Consultation Summary Report:

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

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 over 2,300 individuals and organisations. Expert Reference Groups have been formed and online surveys, consultation forums, and individual meetings have been undertaken to ensure all key stakeholders have had an opportunity to contribute their experience, thoughts, opinions and ideas. The interest shown has been overwhelming and can be taken as a sign of the desire many people have to see real change.

The draft Plan was released on 3 December 2014 for a final consultation period, and was completed on 30 March 2015. See Figure 1 for an overview of the consultation. Feedback provided during the consultation period was used to inform revision of the final Plan. A summary of feedback received is included in Table 1. In some cases, feedback was not reflected in the final Plan as it related to issues that need to be considered during the implementation of the Plan. Feedback also contained queries relating to the Plan content, which were not answered in the final Plan, but responses have been included in Table 1.

Figure 1: Overview of consultation: 3 December 2014 to 30 March 2015

Table 1: Summary of feedback received during consultation, and a response from the Mental Health Commission

What you said		What we did
General Comments		
1	Respondents[1] want to see a strong commitment to **funding** the services and programs outlined in the Plan and an indication of what is happening with Commonwealth funding. Questions were also raised about interim funding whilst the Plan is being implemented.	The Plan articulates the overall intentions regarding service development over the next ten years. Business cases will need to be developed for Government's consideration and are subject to the State's financial capacity. However, as the Plan is funder and provider neutral, discussions have already commenced with private organisations and the Commonwealth to encourage strategic investment. The above has been explained in the Plan (see pages 5 and 9).
2	Although the Plan was welcomed, some people commented there was a need to implement it in a shorter **timeframe**.	It is acknowledged service growth and reform is urgently required. The implementation of priority areas has already commenced. Furthermore, to ensure appropriate planning is undertaken, funding is sustainable and workforce are available, actions must be phased. Phasing of the Plan implementation is shown on pages 169-171 of the Plan.
3	Concern was expressed that the Plan was **service centred** and too focused on data, at the expense of being **person-centred**.	The National Mental Health Service Planning Framework (NMHSPF) and the Drug and Alcohol Service Planning Model (DASPM) were used to underpin the Plan. These evidence-based models were developed nationally with input from experts and stakeholders across Australia. Both models estimate the optimal mix and level of services required to meet the needs of the population, therefore inherently are service focused. In order for the Government and funding agencies to understand the gaps in service provision and therefore target investment, a service focused plan is required. This does not negate the need for the *implementation* of services to be person focused. As shown throughout the Plan (including in the vision, principles, what we hope to achieve, and implementation sections), the intention is to implement a person-centred service system and this will continue to guide implementation over the next ten years. Individualised funding approaches will also be explored in greater detail in the short to medium term, which may further progress the implementation of a person-centred service system where individuals are supported to choose the most appropriate supports and services they want to

[1] Respondents include people who attended the consultation forums, responded to the online survey and/or provided written submissions.

		access.
4	Greater clarity was requested on the details of Plan **implementation.** Respondents commented that although the general principles and direction of the Plan is appropriate, the practicalities of implementation are missing. This includes a need to see how community services and hospital services will be balanced in each region, how specific organisations will be involved in implementation and how potential duplication, inefficiencies and rivalry between services will be addressed.	The Plan provides an estimate of the optimal mix and level of mental health, alcohol and other drug services required to meet the needs of the population. As mentioned above, the Plan provides a means for the Government and funding agencies to understand gaps in service and therefore target investment appropriately. The Plan does not go into detail about implementation as it is essential implementation is done in partnership with other government agencies, the Commonwealth, consumers, families, carers, clinicians, service providers and other key stakeholders. The section titled *A partnership approach to implementing reform* in the Plan provides greater detail on Plan implementation. It should be noted, however, that the exact location and distribution of services will be determined by a combination of consultation processes and the assessment of relative feasibility to deliver the service. Ultimately, the Mental Health Commission will be responsible for ensuring there is a balance of services across the State and that duplication, inefficiencies and rivalry are minimised.
5	A requirement for **bi-partisan support** was raised by respondents to ensure the Plan continues to be implemented regardless of the Government of the day.	Evidence based modelling was used to inform the Plan. Further discussions will be held with relevant parties to ensure bi-partisan support can be gained. A broad range of key stakeholders have worked hard to develop the Plan over a number of years. The response to the Plan has been very positive. Stakeholders have been waiting for a Plan of this kind for many years and are motivated to work together to achieve real change. Options for investment are provided in the Plan for future Government and funding agency consideration. The Plan is also funder and provider neutral. Regardless of the political party in Government, it is anticipated the service development directions outlined in the Plan will be strongly supported and progressed over the next ten years.
6	Respondents commented there was a need to see better **integration between mental health, and alcohol and drug services** in the Plan. Concerns were expressed that there appeared to be two separate plans working in parallel. Comments also included a need for building dual diagnosis workforce	As there were two models used (NMHSPF and DASPM) to underpin the Plan, there is inevitably some separation of mental health, and alcohol and other drug services. It is recognised, however, that co-occurring mental health, alcohol and other drug problems is very common therefore both mental health, and alcohol and other drug services need to have the capability to address both problems, concurrently where possible.

	capability and a requirement for services that concurrently treat both mental health, alcohol and other drug problems. Despite the call for greater integration, some respondents expressed concern that throughout the Plan there is a blurring of responsibility for delivery of services between alcohol and other drug and mental health service providers. It was noted this can make it difficult to identify which specific service will be accountable for each activity. It was also noted by respondents that services need to provide choice and diversity and that not all services require integration but improved person-centred collaboration.	The expectation that mental health and alcohol and other drug services provide seamless care for people with co-occurring problems has been more strongly reflected in the final Plan. For example, it is the intention to integrate public mental health, and alcohol and other drug community treatment services wherever possible (see pages 49-51 of the Plan). The intention behind the amalgamation of the Mental Health Commission and the Drug and Alcohol Office is to substantially improve collaboration between services and integration of mental health, and alcohol and other drug services.
7	In addition to a request to see more emphasis on integrated mental health, alcohol and other drug services, respondents frequently called for **overall improved system integration** and the provision of seamless, coordinated treatment and support. The challenging nature of improving communication, information flow, linkages, and coordination was also recognised and suggestions made to investigate privacy hurdles and the development of Memorandum of Understandings (MOUs).	The importance of overall system integration is recognised in the Plan (for example, see pages 151-158). The development of models of service and introduction of the community coordination pilot will aid the achievement of system integration and coordination to some extent. System integration also requires individual services to proactively establish linkages with other relevant agencies and holistically support individuals accessing their service to seek assistance from other sectors where required. Privacy and confidentiality needs to be considered and the wellbeing of individuals prioritised at all times.
8	A need for increased emphasis on meeting the needs of people in **regional and remote** areas was frequently raised by respondents. Issues raised include: • the challenges of accessing and delivering services across large geographical areas; • transport difficulties; • varying incidence rates; • a higher proportion of Aboriginal people and/or young people in some areas;	In response to a call for a greater level of detail on services in regional areas, the final Plan includes a *Services by region* section (see pages 101-138). This provides people in regional areas a clearer picture of what the Plan estimates is required in their area to meet the needs of the population over the next ten years. It should be noted, however, that the exact location and distribution of services will be determined by a combination of consultation processes and the assessment of relative feasibility to deliver the service. The additional resources (e.g. travel time, higher wages) required to deliver services in regional and remote areas has been accounted for in the Plan

	• difficulties attracting qualified workforce; and • the practicality of extended hours of service especially for community services. Regional and remote respondents also expressed a strong desire to be involved in regional service planning, design and development.	modelling through a regional and remote loading, as well as in the costings. The additional regional resources have been allocated to each region according to a remoteness scale and population. An Aboriginal population loading has also been included to account for additional resources required in areas with a high proportion of Aboriginal people. Again, these resources were distributed according to the proportion of Aboriginal people living in particular regions. For more information see Appendix D (pages 199-207) of the final Plan. The Plan does not go into detail about implementation, however, it is the intention of the Mental Health Commission to work with local stakeholders when progressing implementation of the Plan in regional areas.
9	There were queries raised as to why the **metropolitan area were allocated more resources** (e.g. beds, hours of service etc) compared to regional areas.	The national models used to inform the Plan are based on services required per 100,000 population. In 2014, 78.6% of the total Western Australian population resided in the metropolitan area therefore a greater level of resources are required in the metropolitan area to meet demand. The resources are modelled based on the projected population for each region in the State, and are allocated in the Plan accordingly. As explained in point eight above, additional resources have been allocated to regional and remote areas to account for the challenges of delivering services in these areas.
10	Respondents acknowledged the need to work with **primary care** to optimise service delivery for consumers, but also to increase access to primary care services including General Practitioners (GPs). Respondents want to see more partnerships and collaboration between primary care and State funded services. There was also concern expressed by clinicians and service providers that until the primary care sector is appropriately meeting the needs of people with mild to moderate mental illness, State funded services will continue to have to see people with a mild/moderate illness whose needs may be better met in a well-resourced primary care sector– thereby putting pressure on resources.	The optimal mix and level of services is outlined by the national models (NMHSPF and the DASPM). The NMHSPF suggests that the State should fund services for the severe population only, and that mild and moderate populations should be addressed within the primary care sector. Current practice and demand does not reflect this optimal mix and level of services. The DASPM models services for people with mild, moderate and severe alcohol and other drug problems. GP services in Western Australia are below the national average, and are below the optimal level required in order to achieve an efficient service system. This is a large contributing factor as to why people with a mild/moderate mental illness are currently being treated within the publicly funded sector. It is also acknowledged people who are acutely unwell, are at risk or have complex and/or treatment resistant illness may be require access to treatment in the State funded sector. The Mental Health Commission is working with the Commonwealth and the primary care sector in order to improve access to GPs/primary care in Western

		Australia. This will enable people with a mild/moderate mental illness to be provided treatment in the primary care sector.
11	Linked to the issues raised above, respondents also commented that the Plan appears to assume that clinical mental health services are applicable only to patients with severe mental illness. Respondents consider this an invalid assumption as current best practice for clinical mental health services includes the treatment of **people with a mild/moderate mental illness who may be experiencing an episode of acute illness.**	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 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 cross over between the sectors.
12	The intention to ensure existing and new mental health services are **recovery-oriented** is well supported by respondents; however, further reassurance is sought about the practicalities of how this will be implemented. Caution was also expressed about how the term recovery is interpreted in the alcohol and other drug sector, where the term has historically been linked with abstinence.	The Plan does not go into detail about implementation as it is essential implementation is done in partnership with consumers, carers, clinicians, service providers and other key stakeholders. Implementation will involve the specification of how services can provide recovery oriented services. It is acknowledged the term "recovery" can have different connotations in the alcohol and other drug sector. Further discussion and a description of the term recovery is included on page 11 of the Plan. An action relating to the need to explore the applicability of the concept of recovery to alcohol and other drug services is included in the final Plan (see page 142).
13	Some respondents requested the Plan be more specific about the **occupations and number of Full-Time Equivalents (FTEs)** that will be employed across the system over the next ten years (as opposed to hours of service/support). In addition, clarification on hours of service/days of the week was also sought.	The demand modelling tools outline the FTE by occupation, and this has been used for the costing of the Plan. The models of service are yet to be developed, which would have an impact on the type and level of FTE by occupation required. Therefore, the Plan converts FTEs into hours of service as a proxy for the resource level required for the Western Australian population by 2025. 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. It encompasses all responsibilities FTE are required to do in their role.
14	Respondents are seeking additional information/clarification on the **modelling** used to underpin the Plan, including: • a clear definition of 'severe' mental illness; • how resources are equitably allocated across	Due to feedback received, further detail has been included in Appendix D of the Plan on pages 199-207 (*How the Plan was developed*).

	regions according to demographics; • population statistics and projections; and • estimates of the incidence and prevalence of mental illness.	
15	Respondents wanted to see greater recognition of the **current pressures on the system** including on community treatment teams, emergency departments and inpatient wards.	It is acknowledged the current system is unbalanced therefore relies too heavily on community treatment and hospital based services. The pressures on the current unbalanced system is described on pages 19-23 of the Plan. Another key cause of excessive demand is the lower than optimal GP/primary care services in Western Australia. People with a mild/moderate mental illness are currently being seen in the public system, when the best form of care for may be in a well-resourced and capable primary care sector. If the level and capability of GP/primary care services is increased, this will result in a decrease in the number of people with mild/moderate mental illness being seen in the State funded public sector. It is acknowledged that in some cases clinicians in the public sector may continue to see those with acute, high risk, complex and/or treatment resistant illnesses. It is anticipated with the increased investment in community-based services as a first priority, pressure on hospital based services will be reduced and people will be able to access the right type of care to suit their needs. Investment in all areas across the service spectrum needs to be connected and work seamlessly.
16	Greater attention needs to be paid to the small group of people with **highly complex, treatment resistant mental illness** (sometimes with co-occurring alcohol and other drug problems) according to some respondents. These people may be staying for extended periods in inpatient facilities e.g. Graylands) or psychiatric hostels but require access to safe, contemporary, home-like services.	The services required for people with highly complex, treatment resistant illness are included in the modelling for the Plan. The modelling includes community bed-based services which would accommodate long-stay patients (usually, the minimum length of stay being one year), in a home-like facility. The Plan includes an expansion of community-based mental health non-acute long-stay beds and the development of a housing strategy. Planning and development of appropriate services for this group will be an early priority when progressing the divestment of Graylands.
17	A range of issues relating to **workforce** were raised by a variety of respondents. This includes: • the number of additional psychiatrists (including child psychiatrists) needed, and how they will be recruited into the Western Australian public mental health sector;	It is acknowledged and well understood that substantial work in the area of workforce planning and workforce development is required to ensure the right number of suitably qualified staff are available to deliver the services outlined in the Plan. Workforce planning and workforce development is the responsibility of commissioning agencies as well as service providers. Although much work already occurs in the area of workforce development,

	• broader workforce development/training across the sector, such as a requirement for training primary care, aged care and other health services to manage patients with mental illness with specialist support from clinical mental health services; • additional information on how the peer workforce will be expanded and support; • capacity building for the Aboriginal workforce and training on culturally secure practice for mainstream services; • building dual diagnosis capability; • the reciprocal transfer of workers from sectors such as disability services to better meet the needs of people with co-occurring mental health and disability; • the need for improved ability of services to provide trauma informed care; • the provision of physical health care; and • non-government organisation (NGO) training requirements.	much more is needed. The Mental Health Commission will work closely with key stakeholders to ensure the appropriate level and mix of qualified staff are available to deliver the Plan. See pages 161-162 of the Plan for more information.
18	The importance of **culturally secure** specific and universal programs and services was raised. In addition, respondents asked for recognition of the health disparity between **Aboriginal** and non-Aboriginal people, and the need to engage Aboriginal people fully and respectfully in service design and implementation.	The importance of cultural security has been included as a principle on page 11 of the Plan. An item relating to the need for "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" is also included in the W*hat we hope to achieve* section on page 12. The responsibility of all services to provide culturally secure services is referenced in the *Aboriginal people* section (pages 147-149) and in the *Workforce* section (pages 161-162). Recognition of the health disparity between Aboriginal and non-Aboriginal people is included on page 147. The need to enable the involvement of marginalised groups (including Aboriginal people) in co-production and co-design of policy, planning, service delivery, evaluation and research is included on page 143 of the Plan. Further to this, specific strategies in relevant service stream sections (e.g.

		prevention, community support, community treatment) have been included – in particular strategies that refer to a need to develop targeted programs and strategies for at risk groups (including Aboriginal people).
19	Respondents across the State frequently raised the issue of **homelessness** and the need for improved access to **housing and accommodation**, including contemporary homes for people currently living in psychiatric hostels and improved safety and quality of housing now and in the future. A specific accommodation strategy was also requested.	Further modelling has been undertaken to estimate the minimum number of people with a mental health, alcohol and other drug problems that require access to housing (see page 37 of the Plan). The Plan includes an action relating to the need to develop a comprehensive housing strategy. The strategy would include the specification of contemporary housing for people with a mental health, alcohol and other drug problem, including people who are in institutionalised care settings due to limited availability of alternative housing and support options. A priority for people with severe and complex alcohol and other drug problems is transitional support post-residential rehabilitation. Consideration will also be given to the ongoing safety and quality of housing. To implement the housing strategy, the Mental Health Commission will work with other agencies, including the Department of Housing, to determine priorities and areas of responsibility. This will also involve determining the impact of the National Disability Insurance Scheme (NDIS). More information on the development of a housing strategy can be found on page 40 of the Plan.
20	Greater recognition of emerging drug trends, particularly **methamphetamines** was called for, particularly by respondents from regional areas.	The Plan sets out a phased approach to increasing treatment and support for alcohol and other drug services, including withdrawal and residential rehabilitation in regional areas. Many of the respondents in non-metropolitan regions were concerned about access to services and waiting times. Service expansion in regions and locations where they are most required is a guiding principle in the Plan. More information has been included on pages 39 and 49 noting that attention will be given to the provision of more diverse models of rehabilitation. The integration of alcohol and other drug capabilities into emergency department responses such as hospital consultation liaison and Mental Health Observation Areas (MHOAs) will support responses. The development and implementation of the prevention plan will support responses to emerging drug trends. The resourcing of public education campaigns is included in actions on pages 32-33. A key strategy is the education and training of frontline workers in response to emerging drug trends

		such as methamphetamine and this will be part of workforce development. In relation to emerging trends, which includes pharmaceutical misuse, the Plan now includes an action relating to the development of a real time Schedule 8 (drugs of addiction) medicine dispensing tracing system (see page 53).
21	The accuracy of Community Treatment and Community Support **current hours of service/support** was questioned by some respondents.	The 2012-13 community support hours of support, as outlined in the Plan, were determined by the Mental Health Commission. Further work is required in the analysis of the actuals figures which may result in some variance. The 2012-13 community treatment hours of service as outlined in the Plan were supplied by Area Health Services and the Department of Health. Further work is required in the analysis of the actuals figures which may result in some variance. Initial short term funding to boost community treatment services may be considered until the system is reconfigured, balanced and the optimal mix of services are established.
22	Although high level **costings** were provided in the Plan, respondents sought additional information on some of the assumptions underpinning the costings, such as: • regional and remote loadings; • overheads, other goods and service costs; and • consultation and liaison costs.	To undertake the operational costings, no regional and remote loadings were applied. Instead, actual costs were used to estimate future operational costs. This included salaries, allowances, penalties, overheads, and other goods and services, by region. Consultation and liaison services in hospitals were costed using actuals information (as above), as well as the FTEs generated by the estimator tool. These costs are reflected in the hospital-based services, as this is the environment where these services are delivered.
23	Queries were raised by some respondents about the alignment between the Plan and the **Department of Health's Clinical Services Framework.**	The Mental Health Commission and the Department of Health are working together closely to align the Clinical Services Framework and the Plan.
24	Greater recognition and **increased focus on a range of different groups and age-cohorts** was called for by some respondents, including: • infants and children; • young people; • children of parents with a mental health and/or alcohol and other drug problem; • families/parents; • older adults; • victims of crime; • women;	Where possible extra emphasis on particular groups has been included throughout the Plan. Dedicated age-cohort services are included in most streams (e.g. dedicated infant, child and adolescent services in the community treatment service stream). Where relevant, reference to a need for targeted programs for priority groups or people at greater risk has been included as a key strategy (e.g. see page 32 of the *Prevention* section). Further, an additional section has been added to the Plan, which outlines the *Age appropriate services across the service spectrum* (pages 24-26 of the Plan). It is also an expectation that general services will have the capacity and capability to address the needs of a broad range of people, recognising that in

	• Aboriginal people; • CALD people; and • people experiencing psychological distress and suicidality (but may not have a mental illness). In some cases respondents requested a specific plan or strategy be dedicated to the group for whom they were advocating (e.g. a specific plan for older adults).	some cases specialist services may be required for some disorders. Where relevant, the Mental Health Network will work closely with key stakeholders to identify particular priority groups that require additional expertise or a specific/dedicated model of service. This can then inform service development and commissioning practices.
25	A number of respondents (namely clinicians) expressed concern that there are currently insufficient resources to assist with training clinicians in terms of their responsibilities under the new ***Mental Health Act 2014*** (the Act). In addition, the administrative burden that the Act will place on psychiatrists was raised as a problem, given existing resources are overstretched.	The 2012-13 budget provided $15 million funding over four years for implementation of the Act, however the scope of these funds did not include funding allocation to Area Health Services to address increased staff demands. At this time the Mental Health Commission has not received specific additional funding to allocate for the purpose of assisting clinicians in fulfilling their requirements under the Act. The Mental Health Commission has however identified that any growth funding provided to Area Health Services allocation of the Teaching, Training and Research budget for 2015-16 be used for the specific purpose of supporting the implementation of the Act. Further work is required to identify additional resources required for the Act implementation. The Mental Health Commission, in collaboration with psychiatrists and other clinicians, has prepared legal forms for approved by the Chief Psychiatrist. Key objectives have been to ensure that the forms are user-friendly, and to ensure that they create minimal administrative burden. The eLearning package delivered by the Mental Health Commission incorporates guidance as to which forms to complete and how to complete them. The Mental Health Commission is deploying replacement data systems at the Mental Health Review Board and Council of Official Visitors that can be configured to receive automated notifications from service providers that will potentially reduce an administrative burden. This functionality is also dependent on service provider systems being configured to send automated notifications and is scheduled to be in place by July 2016. It is acknowledged there are continuing concerns amongst clinicians that the introduction of the Act will not only increase workload but also administrative time.
26	A specific plan on current and future **infrastructure** was requested, in particular, a plan to replace	As the Plan is provider neutral it is considered pre-emptive to develop an infrastructure strategy (e.g. private providers may tender to deliver a service

	inpatient beds at Graylands Hospital and Selby Older Adult Unit before decommissioning.	and may therefore have their own infrastructure). The overall cost of infrastructure was estimated in the Plan (with a number of assumptions – such as all services to be a new build). See Appendix F (pages 214-217) of the Plan. In relation to Graylands Hospital divestment, a more detailed infrastructure plan will be required for the establishment of alternate, contemporary services.
27	A small number of respondents commented that the lack of acute/subacute and 24-hour community-based services are resulting in the **greatest societal harm and system dysfunction** (as opposed to "low acuity" community-based supports), therefore this is where the Plan should have its major focus.	The NMHSPF and the DASPM are the nationally agreed models for the mental health and alcohol and other drug service sectors, respectively. These models, based on robust evidence, provide the optimal mix and level of service required to meet the needs of the population. The models specify the requirement for services in community support, community treatment, community beds and hospital-based service streams. Working towards the optimal mix and level of service, as specified by the models, will result in people having access to a broad range of care and support to meet their needs. It is acknowledged there is a requirement for improved access to 24-hour community-based services. Reference to improving access to 24-hour services is included on pages 47-48 of the Plan. Community bed-based services also provide 24-hour care and support (see pages 57-58).
28	One respondent questioned the eligibility of people who access the **private sector,** but also want to access "publicly funded" community support services.	Excluding a person from accessing public mental health, alcohol and other drug services if they are already in contact with a private provide is not acceptable. As to be expected, services are required to prioritise based on the level of need of each individual. No specific reference to this has been made in the Plan as it is considered an operational matter.
29	**Telehealth** was recognised as an 'easier' option to provide face-to-face support in regional areas, as long as the service is backed by suitable funding and Information and Communication Technology (ICT) infrastructure, as problems in either area would diminish the impact of the service. Other comments included: • the service needs to be staffed 24-hours and this form of service should not be at the expense of localised services; • telehealth can be impersonal; and • services are not always accessible to the	Telehealth has been recognised as a mechanism of service delivery in the Plan, as opposed to a separate/stand-alone service. Telehealth will not replace face-to-face service provision but can be used to improve access where appropriate, particularly in emergencies. Telehealth to support clinicians in emergencies will be available through the 'one stop shop' (see pages 47-48 of the Plan) and where suitable across the service spectrum. Reliable ICT infrastructure will need to be in place to support delivery. In the Plan, reference to telehealth can be found on pages 39, 47, 49, 64, 66, 71, and 164). Although policies and procedures would need to be developed during Plan implementation to support the delivery of telehealth, it should be noted that best practice would involve a clinician and/or support worker (including Aboriginal

	elderly, remote communities or Aboriginal people – investment in liaising and involving Indigenous workers may be more beneficial in these areas.	health/support workers) accompanying a consumer who is to participate in a telehealth consultation.
30	When an action did not mention a **specific region**, respondents from that region questioned why they were not included. Actions that did not name a particular region were recognised as important, but comments were made that services are needed for regions in Western Australia.	The model shows services across the spectrum are required in most regional areas – see the *Plan Matrix* (page 104-106). Not all elements of the modelling were reflected in the actions in the draft Plan – but were shown in the *Plan Matrix*. In the final Plan, the full picture of what services are required in each region is again shown in the *Plan Matrix* and further explained in the *Services by region* section (pages 101-138). It should be noted, however, that the exact location and distribution of services will be determined by a combination of consultation processes and the assessment of relative feasibility to deliver the service.
31	Respondents ranked actions that provided **more information** higher than those that proposed an idea that needed to be explored/further developed.	In some cases, further work is required to determine the feasibility of a particular action, hence a small number of actions were generic to allow for more detailed discussion with key stakeholders and further planning. This is still the case in the final Plan.
Prevention		
32	The **high importance** of prevention and promotion was acknowledged by respondents; however some felt there should be **more detail** in this section. Requests were made to include the following: • a recognition of the need for a diverse approach; • education and early intervention initiatives including schools; • perinatal/post-natal and infant mental health; • foetal alcohol syndrome (including diagnosis, treatment, impact on families); • children of parents with a mental illness; and • consolidation/integration of alcohol and other drug with mental health where possible.	The Plan proposes an increase in the proportion of budget allocated to prevention, which indicates the level of importance placed on this area of work. Additional detail has not been provided in the Plan as it is the intention to develop a comprehensive and detailed mental health, alcohol and other drug prevention plan after the amalgamation of the Mental Health Commission and Drug and Alcohol Office. The prevention plan will clearly show any synergies between the mental health and alcohol and other drug prevention areas. Where relevant, specific reference has been made to priorities such as education/early intervention in schools, peri-natal and infant mental health, foetal alcohol syndrome, and children of parents with mental illness. Greater detail will be reflected in the mental health, alcohol and other drug prevention plan – which will also go through a consultation process.
33	Respondents felt there should be an increase in the proportion of **funding dedicated to prevention** and	Expert reference groups recommended the level of funding for prevention activity for both mental health and alcohol and other drugs. Over the life of the

	that funding should increase faster than that suggested in the draft Plan. Concerns were raised regarding the continuation of funding for some programs and the ability to implement high quality and effective prevention activity.	Plan, as evidence emerges on effective prevention activity, further consideration will be given to resourcing. In response to a call for a faster increase in resources dedicated to prevention, the phasing of funding has been brought forward. Having an evidence based, robust prevention plan (see page 32 in the Plan), will ensure funding is strategically directed to areas where the evidence indicates we will have the greatest population level impact. This may assist in securing longer term funding, however, this cannot be guaranteed long term due to changes in fiscal capacity. Lastly, alongside the implementation of an evidence based prevention plan, the Plan proposes to increase the capacity and capability of prevention staff to ensure high quality and effective prevention activity is implemented across the State.
34	**School based** mental health, alcohol and other drug and resilience education programs were strongly supported, with a call to bring forward the full roll out of these programs. There were requests to make school-based programs compulsory; however acknowledgement was given to the already packed school curriculum. Respondents also asked that programs are culturally secure and mindful of what strategies work in Aboriginal communities.	The intention to fully roll out school-based mental health, alcohol and other drug and resilience education programs has been brought forward in the phasing of actions in the Plan. This action will need to be implemented in partnership with schools and the Department of Education. The implementation of the program will ensure the content of programs are culturally secure and relevant to Aboriginal communities.
35	**Legislative measures** received the least amount of support in the consultation forums and comments primarily suggested that a greater emphasis on prevention and early intervention would have a greater impact than legislation.	Although this feedback was noted, a commitment to implementing legislation to address the increase in synthetic psychoactive substances was made by the Government in 2015. Legislation is considered one aspect of a multi-strategic approach to prevention and therefore cannot be viewed in isolation. Legislative measures must be supported by complementary prevention strategies such as public education, community capacity building and the promotion of healthy public policy.
36	**Web-based/online strategies** was met with mixed support. Respondents felt strategies need to be evidence based. It was noted that numerous online services were already available. Some commented that the internet was still viewed as impersonal and should not be a substitute for face-to-face contact.	Web-based and online strategies are part of a multi-strategic approach to prevention and cannot be offered in isolation. It is acknowledged a variety of programs already exist therefore any moves to expand access would be made with this in mind. Further consideration of the benefits and applicability of web-based and online strategies, particularly for young people and regional areas, will be determined following the development of the prevention plan (see

	Difficulties accessing the internet in regional and remote areas were raised as a barrier to the use of web-based strategies. People who supported this action recognised the impact it could have on youth and adolescents.	page 32 of the Plan).
37	**Suicide prevention** was considered an issue of utmost importance.	A new Western Australian suicide prevention strategy, *Suicide Prevention 2020: Together we can save lives (Suicide Prevention 2020)*, was released early 2015, along with a $25.9 million funding commitment. Suicide Prevention 2020 recognises the importance of targeting high risk groups including young people, Aboriginal people and people who have alcohol or other drug problems.
38	The importance of addressing **stigma and discrimination**, including in relation to housing and employment was raised by respondents. Concern was also expressed about the stigma that can impact peer workers.	The importance of addressing stigma and discrimination is reflected in the Plan (see page 32).
39	A small number of respondents questioned the diversion of funds from beds and acute services to **prevention programs** as they commented there is no evidence at hand that these programs will really make a difference to patient outcomes.	There are a variety of evidence based prevention programs that are shown to be effective. If we do not invest in effective evidence based prevention programs we will be unable to turn the system around, keep people well and reduce avoidable illness. The vast majority of respondents are very supportive of boosting investment in prevention activity. There are no intentions to divert funds from acute services to prevention programs.
40	The issue of **Foetal Alcohol Spectrum Disorder** (FASD) was raised numerous times, particularly in regional areas. Concerns were raised regarding prevention as well as assessment, diagnosis and support services.	The prevention of FASD is a priority of the Plan going forward (see page 50 of the Plan for more information). Action in this area has been, and will continue to be, part of the work of the alcohol and other drug sector as well as other sectors. It is acknowledged further work is required to ensure people with suspected or confirmed FASD receive appropriate treatment and support. The Mental Health Commission will progress further discussions with services such as Disability Services Commission Department of Education, Department of Health and the Department of Child Protection and Family Services to ensure people and families affected by FASD are provided with appropriate services.
41	The health needs of the **prisoner population** were	There are some harm reduction strategies implemented in the prison system in

	raised by some respondents. It was noted in consultation and submissions that the Plan states that *"persons in contact with the criminal justice system should receive mental health, alcohol and other drug services equivalent to services available to individuals in the community, with due regard to community safety."* The issue of harm reduction and, more specifically, needle and syringe programs in prison was raised. There is a trial in the Australian Capital Territory and there is also international evidence which demonstrates the success of prison-based needle and syringe programs in other countries.	Western Australia, for example methadone dispensation. Methadone dispensation is a harm reduction strategy that supports the reduction of injecting and of sharing injecting equipment. The Department of Corrective Services is reviewing health services within prisons and further harm reduction options could be considered in this process. Treatment of Hepatitis C in prisons needs to be maintained as this also reduces the existing pool of infection which may also contribute to prevention and harm reduction efforts. In the implementation of the Plan, further joint planning will be undertaken in relation to alcohol and other drug use treatment and support and through care.
Community support services		
42	According to respondents, community support services need to: • be integrated, inclusive, accessible, co-designed, evidence based, self-directed, based on social rather than medical model, culturally secure; • provide opportunities for learning, socialisation, education, community connection; and • support people to attain housing/employment. The important role of peer support in community support service provision was also raised.	This feedback has been noted, and where appropriate the Plan reflects these comments. Community support models of service will also consider these important aspects of service provision. The support and expansion of the peer support workforce has been highlighted in the Plan. Peer support workers are currently, and will continue to be, an important work role in community support services.
43	The importance of **systemic and individual advocacy** was frequently raised by respondents.	Individual and systemic advocacy has been specifically included in the revised Plan (see pages 40 and 145).
44	Some respondents expressed strong support for the development of **Recovery Colleges**.	Reference to the provision of education and training is included on page 39 of the *Community support services* section. As with all other service streams, models of service are yet to be developed. Although the development of recovery oriented services is flagged as a strategy in the *Community support services* section of the Plan, this may or may not involve the establishment of recovery colleges. The Mental Health Commission will continue to monitor international evidence

		emerging about the effectiveness of recovery colleges and will consider this in the development of community support models of service. Models of service for all service streams will be developed during Plan implementation and will involve working in partnership with key stakeholders, service providers, clinicians, consumers and carers.
Community treatment services		
45	Respondents made a number of comments on the community treatment section, including: • a need to better reflect the **integration** of mental health, and alcohol and other drug; • a need to recognise the needs of **young people** (particularly in regional areas with a high proportion of young people); and • the requirement for increased service provision in **regional** areas.	The need for better integration of mental health, alcohol and other drug services has been noted and changes have been throughout the Plan to reflect this feedback. Where possible, services will be integrated, but as a minimum all services will be required to have the capability to meet the needs of people with co-occurring problems. Dedicated services for young people are included throughout the Plan, including in the community treatment services section. Please also see pages 24-26, *Age appropriate services across the service spectrum*. It is acknowledged increased service provision is required in regional areas and this will be a priority during implementation.
46	Respondents frequently commented on the urgency to improve crisis and emergency options. One respondent commented consumers and carers have consistently and loudly called for a '**one stop shop'** – which would provide a crisis and emergency service as well as a range of other functions, such as assistance with system navigation. Several suggested that alcohol and other drug should also be included and that this service should be integrated with a trained police response.	This priority has been noted and substantial change to the Plan has been made in response to comments received (see pages 47-48). Progress has already commenced on the development of the new 'one stop shop' service.
47	Respondents requested that services be **co-located and localised** within communities rather than centralised, and supported the upskilling of other service providers – particularly police and GPs, to be in a position to support mental health services.	Where possible services will be co-located and localised. However, feasibility to deliver a service (in terms of staff attraction, clinical safety and so on) must also be taken into account. Front line staff (e.g. police, primary care) training will be a function of the 'one stop shop' – discussed on pages 47-48.
48	**Headspace** should be considered for inclusion according to some respondents.	Headspace is considered a primary care service (funded by the Commonwealth), therefore the State will work with the Commonwealth to ensure access to this service is maximised. Building the capacity of primary

		care services, such as Headspace, can ensure young people are provided treatment and support as early as possible thereby (where possible) preventing the development of severe mental health, alcohol and other drug problems.
49	Working with police to develop a **co-response program** received a large number of supportive comments.	This program has been included in the final Plan and discussions are already progressing with Western Australian Police.
50	While building on current **youth services** was highly supported, it was often questioned that this would be at the expense of adult services and several respondents stated that it should not be to the detriment of existing adult services.	Modelling for community treatment services (in the draft Plan) showed current adult services were delivering a higher number of hours of service than modelling suggested was required in 2025, hence the draft Plan suggested a reconfiguration of some resources from adult to youth service. During the consultation period, current resources were revisited to confirm accuracy (these figures were supplied by Area Health Services and the Department of Health, and based on 2012-13 information). It has been noted that further work is required in the analysis of the actuals figures which may result in some variance. During the consultation period, the modelling assumptions were updated to take into account the latest available data. The final Plan now shows a slight increase in resources are required for adult community treatment services, therefore resources no longer need to be reconfigured from adult into youth.
Community bed-based services		
51	The comments relating to community beds focused on a need to ensure access to these services in **regional areas** and a clearer understanding of the **support** and care that will be provided in these settings.	The *Plan Matrix* on page 104-106 outlines the estimated mix and level of community beds required for each regional area. It should be noted, however, that the exact location and distribution of services will be determined by a combination of consultation processes and the assessment of relative feasibility to deliver the service. Clarification of the support provided by community bed-based services is included in the service definitions on pages 57-58. In-reach and clinical oversight by community treatment services is also discussed on page 59 of the Plan.
52	Queries were raised when a **region** was not included in an action.	The model shows community-based beds are required in all regional areas – see the *Plan Matrix* (page 104-106). Not all elements of the modelling were reflected in the actions in the draft Plan – but were shown in the *Plan Matrix*. In the final Plan, the full picture of what services are required in each region is again shown in the *Plan Matrix* and further explained in the *Services by region* section (pages 101-138).

53	Respondents in the Northern and Remote region commented that new beds in the **Kimberley (in particular) and the Pilbara** need to be more regionalised to reduce the need for travel.	Where possible services will be localised, however, feasibility to deliver a service (in terms of staff attraction, clinical safety and so on) must also be taken into account.
54	Respondents also asked for a **higher number of beds** than that proposed for the Northern and Remote region.	The modelling that underpins the Plan was based on population, but also accounted for regional and remoteness and Aboriginal population levels in regional areas (see Appendix D on pages 199-207 for more information on modelling). The Plan modelling will be revised every two years.
55	New community bed-based services approved by Government received highly supportive comments however respondents requested that services include **youth beds**. Respondents also requested that the **Great Southern** region be included.	The Government made an election commitment to build community-based subacute (step-up, step-down) services in a range of metropolitan and regional areas. Although the announcement did not include the Great Southern area, modelling shows a requirement for community bed-based services in the Great Southern area. Where clinically appropriate and on a case by case basis, these services will admit 16 and 17 year olds.
56	New community bed-based services should include beds for people with **co-occurring** mental health, alcohol and other drug problems according to a number of respondents.	The expectation that all services, where appropriate, will have the capability to meet the needs of people with co-occurring mental health, alcohol and other drug problems has been reflected in the Plan. Co-location of services where suitable will also be explored during the implementation phase of the Plan.
57	Actions relating to the staged increase in the subsidy for **nursing home places** raised comments that not enough places were provided, given the increased demand of the aging population. The importance of ensuring these services are capable to provide best practice treatment and support for older adults was also raised.	The Department of Treasury approved population projections were used to inform the modelling therefore population projections have taken into account the ageing population. Changes in population projections will be taken into account every two years when Plan modelling is revised. The Mental Health Network will be leading the development of models of service for older adults therefore best practice standards will be considered and included where relevant. Future commissioning will be based on agreed models of service. Service contract monitoring processes currently, and will continue to, involve an assessment of service quality and safety.
Hospital-based services		
58	Some respondents commented that they were concerned there was an intention to reduce the number of **acute beds**.	There is no proposal to decrease the number of acute beds in the system. All services across the service spectrum are required to grow over the next ten years, but as the system is currently skewed towards the costly acute sector, the first priority is to boost community services. This will be followed by an increase in services across the full service spectrum, including hospital-based services.

59	The expansion of the **Hospital in the Home** (HITH) program was welcomed by respondents. Clarity was sought on the model of service, the availability of hospital beds to support the delivery of HITH and the appropriateness of substituting Graylands beds for HITH beds.	It is recognised there is a need to ensure only those who can be safely admitted to the HITH program are admitted. Effective models of care already exist for HITH services in the State therefore new programs will draw on these models. The Plan does not (and will not) go into detail about models of service as these will be developed in partnership with consumers, carers and clinicians.
60	The safety and sensitivity of **mixed gender wards** was raised as a significant concern.	The provision of safe, gender sensitive services is considered an operational and clinical governance matter; however the Mental Health Network will be requested to consider this issue during the development of models of service.
61	Clarity was sought on whether **youth beds** are planned to be part of a general adult unit or separate specialist units and whether young people would still be allowed to be admitted into a general adult unit, particularly if it is closer to their home.	Youth will not be precluded from adult inpatient services, providing appropriate care is provided and safety is in place. In future, as the dedicated youth stream is developed, it will be the preference for youth to be admitted to dedicated youth inpatient services.
62	Actions of greatest priority within the metropolitan region are those that provide increased support within the **hospital system**, notably in the outer and southern suburbs, and the expansion of MHOAs. Rockingham and Peel were highlighted as areas also in need of MHOAs.	This feedback has been noted; however, as explained in the Plan, there is a requirement to re-balance the system to keep people well and in the community wherever possible, through the boosting of community-based services as a first priority. In most cases, hospital-based services and supports will expand but this will occur following an investment in community services. MHOAs, however, can provide safe, effective and efficient treatment and care for people presenting to emergency departments. The expansion of MHOAs will be a priority in the early years of the Plan implementation, including an exploration of how these services can be best provided in regional areas. More information can be found on page 71 of the Plan. Due to feedback received, the Mental Health Commission undertook further modelling work, and the Plan now outlines the requirement for MHOAs in Rockingham and Peel.
63	Respondents commented that the completion of the evaluation of the **pilot transport service** should occur earlier than by the end of 2017.	This action has been publicly committed to and has therefore been moved to *Implement existing commitments* section (see page 73). This action will be delivered before the end of 2017.
64	Respondents commented that the closure of **Graylands** Hospital requires careful planning that is properly sequenced and considerate of Graylands as a community setting, as well as a hospital setting.	It is agreed the closure of Graylands Hospital will require extensive planning and consideration of the needs of individuals who use this facility as well as the surrounding community. New services will be established before Graylands beds close. See page 70 of the Plan for more information. A divestment working group has already been formed and is meeting to

		progress divestment of services on the Graylands site.
65	While many supported the opening of a new mental health **inpatient unit in Pilbara**, in principle, comments from the Pilbara and other regions pointed out resourcing issues and the difficulty in staffing the new units. Generally, HITH beds received higher support within the Pilbara itself.	The action in the Plan relating to Pilbara inpatient beds has been adjusted in response to the feedback received. In summary, the intention is to work with stakeholders in regional areas, who do not currently have an inpatient unit, to determine how they best see this type of service being delivered in their area.
Specialised statewide services		
66	A range of **additional specialised statewide services** were requested to be included in the Plan, including services for: • personality disorder; • emotional dysregulation; • specialised mood disorders; • trauma; • electroconvulsive therapy; • domestic violence and sexual offenders; and • older adults.	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. This has been explained on page 75 of the Plan. Services for sexual offenders are included in the forensic section of the Plan (page 95 and 98). Dedicated services for specific age cohorts are included in various sections of the Plan (and outlined in the *Age appropriate services across the service spectrum* on pages 24-26). There is no intention, at this stage, to develop additional specialised statewide services. However, the Mental Health Network will be able to advise on future additional groups that may require access to specialised services.
67	The inclusion of people with **alcohol and other drug** problems in specialised statewide services was raised.	It is likely people with co-occurring mental health, alcohol and other drug problems will access all specialised statewide services and it is expected all services would have the capability to provide appropriate services for these people.
68	Clarity was sought on the number of **public versus private** specialised statewide service inpatient beds. A request was made to not include private beds in the Plan as the state has no control over admission criteria or patient flow and is not required to fund these services.	The Plan estimates the optimal mix and level of service required across the State to meet the needs of the State. The Plan is provider and funder neutral. The percentage of people that would access public versus private mental health, alcohol and other drug services is unknown and difficult to estimate (e.g. some people may access both, or may move between private and public) therefore services required across the whole State for the entire population are estimated in the Plan.
69	The completion of the Government's 2013 election commitment for a **Statewide Specialist Aboriginal Mental Health Service** (SSAMHS) was recognised as very important. Comments stated that trans-generational trauma was	The Government committed $29 million as part of the 2014-15 Budget to continue SSAMHS until 2017. The Mental Health Commission is currently in the process of preparing a comprehensive evaluation of the SSAMHS program with the view of securing ongoing funding after 2017. The vital role of ensuring mainstream services can meet the needs of Aboriginal people in a culturally

	a leading cause of many problems. Questions were also raised as to whether FASD was to be addressed by SSAMHS.	secure way is also recognised in the Plan, as is the need to boost the Aboriginal workforce and implement targeted programs and services for at risk groups (including Aboriginal people). Targeted programs may include the commissioning of cultural healing programs. It is the intention that effective FASD prevention programs continue to be implemented across the State (see page 50). The SSAMHS service will not have primary responsibility for the prevention of FASD, however it is expected the SSAMHS has established links with other relevant services that can provide appropriate intervention.
70	Respondents strongly supported the **Children in Care** program, commenting that it is needed for early intervention, to prevent mental illness and to prevent future contact with the criminal justice system.	The Children in Care service is seen as critical and progress to implement the service is already underway.
71	A small number of respondents commented that **Attention Deficit Hyperactivity Disorder (ADHD)** services need to include all disruptive/conduct disorders, not just ADHD.	Based on clinical advice, it is the intention that the ADHD service will remain dedicated to providing services for people with co-occurring ADHD and mental illness, however, services for people with disruptive/conduct disorders (and any other relevant conditions) can be developed as part of general community treatment services. Where appropriate, linkages between the services can be established as needed.
72	The lack of beds for **eating disorders** and the need for appropriately trained staff and services for youth and adolescents was seen as essential. In some regional areas, however, this action was not seen as critical.	Currently, eating disorder services (particularly inpatient beds) are not meeting the needs of the population. It is the intention to boost access to these services across the State where required.
73	Respondents queried the impact of the specialised statewide services on the **Aboriginal** community - in particular homelessness services.	As acknowledged in the Plan, all services across the spectrum need to be culturally secure. This will be particularly important for services that may see a high number of Aboriginal people, including homelessness services. The intention to support an increase in the Aboriginal workforce across the service spectrum will also go some way to ensuring services are culturally secure and can offer services that are accessible to Aboriginal people.
74	Comments were made relating to the need for services to be regionalised and **not metropolitan centric**.	Where feasible, statewide specialised services may be delivered through a hub and spoke model. Consideration must be given, however, to the practicality of implementing a specialised service in each region. The very small size of some services and the requirement to employ staff with specialist skills can make it difficult to locate a service in each region.

Forensic services		
75	Respondents requested increased information on the prevalence of **alcohol and other drug** issues experienced by people involved in the criminal justice system and a greater focus on forensic alcohol and other drug services in general.	Increased reference to the prevalence of alcohol and other drug problems and services has been included in the *Forensic services* section of the Plan.
76	Numerous respondents requested that **forensic inpatient beds** are not located on a prison site.	This feedback has been noted. Reference to the location of the forensic inpatient service on a prison site has been removed from the Plan pending further discussion with key stakeholders, including the Department of Corrective Services.
77	Repealing or amending the ***Criminal Law (Mentally Impaired Accused) Act 1996*** **(CL (MIA) Act)** was requested to be included as a priority in the Plan.	Increased reference to the CL (MIA) Act is included on page 85 of the Plan. A new action has also been included regarding a review of the CL (MIA) Act.
78	Respondents requested that the development of safe and appropriate places for **at-risk individuals who have served their custodial sentence** but are not suitable for release into the community be included in the *Forensic services* section of the Plan.	This feedback is noted. There is a need for ongoing secure care for those who are deemed a risk to themselves or others. This is an issue that will require further discussion with key parties, including the Department of Corrective Services.
79	Requests were made to deliver the **92 bed secure forensic inpatient service** earlier than 2025.	It is acknowledged this service is urgently required, however the planning and design for a service of this size will take time (and significant investment by Government). It may be possible to deliver the service before 2025; however it will not be possible to deliver the service by the end of 2020. The Mental Health Commission has a Project Working Group with Department for Corrective Services to progress actions relating to forensic services.
80	Actions relating to the development of in-prison facilities and **transition** services for people leaving prison and entering the community were seen as a high priority. Respondents commented that programs for people with **problem behaviours** need to occur much sooner than currently planned.	Discussions have already commenced with the Department of Corrective Services to progress the development of in-prison services. Forensic community treatment services are also identified as an early priority, to boost the availability of transition services between prison and the community. Community programs for people with problem behaviours have been moved to an earlier time horizon in response to feedback received.
81	**Some commented that diversion** programs need to be rolled out statewide.	The expansion of Mental Health Court Diversion will be considered following completion of the outcomes of the current evaluation. The Plan includes the rolling out of diversion services and programs across the State. Increased alcohol and other drug community (diversion) hours are

		presented in the *Plan Matrix* (see page 104-106).
82	Respondents in the **Northern and Remote** region gave greatest priority to an increase in hours dedicated to community based forensic treatment services over those actions regarding in-prison services and facilities. This implied a larger focus should be placed in these regions on preventing the need for imprisonment, closely followed by the delivery and increase of diversion programs.	These preferences have been noted and will be considered during Plan implementation. As noted in the Plan, it will be critical to work with local stakeholders when implementing actions.
83	Comments within the **Pilbara and Kimberley** stressed the need for services to be more community focused and that in-prison services required cultural awareness and specialised or trained staff. Comments within the Goldfields and Midwest confirmed the need for increased in-prison services within these regions.	These preferences have been noted and will be considered during Plan implementation. As noted in the Plan, it will be critical to work with local stakeholders when implementing actions. Two new strategies have also been included in the *Forensic services* section of the Plan, see pages 83-100 of the Plan.
84	**Southern Country** respondents rated all actions almost of equal priority within this stream; actions rated marginally higher than the others are those dealing with the increase in hours in the community based forensic mental health services.	These preferences have been noted and will be considered during Plan implementation. As noted in the Plan, it will be critical to work with local stakeholders when implementing actions.
85	According to some respondents, transition services and other mental health, alcohol and other drug services should be made **mandatory** for prisoners or part of their release plan, and requires community/on-going support.	Although it may not be possible to make participation in transition services mandatory, this will be raised with the Department for Corrective Services and other relevant agencies as appropriate.
86	Regional and remote respondents commented that consideration needs to be given to **regionalised prison beds**.	During the implementation of the Plan, the Mental Health Commission will work with the Department of Corrective Services to consider forensic services across the regions. As with other service expansions, this would be based on consultation with key stakeholders, feasibility and practicality, and affordability.
87	The involvement of other organisations should be considered when increasing mental health **forensic community treatment** services, such as working alongside police, or the development of the action being undertaken by NGOs, not-for-profit and/or public	These comments have been noted. The Plan is provider neutral. As with all actions in the Plan, implementation will require working with key partners across the government and non-government sectors. Where appropriate, services will be put out to tender.

	organisations.	
System reform		
88	Strong feedback was provided by respondents regarding the need for improved **system integration and navigation**.	The urgent need for improved system integration and navigation is recognised. Consumers and carers understandably want access to seamless services that are easy find and access. The 'one stop shop' outlined on pages 47-48 will provide a single access point to for crisis support and information about available services. In the *A partnership approach to implementing reform* section of the Plan, reference is also made to a need for seamless service delivery which may involve the commissioning of a lead agency to bring together a consortia of service providers who can provide a variety of integrated services across the service spectrum. Additional information on how system integration and navigation will be improved is provided in the *System-wide reform* section (pages 151-158).
89	The importance of **family inclusive practice** was raised by some respondents.	Inclusion of families has been enhanced in the *Prevention* section of the Plan (see pages 28-34). The provision of family inclusive practice will also be a requirement of services included in models of service (see page 151).
90	Respondents called for greater **cultural competence** and the valuing of diversity across the service spectrum.	The importance of cultural competence, cultural security and social diversity has been further enhanced in the Plan. See pages 147-150 for more information.
91	Respondents requested the inclusion of improved **complaints** mechanisms in the Plan.	Improving complaints mechanisms has been included on page 145 of the Plan.
92	Increasing the emphasis on individual and systemic **advocacy** and rights protection for individuals was raised by respondents.	The importance of individual advocacy has been reflected in the principles on pages 10-11 of the Plan. Specific reference to the need to expand access to individual advocacy services is on page 40 and 145. Systemic advocacy is acknowledged as an important element of the service system and is therefore discussed further on page 145.
93	Concerns were raised regarding striking a balance between the **privacy and confidentiality** of information versus information sharing/communication to support system integration.	It is acknowledged there are differing points of view regarding the sharing of information. Any implementation of actions to improve communication will take into account legislation and policy regarding information sharing, privacy and confidentiality. The interests of consumers and carers will always be at the forefront.
94	Greater **system integration** between community treatment and community support services was requested by respondents.	Reference to the need for community treatment and community support services to work more closely together has been included in the Plan on pages 36 and 44. The intention to better integrate community treatment and

		community bed-based services is also referenced on page 59. In the *Partnership Approach to Change* section of the Plan reference is also made to a need for seamless service delivery which may involve the commissioning of a lead agency to develop a consortia of service providers who can provide a variety of integrated services across the service spectrum.
95	Respondents called for co-ordination, efficiency, consistency and **standardisation of service** across all sectors working in mental health and alcohol and other drugs.	The development of models of service will aid in the standardisation of services, however, flexibility is required to meet the needs of individuals accessing services. Models of service of discussed further on page 151 of the Plan.
96	The importance of **consumer involvement** was raised - including the need for co-production, co-design and training to support the capacity of consumers to be involved.	The Plan acknowledges the important of consumer involvement in the principles on pages 10-11. Furthermore, a section dedicated to consumer involvement is included on page 143 where co-production, co-design and the requirement for training for consumers has been included. The Mental Health Network will also have members who are consumer representatives.
97	Interagency communication/one **system of communication** is required according to many respondents. Too many ICT platforms currently exist, which leads to patients falling through the gaps, and as such one system is preferred.	The commissioning of a single, effective information, communication and technology system for the mental health, alcohol and other drug sector has been identified as an action within the Plan (see pages 163-164); however consideration will be given to privacy and confidentiality.
98	Respondents called for increased **Aboriginal employment** at all levels.	Increased Aboriginal employment across the service spectrum is recognised as critical. This has been reflected in the *Workforce* section of the Plan (see pages 161-162).
99	Suitable **training** is imperative, including training for staff to meet the needs of people with co-occurring mental health, alcohol and other drug problems.	The importance of training for front line workers is included in the 'one stop shop' strategy (see pages 47-48). Training of other workers has been reflected in the *Workforce* section of the Plan (pages 161-162)
100	Providing **incentives** to work locally and training local staff is preferred to skilled migration.	A requirement to implement innovative strategies to attract and retain regional qualified staff has been reflected in the *Workforce* section of the Plan (see pages 161-162).