to improve and/or reconfigure existing services
- provide advice on strategies to achieve a whole-of-sector approach to implementing the mental health, alcohol and other drug priorities identified within the Plan
- provide oversight of specific projects and actions within the Plan, including risk management
- work with key stakeholders, including the Mental Health Network, to develop relevant models of service
- facilitate collaboration with state representatives, non-government agencies, the private sector and consumer and carer representatives
- contribute to reporting on the Plan.

Reporting on Plan progress will occur through existing local, regional and state level groups. These groups include, but are not limited to:

- meetings with the Minister for Mental Health
- partnership meetings with peak bodies and key non-government organisations
- partnership meetings with the Department of Health (including the Director General, Executive Director of Mental Health, and Area Health Chief Executives)
- Mental Health Advisory Council meetings.

Annual reporting processes will also be a means to communicate progress on the Plan implementation.

APPENDICES

APPENDIX D – HOW THE PLAN WAS DEVELOPED

This appendix broadly outlines the national frameworks, population based planning tools and the Western Australian Framework that have been used in the development of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025* (Plan).

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 Estimator Tool (ET) was completed.

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)

In 2014 the Drug and Alcohol Clinical Care and Prevention Model (DA-CCP) was renamed to the Drug and Alcohol Service Planning Model (DASPM).

The DASPM 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 alcohol and other drug services across Australia. In 2013, the DASPM, which also included an ET for alcohol and other drug services, was released to jurisdictions for the purposes of planning and analysis.

APPENDICES

WESTERN AUSTRALIAN SERVICE PLANNING FRAMEWORKS

The two national population-based modelling tools 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 Department of Health for the development of the Clinical Services Framework.

THE WESTERN AUSTRALIAN MODELLING TOOLS

Western Australia has adapted the NMHSPF-ET to develop the Western Australian Mental Health Estimator Tool (WAMH-ET). The WAMH-ET 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 regional communities in Western Australia.

Like the WAMH-ET, the DASPM-ET estimates the number and type of services required for a comprehensive alcohol and other drug treatment system. An internal Steering Group within the former Western Australian Drug and Alcohol Office, in consultation with experts and stakeholders, has worked to ensure that the DASPM modelling is reflective of Western Australia's unique needs including Aboriginal people, and regional communities in Western Australia (i.e. the WADASPM-ET).

The former Drug and Alcohol Office developed the Model of Demand Index (MODI), which is an index of multiple alcohol and other drug-related indicators. The MODI helps to identify areas of alcohol and other drug service demand in Western Australia by mapping alcohol and other drug 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 ten year period 2014-2024 and has been developed in collaboration with the Mental Health Commission and the former Drug and Alcohol Office. This approach has enabled mental health, alcohol and other drug services to complement the Department of Health's broader planning processes and financial modelling.

The demand model used by the Department of Health differs from the WAMH-ET and WADASPM-ET. 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.

APPENDICES

ESTIMATING SERVICES NEEDED

MODELLING FOR SEVERITY

Individuals with mental health, alcohol and other drug problems are categorised in the Plan as either 'mild', 'moderate' or 'severe' to aid in determining the type of services required:

- **mild** populations are treated entirely in the primary care stream and do not need either specialised ambulatory support, specialised psychosocial support or inpatient care. Symptoms are usually resolved within a 12 month period and disruption to performing in normal roles is minimal (e.g. one to two days out of role).
- **moderate** populations require 'enhanced primary care' services, but no inpatient services. Their symptoms persist for longer than 12 months and days out of role is limited to several days only.
- **severe** populations may include the need for ambulatory only and/or inpatient care, and many would benefit from community support services. They experience several negative symptoms that significantly impact on their functioning. As a result of the symptoms experienced, it is estimated that all (100 per cent) of these people will come to the attention of services, and seek or receive mental health treatment.

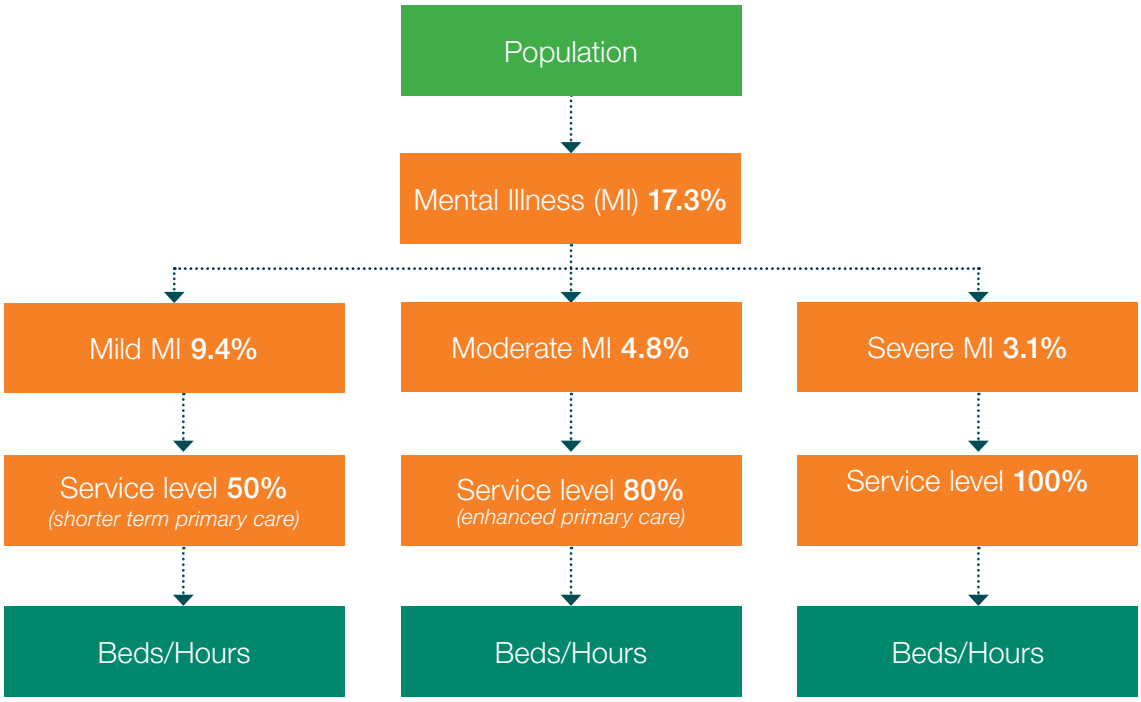
The Plan estimates resources to service people with a severe mental illness only. It is considered that people with a moderate or mild illness will be treated in primary care.

The Plan estimates resources to service people with mild, moderate and severe alcohol and other drug problems. It is considered people with alcohol and other drug problems are seen in publicly funded services, with few seeking treatment with few seeking treatment privately or in the Commonwealth funded primary care sector.

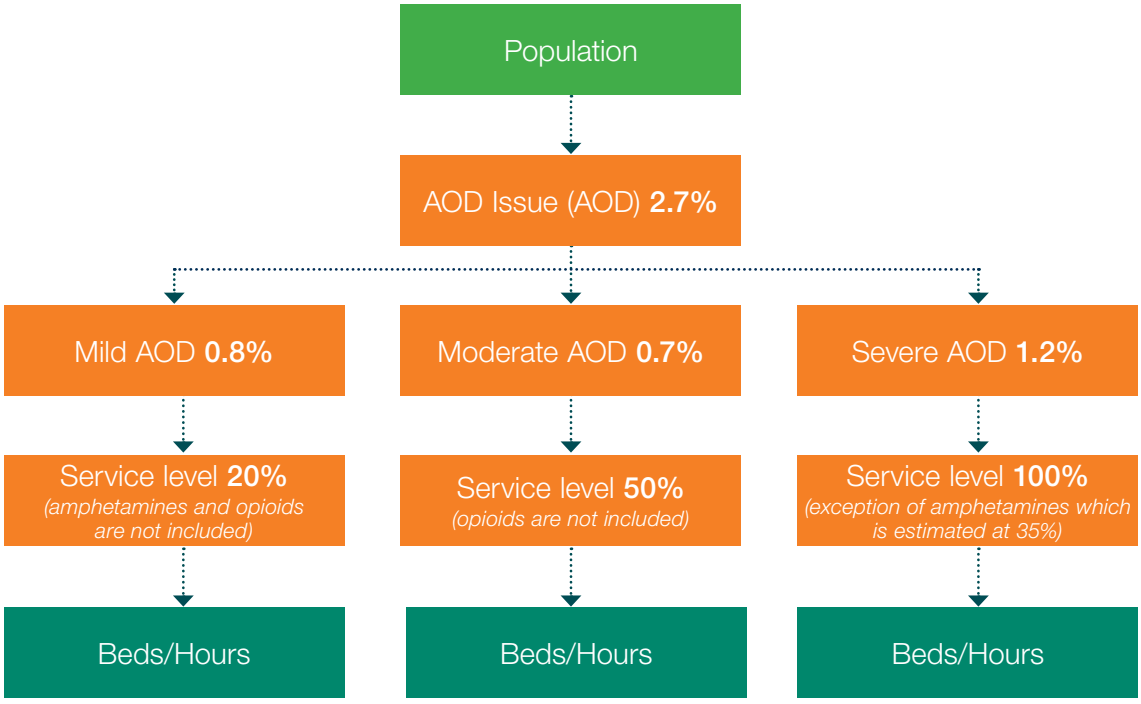
Figures 1 and 2 on the next page show the step by step modelling used in the NMHSPF-ET and the DASPM-ET, including the severity. Light green shows the input required into the model (modifiable), the orange shows the modelling assumptions (unmodifiable), and dark green indicates resource outputs.

APPENDICES

Appendix D, Figure 1: Mental illness prevalence and service level in NMHSPF-ET



Appendix D, Figure 2: Alcohol and Other Drug prevalence and service level in DASPM-ET



AOD = Alcohol and Other Drug

APPENDICES

MODELLING PROCESS SUMMARY

The WAMH-ET and WADASPM-ET were used to calculate the type and quantity of services needed for the projected Western Australian population. The Western Australian population projections used in the modelling were sourced from the Department of Treasury, Western Australia, in consultation and liaison with the Western Australian Department of Health. 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).

The modelling tools apply a stepwise modelling process to all service streams (as shown on page 204) 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. The modelling will be updated to reflect the most up-to-date data and evidence every two years.

Figure 3 on page 204 provides the modelling summary used in the planning processes (WAMH-ET and WADASPM-ET). Dark green shows the NMHSPF-ET and DASPM-ET resource outputs (unmodifiable), light green shows the Western Australian modelling assumptions (modifiable), and orange shows the WAMH-ET and WADASPM-ET resource outputs.

The Plan provides an estimate of the services and resources (i.e. facilities and workforce) 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 poor outcomes and inflated costs).

There are limitations to population based planning modelling. 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).

APPENDICES

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

1. NMHSPF-ET AND DASPM-ET OUTPUTS

Bed/Hours estimates taken from the NMHSPF-ET and DASPM-ET, which is based on population input determined by the user. See figures 1 and 2 on page 202.

2. WESTERN AUSTRALIAN AGE GROUPS

Service estimates by Western Australian Age Groups are extrapolated from the NMHSPF-ET age groups: 0-15 years (Infant, Child and Adolescent); 16-24 years (Youth); 25-64 years (Adult); and 65+ years (Older Adult).
Service estimates by Western Australian Age Groups from the DASPM-ET: 0-11 years (Infant and Child); 12-17 years (Youth); 18-64 years (Adult); and 65+ years (Older Adult).

3. ADJUST THE READMISSION RATE (MENTAL HEALTH HOSPITAL BEDS ONLY)

The NMHSPF-ET applied a 28-day readmission rate (10 per cent) annually. The WAMH-ET adjusts this to correct the NMHSPF-ET underestimate and to reflect readmissions for the Western Australian context.

AGE GROUP	ANNUAL READMISSION RATE
Infant, Child and 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 LOADINGS

Data from the Australian Bureau of Statistics is used to determine the input population by remoteness before the Independent Hospital Pricing Authority (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	APPLICABLE POPULATION
Outer Regional	8.0%	6.5%
Remote	16.0%	3.6%
Very remote	22.0%	2.9%

5. ABORIGINAL SERVICE UTILISATION RATE

The Australian Institute of Health and Welfare reported that hospitalisations among the Aboriginal population are higher than that of the general population, nationally. Specifically, in Western Australia the ratio in 2013-14 was 3.94 times. This is the latest data available.
Part of the resource need for the Aboriginal population is factored into the general service demand built into the care packages. The 3.94 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.

POPULATION	ABORIGINAL	NON-ABORIGINAL
North Metropolitan	1.6%	98.4%
South Metropolitan	2.1%	97.9%
Northern and Remote	23.4%	76.6%
Southern Country	3.8%	96.2%
State Total	**3.8%**	**96.2%**

6. WAMH-ET AND WADASPM-ET OUTPUTS

SERVICE STREAM	OUTPUT MEASURE
Hospital inpatient services	Beds
Hospital consultation and liaison services	Hours of service
Community bed-based services	Beds
Community treatment services	Hours of service
Community support services	Hours of support/hours of service/beds

APPENDICES

ESTIMATING SERVICES FOR OUT OF SCOPE SERVICE STREAMS

PREVENTION

The NMHSPF and DASPM do not specifically address prevention service requirements for mental health, alcohol and other drugs.

For mental health, a Promotion and Prevention Consultation Group (PPCG) was formed, which comprised of representatives from key stakeholders including consumers, carers, educational institutions, other relevant government departments, primary care representatives, and other interest groups. The PPCG provided advice on the development of the *Prevention* section of the Plan, and undertook research upon which the mental health prevention resource requirement is based.

While there is published evidence to guide what makes for an evidence-based approach to prevention, there is no modelling that exists to guide an optimal level of service for prevention activities. Modelling for the alcohol and other drug prevention components is based on existing programs, population projections and expert advice (via the establishment of and input from the Alcohol and Other Drug Prevention Expert Reference Group, including Curtin University, Western Australian Police, Department of Health and the National Drug Research Institute).

FORENSIC

The NMHSPF and DASPM do not specifically address forensic mental health, alcohol and other drug 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, alcohol and other drug 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.

The Forensic Mental Health Services Planning Group therefore applied a modified method, informed by the NMHSPF, and best evidence to describe the services required and the resources needed.

In circumstances where forensic mental health interventions comprised of service elements that were not defined within the NMHSPF care packages, service quantity was calculated using the logic of the NMHSPF. For example, one element of court diversion was informed by the care package that defined the amount of face-to-face time required for brief mental health assessments and the type of staff required. These data were then used to calculate the Court Diversion and Support Services.

APPENDICES

The acute bed-based requirements were determined using demand modelling, as the NMHSPF estimator tool method for estimating bed numbers only works when applied to a large population and where admission is driven by clinical need. The numbers of prisoners requiring beds was calculated using the estimated prevalence of mental disorders in prison. The number of beds required for those sent to hospital by courts on hospital orders and custody orders was estimated based on historical data.

The key focus for forensic alcohol and other drug 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 Department of Corrective Services, the Department of the Attorney General and the Western Australian Police. 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 alcohol and other drug court and police-based diversion programs (such as diversion officer and booking service staff).

CONSULTATION AND EXPERT ADVICE

DEVELOPING THE PLAN

Formal governance arrangements were established to facilitate the processes of expert and stakeholder engagement in the design and development of the Plan. Consultation took the form of consultation groups, forums, workshops, videoconferences, briefings, and presentations from visiting experts. Stakeholders offered expert advice and input on:

- the Western Australian Services Framework (classification system) and service descriptions (see Appendix E)
- the Western Australian Services Framework applicability to local mental health, alcohol and other drug service issues
- unique Western Australian population features
- future planning and other relevant issues.

For the mental health components of the Plan the following consultation occurred:

- more than 350 individuals, representing more than 100 relevant Statewide agencies and interest groups, took part in this consultation process
- a custom-designed survey provided further valuable input from more than 700 respondents
- consultation groups across the State provided advice on its major components.

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To assist in developing the alcohol and other drug treatment and support components of the Plan, the former Drug and Alcohol Office:

- held a stakeholder consultation workshop with a total of 87 representatives from the alcohol and other drug sector, mental health sector, consumers and families
- further consultation was undertaken with community members and stakeholders in the metropolitan area and in six other regions. A total of 172 people attended the forums. Representatives were from local alcohol and drug services, government departments, Medicare Locals and community support groups, including 24 community members.

REVIEW OF THE PLAN

The draft Plan was released for public consultation between 3 December 2014 and 30 March 2015. The feedback gathered during that time period has contributed to the revision of the draft Plan, to deliver this final Plan.

The consultation included valuable input from key stakeholders including relevant State agencies, interest groups, consumers, carers and families from across the State and in regional areas. Consultations included:

- 19 consultation forums, comprising of:
  - nine regional-based (Albany, Broome, Bunbury, Geraldton, Kalgoorlie, Karratha, Kununurra, Northam and Roebourne)
  - one public forum (in the metropolitan area)
  - one consumer, carer and families forum (in the metropolitan area)
  - one specific forum on alcohol and other drugs (in the metropolitan area)
  - seven metropolitan-based forums focusing on specific service streams in the Plan (prevention, community support, community treatment, community bed-based services, hospital-based services, specialised statewide services, and forensic services)
- there were 696 individuals who attended the consultation forums
- there was a total of 245 online survey participants
- the Mental Health Commission received a total of 63 written submissions.

For further information on feedback received please visit the Mental Health Commission website: www.mhc.wa.gov.au

APPENDIX E – THE WESTERN AUSTRALIAN SERVICES FRAMEWORK

The Western Australian Mental Health, Alcohol and Other Drug Services Framework (the Western Australian Services Framework) describes the comprehensive service system required to meet the needs of the State. It has been developed based on national taxonomy (classification system). The Western Australian Services Framework is consistent with national approaches, and includes five main service streams as shown in Appendix E – Figure 1 below.

Appendix E – Figure 1: Western Australian Services Framework: Service Streams

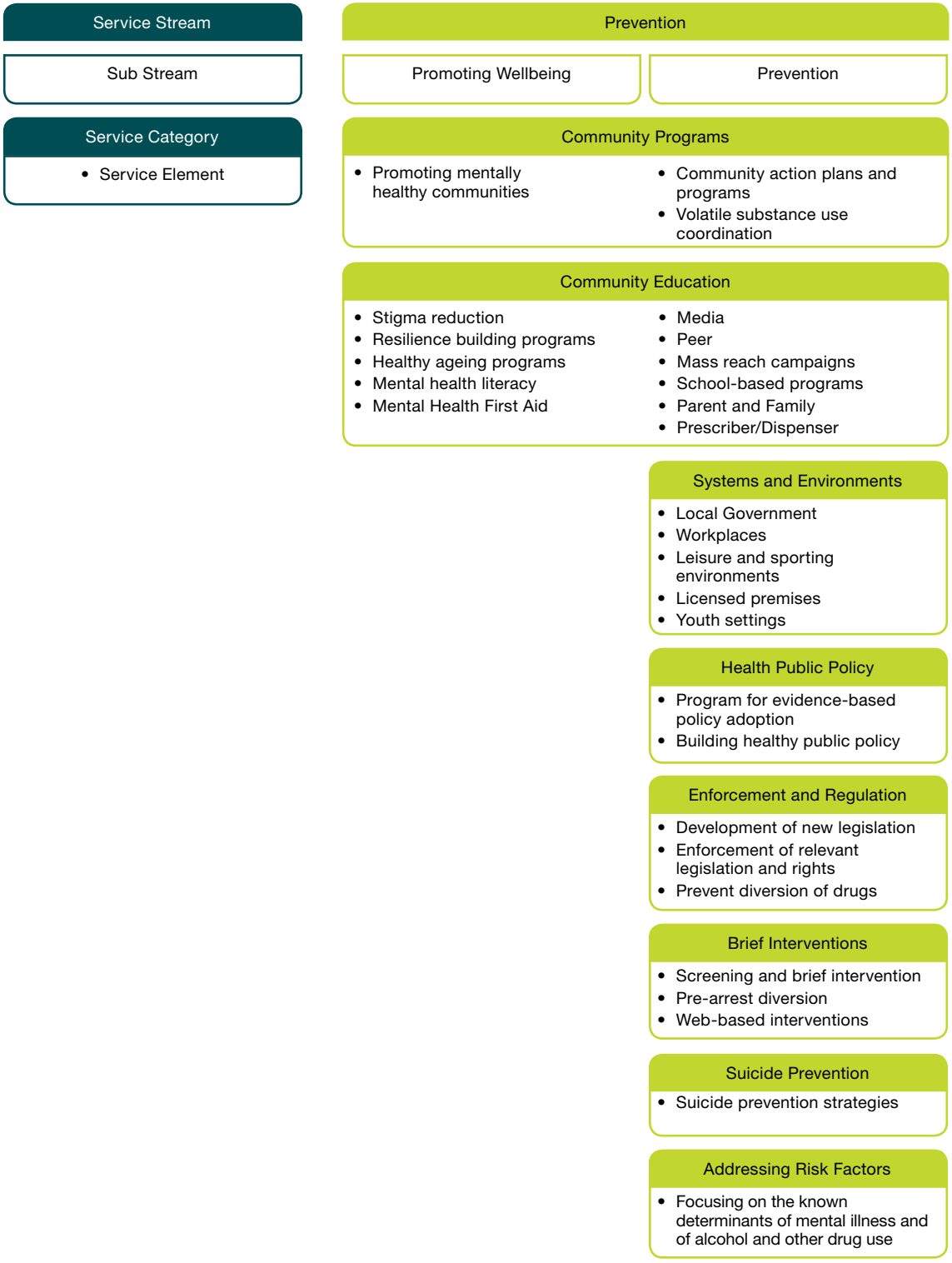
The service streams form part of a complex system of services that may overlap and interact. Underpinning each service stream is a number of sub-streams, categories, elements and target groups (where appropriate).

The Western Australian Services Framework (see Appendix E – Figure 2) does not attempt to describe service delivery model features such as the service environment, provider, nor how the service is funded.

Rather by classifying the services required, the current system of services can be mapped and service gaps identified to facilitate strategic and effective investment decisions. In addition, by being provider neutral, the Western Australian Services Framework can accommodate services provided by public, private (profit and not-for-profit) and public-private partnership service providers.

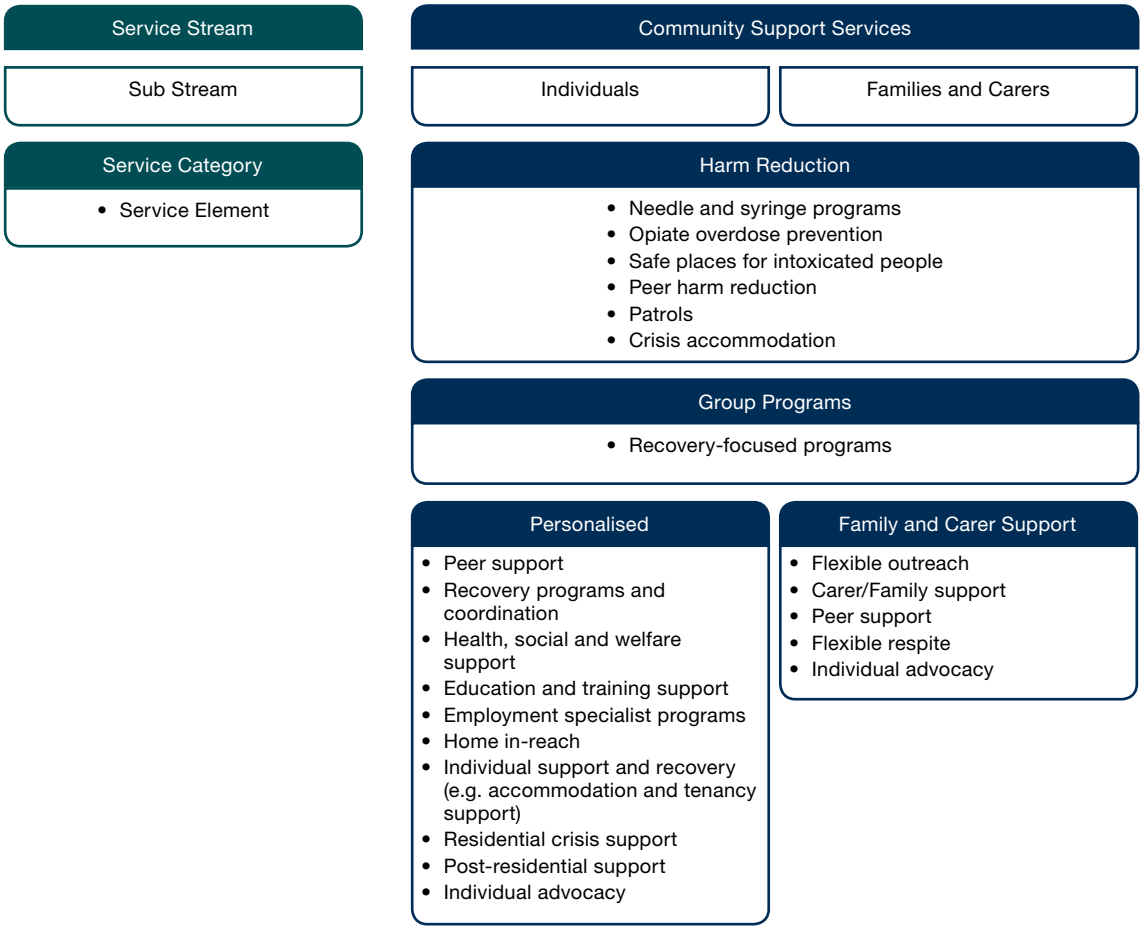
APPENDICES

Appendix E – Figure 2: Western Australian Services Framework



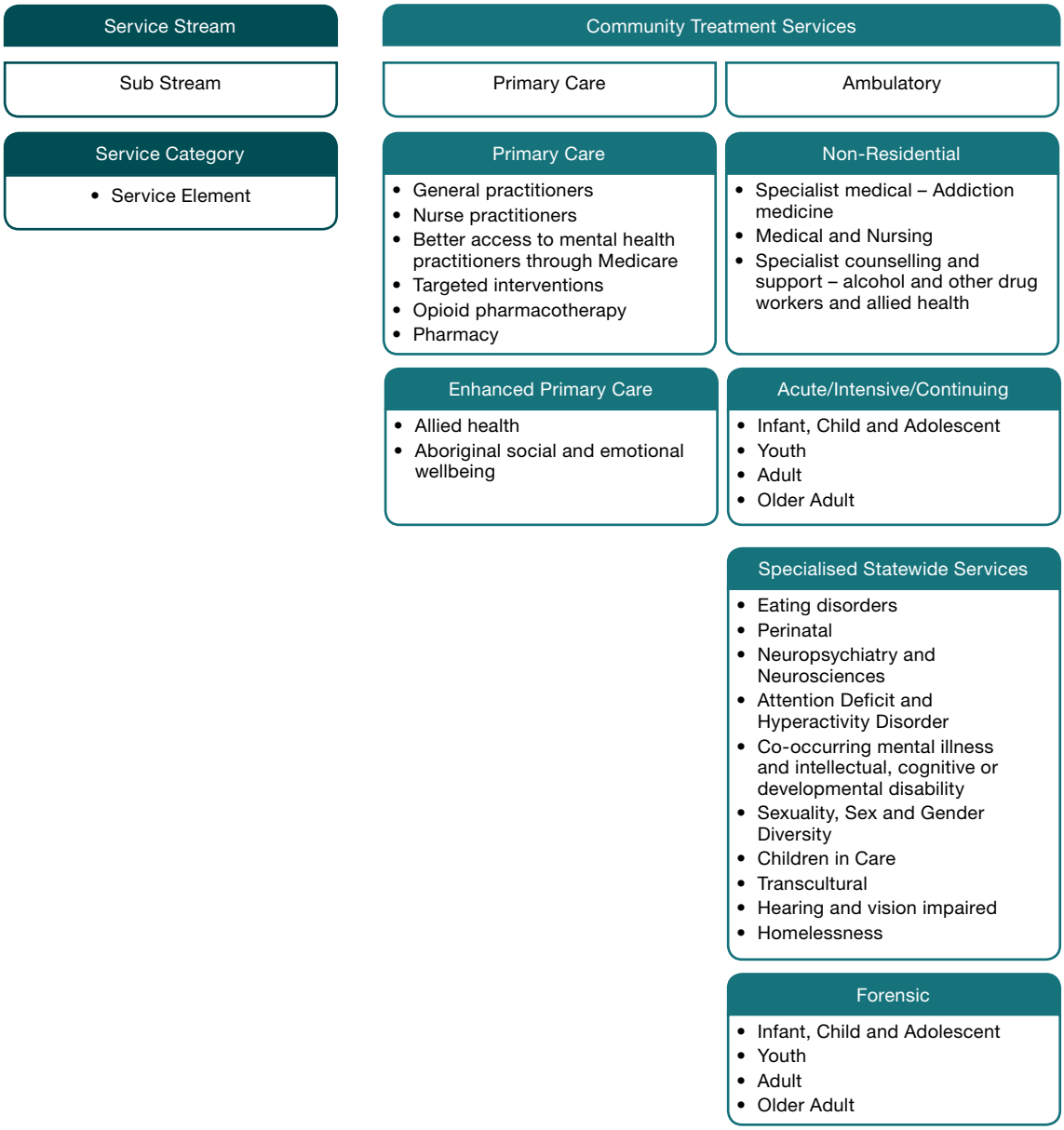
APPENDICES

Appendix E – Figure 2: Western Australian Services Framework continued



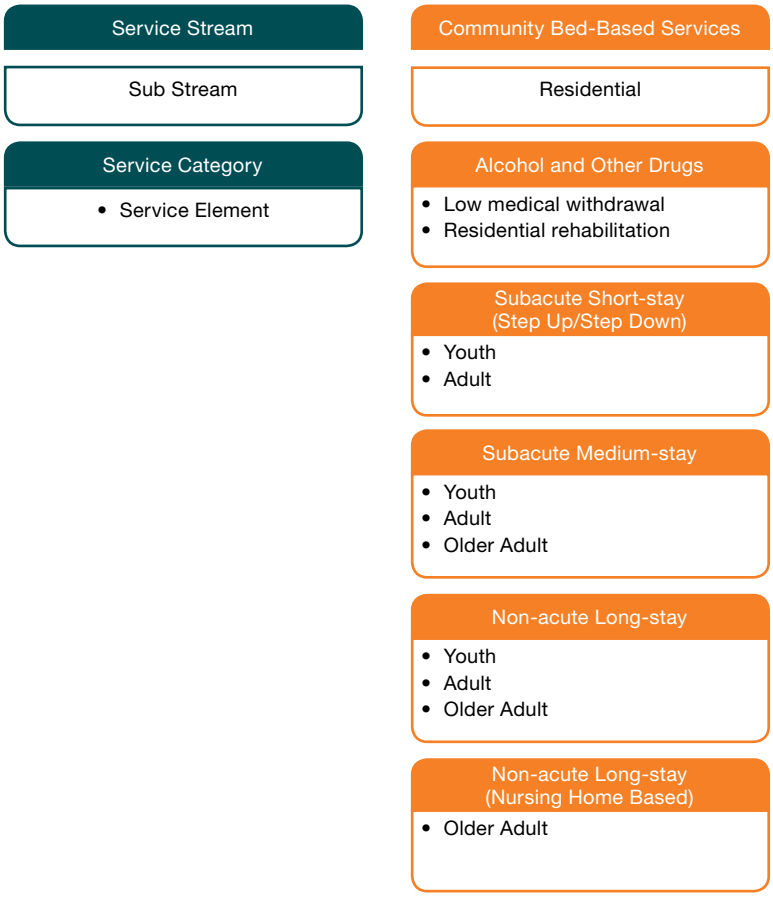
APPENDICES

Appendix E – Figure 2: Western Australian Services Framework continued



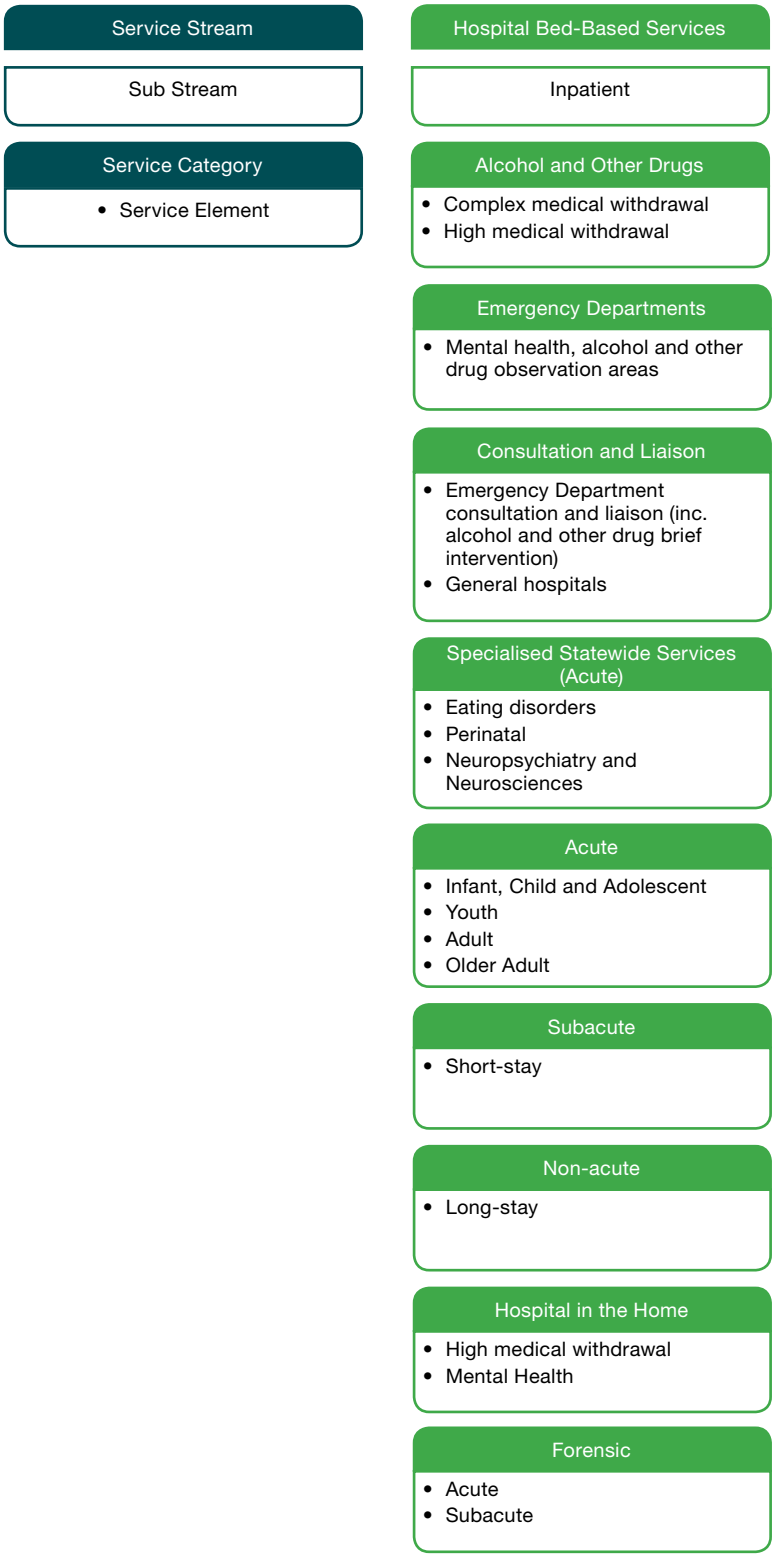
APPENDICES

Appendix E – Figure 2: Western Australian Services Framework continued



APPENDICES

Appendix E – Figure 2: Western Australian Services Framework continued



APPENDIX F – COSTING

Both the operational and the capital costings have been undertaken to show the worst case cost scenario for the State, in relation to delivering the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025* (Plan). In practice, many capital builds will not be required as other options (e.g. leasing, public-private partnerships etc) may be sought as an alternative. Further, the composition of funding sources for operational costs may also change over time (proportion of State, Commonwealth, philanthropic and other funding). There are certain exclusions from the costing, however, the costings represent the likely cost to the State for services which the newly amalgamated Mental Health Commission would purchase.

OPERATIONAL COSTINGS

The operational costings of the Plan has been undertaken in two scenarios: the estimated cost to the whole system (regardless of provider and funder), and the estimated cost to the State. The operational costings are reported in 2012–13 terms (not adjusted for inflation), and show recurrent costs of the system once resources are in place. The operational costings account for: items which would fall under other goods and services; higher wages and allowances for those who would work in regional areas; and public servants working at the Mental Health Commission.

There are three exclusions from the operational costings:

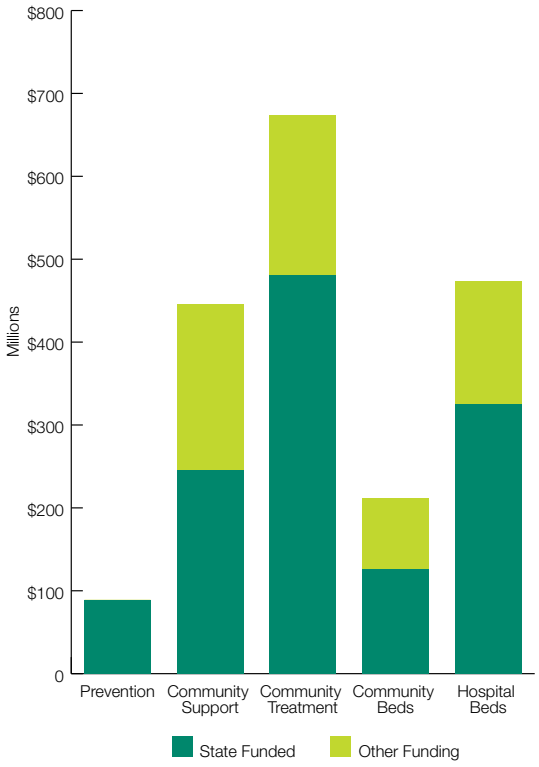
- prevention activities which are not funded through the newly amalgamated Mental Health Commission
- in-prison costs
- the cost of implementing individual initiatives.

Prevention resources outlined in the Plan are limited to those funded solely by the newly amalgamated Mental Health Commission. The in-prison resource requirements were modelled in partnership with the Department of Corrective Services, and would be a State-funded resource requirement. However, the estimated cost of those resources is excluded from the costings.

APPENDICES

The estimated State recurrent cost has been calculated based on known other funding sources, such as the Commonwealth Government, with historic proportions remaining the same. In circumstances where the level of funding from other sources was unknown or could not be quantified, a conservative approach has been taken, and the entire cost has been allocated to the State.

The estimated cost of each service stream is shown in Appendix F – Figure 1 below, which represents the annual costs of resources required in 2025, using 2012-13 dollars (unadjusted for inflation).



Appendix F – Figure 1: Annual operational costs in 2025 by service stream (2012-13 terms)

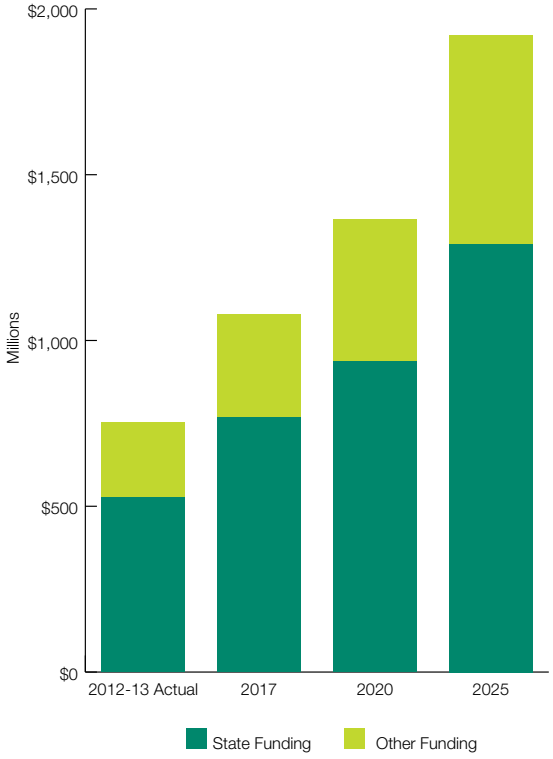
The community forensic hours of service have been grouped with the community treatment hours of service, for ease of costing and comparison. Further, the specialised inpatient beds (eating disorders and perinatal), Hospital in the Home (HITH) beds, Mental Health Observation Area (MHOA) beds, and forensic inpatient beds have been grouped with hospital beds for the above reason. Appendix F – Table 1 below details the annual costs of 2025 resources, in 2012–13 terms.

Appendix F – Table 1: Annual operational costs in 2025 by service stream (2012-13 terms)

SERVICE STREAM	STATE FUNDING ($M)	OTHER FUNDING ($M)	TOTAL SYSTEM COST ($M)
Prevention	89.2	0.0	89.2
Community Support	245.6	201.6	447.2
Community Treatment	481.9	193.0	674.9
Community Beds	126.7	85.7	212.3
Hospital Beds	326.0	149.8	475.7
System-wide Support	22.3	0.0	22.3
TOTAL	**1,291.6**	**630.0**	**1,921.6**

APPENDICES

As discussed in the *Hospital-Based Services* section, the future purchasing direction across the public and private sectors will be further explored, and the demand will be remodelled every two years. For the costing purposes only, all inpatient beds have been allocated to the State. As shown in the *Plan Matrix* on page 105, various services and initiatives will come into operation during one of the three periods: by the end of 2017, 2020 and 2025. It is important to gain an understanding of how the operational costs will change over the three periods with the various new and expanded services in operation. Appendix F – Figure 2 below shows the likely annual operating cost in 2017, 2020 and 2025 if phasing of initiatives occurs as stipulated in the *Plan Matrix*.



Appendix F – Figure 2: Annual operational costs in 2017, 2020 and 2025 (2012-13 terms)

Appendix F – Table 2 below details the annual operational costs in 2017, 2020 and 2025 if the phasing of initiatives and services were in line with the *Plan Matrix*.

Appendix F – Table 2: Annual operational costs in 2017, 2020 and 2025 (2012-13 terms)

PHASES (BY THE END OF)	STATE FUNDING ($M)	OTHER FUNDING ($M)	TOTAL SYSTEM COST ($M)
2012-13 Actual	526.7	228.0	754.8
2017	768.7	312.5	1,081.2
2020	937.1	429.1	1,366.2
2025	1,291.6	630.0	1,921.6

The cost of implementing initiatives will occur during the development of business cases, for Government consideration. At which point the operational costs will also be updated, to include latest market information regarding costs.

CAPITAL COSTINGS

The capital costing of the Plan is reflected in 2012-13 terms and is not adjusted for inflation. Each facility requirement has been costed as a new build, for the purposes of costing capital for the Plan. There are a few exclusions from the costings:

- housing is excluded as is not provided or purchased by the Mental Health Commission, and the method of procurement is yet to be determined and evaluated during business case development
- community beds in aged care facilities is generally funded by the Commonwealth Government, and has been excluded from the capital costings

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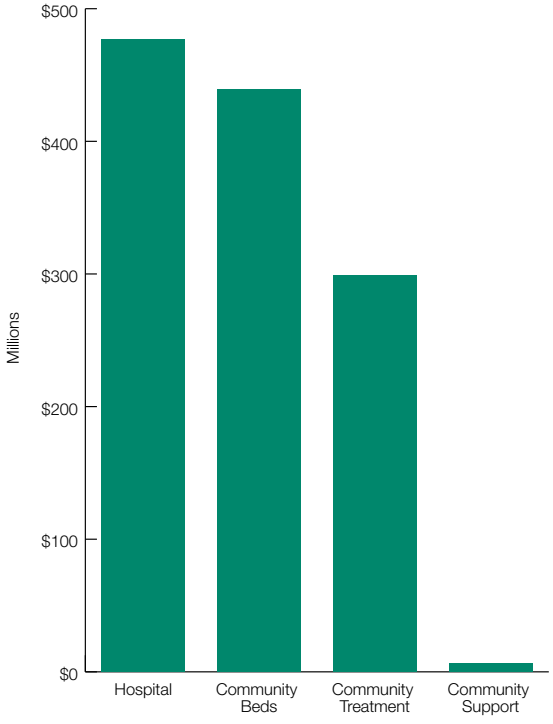
- the closure and decommissioning of Graylands Hospital and Selby Older Adult Unit
- in-prison beds are excluded as is not provided or purchased by the Mental Health Commission.

The in-prison bed requirements were modelled in partnership with the Department of Corrective Services, and would be a State-funded resource requirement. However, the estimated capital cost of those beds is excluded from the costings.

The estimated cost of each service stream is shown in Appendix F – Figure 3 below, which represents the capital costing required by the end of 2025, using 2012-13 dollars (unadjusted for inflation).

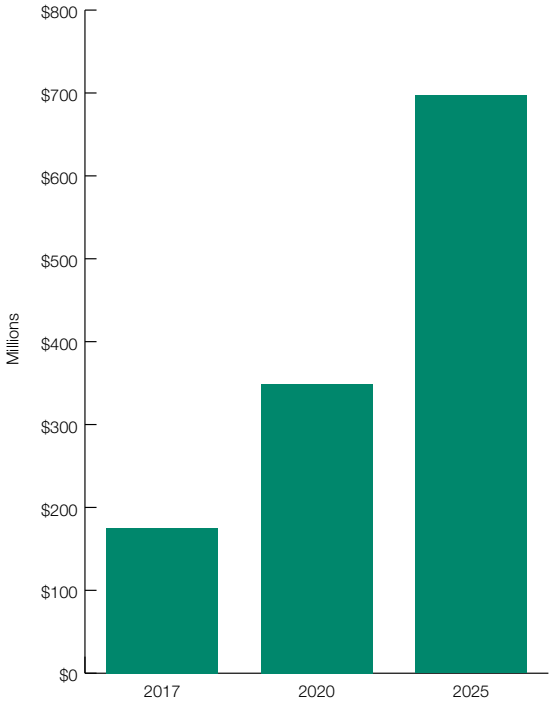
The community forensic services have been grouped with the community treatment services, for ease of costing and comparison.



Appendix F – Figure 3: Capital costs by the end of 2025, by service stream (2012-13 terms)

Further, the specialised inpatient beds (eating disorders and perinatal), the MHOA beds, and forensic inpatient beds have been grouped with hospital beds for the above reason. Appendix F – Figure 4 below shows the estimated capital cost in 2012-13 terms (unadjusted for inflation) for the three periods: by the end of 2017, 2020 and 2025. This is in line with the *Plan Matrix* on page 105, where it shows the time periods the various services and initiatives will come into operation, according to the actions.

Detailed costings in relation to capital will be undertaken and included in individual business cases, as they are developed. Options analysis will also be undertaken in the business cases to ascertain optimal procurement method of delivering the capital for each individual initiative.



Appendix F – Figure 4: Capital costs in 2017, 2020 and 2025 (2012-13 terms)

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