EXHIBIT 315

THE WESTERN AUSTRALIAN
MENTAL HEALTH, ALCOHOL
AND OTHER DRUG SERVICES

Plan 2015–2025

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COI.017.0001.0002

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MINISTER'S STATEMENT

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% 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* (the Plan), which has been developed by the Mental Health Commission, the 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 Plan is bold and sets an ambitious agenda that all levels of Government, the private and not for profit sectors, consumers, and families need to work together to achieve. We need to enhance prevention programs and strategies, intervene early and increase community based services to reduce reliance on an outdated system consisting of expensive hospital beds and substantially improve the ability of consumers and their families to navigate the system.

I would like to thank the many people who have had input into the Plan's development. I especially thank those with lived experience of mental health, alcohol and other drug problems, their families and supporters.

Yours sincerely

MINISTER FOR MENTAL HEALTH
Hon Helen Morton MLC

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IMPORTANT NOTICE

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025, articulates the overall intentions regarding service development and transformation of mental health, alcohol and other drug services over the next ten years. The actions contained within this document and the subsequent investment required is dependent on Government's fiscal capacity and is subject to normal Government approval through budgetary processes.

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VISION

Our vision, as outlined in the Plan, 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.

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OVERVIEW

Why do we need a new Plan?

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan) has been developed to address mental health, alcohol and other drug needs in the Western Australian community. The development of the Plan was the principal recommendation of the 2012 report by Professor Bryant Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia,* undertaken in a response to suicide of people who had been discharged from mental health services in Western Australia.

There are good examples of excellence in service delivery, with further initiatives committed by this Government. These achievements are a result of previous investment in public, private and not-for-profit organisations. We also acknowledge and recognise the efforts of our dedicated workforce. However, the current system is often overwhelmed due to substantial unmet demand for services, particularly in community based services. This can have a negative impact on the stress and morale of staff who are working in a very strained environment.

The alcohol and other drug service system is considered to be more balanced (compared to the mental health system), however the supply is well short of demand. This makes it difficult to effectively prevent and reduce harm from alcohol and other drugs, and provide treatment and support to those who experience problems with alcohol and other drug use when and where they need it.
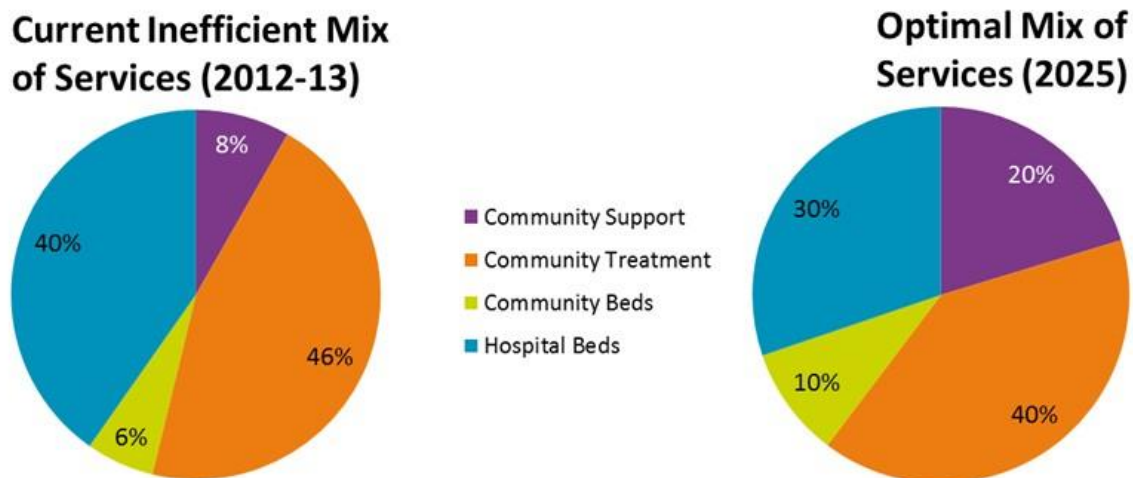
At present, expenditure on mental health services is heavily concentrated on expensive clinical services at the acute end of the service spectrum. Many individuals have little choice but to rely on costly emergency department and inpatient services, irrespective of whether this is the most appropriate type of care. Survey results from a 2009 study, indicated that over 40% of individuals occupying mental health inpatient beds at any given time could be discharged if appropriate community services were available.[1]

The greatest area of unmet demand is community based services, which results in over-reliance on acute care settings. Currently, services are meeting only a portion of the estimated 2014 demand:

- community support services are meeting 22% of demand;
- community bed based services are meeting 49% of demand;
- community treatment services are meeting 60% of demand; and
- hospital bed based services are meeting 75% of demand.

The modelling shows a rebalancing of the services available is required. Maintaining and reconfiguring hospital services whilst increasing investment in community services will ensure individuals are able to access the care that will best meet their needs. Figure 1 below shows current proportion of State expenditure on the mental health, alcohol and other drug service streams. It further shows the balance of expectations across the service streams required to deliver the optimal mix in an effective and efficient system.

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Figure 1: State funding for mental health, alcohol and other drug services

Current Inefficient Mix of Services (2012-13)

- Community Support: 8%
- Community Treatment: 46%
- Community Beds: 6%
- Hospital Beds: 40%

Optimal Mix of Services (2025)

- Community Support: 20%
- Community Treatment: 40%
- Community Beds: 10%
- Hospital Beds: 30%

Why is this Plan different?

Firstly, the Plan is based on a person centred approach.

The Plan highlights the unique strengths and needs of the person experiencing mental health, alcohol and other drug problems and the key focus of individualised planning, and that individuals are at the centre of service planning, provision, and review. This will ensure the delivery of consistent high quality care reflecting national standards and frameworks.

Secondly, the Plan is based on a whole of sector approach.

This Plan is reliant on all sectors including State and Commonwealth Governments, non-government organisations (including the not-for-profit and private sectors), as well as consumers, carers, and families. The whole community needs to work together to improve the system and deliver care and support in a collaborative way. This will ensure that more people have access to the right care, at the right time, in the right place, and that people do not fall through the gaps. It also requires funding and service provision from all sectors, not just the State Government.

Thirdly, the Plan uses evidence based national modelling tools.

For the first time, Western Australia has utilised evidence based national modelling tools (the National Mental Health Service Planning Framework and the National Drug and Alcohol Service Planning Model) that outline the optimal mix of services required to meet the demands of our population. From the national models, we estimate the hours of support or service, and bed numbers required to meet demand. The Plan relies on all other components (such as primary care) being provided in the optimal quantity: any shortfall in one area of service will adversely impact on the other services.

The modelling tools' output (hours and beds) is considered a proxy for the level of service required (see Appendix D and E for more information). The models of service are not pre-determined, as these will be developed with key stakeholders during the implementation of the Plan. The modelling serves as a guide to service development.

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Fourthly, the Plan is phased.

Given the current constrained fiscal environment in Western Australia, investment must be prioritised and staged. Investment can only be made when it is affordable and demonstrates value for money. A 'business as usual' approach to investment is not sustainable in the context of significant unmet demand and continued population growth. Whilst there has been progress and new innovative initiatives in mental health, alcohol and other drug services, we continue to face a growing demand that is outpacing service delivery. The challenge we have is to make better use of existing services and better target our investment. We must work within a constrained economic and financial environment to implement the required reforms.

It should be noted the Plan is provider and funder neutral. This means the Plan articulates what services are required for an optimal and efficient system, but not who should fund or provide such services. Services may be funded by other parties, such as the Commonwealth or private sector and services could be provided through public, not-for-profit or private organisations.

The Plan provides a pathway for investment, in the short, medium and long term, that can be implemented progressively as enabled by the State's fiscal capacity.

Short term: by the end of 2017 we need to prepare for the future.

We will continue to implement existing commitments. We will also aim to progress high priority actions, and undertake detailed planning and consultation to inform business case development for medium and long term initiatives.

Medium term: by the end of 2020 we need to rebalance the system.

We need to move away from the heavy reliance on costly hospital beds, and invest more in community services.

Long term: by the end of 2025 we need to continue the reform.

We need to grow all elements of the system to ensure services meet an increased level of demand.

What do we want to achieve?

This Plan sets an agenda to achieve a more positive, inclusive experience for consumers, carers and their families. This will be accomplished through the development of models of service (including service redesign), strengthening delivery partnerships across all sectors, better service coordination and integration, and a shared commitment to person centred care.

The State Governments' existing investment in mental health, alcohol and other drug services provides a base for this reform. The dedicated workforce delivering current services are of equal importance to progress the transformation. This also requires a rigorous change in the culture of service delivery to achieve a more balanced, welcoming, and shared service environment that is sensitive to all types of diversity. It also requires our systems and processes to support clinicians and other staff to spend as much of their time as possible treating and caring for their clients and consumers.

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Over the next decade, effort across the key priority areas aims to:

- Establish a range of evidence based prevention and promotion programs, strategies and initiatives that will prevent and reduce the harmful effects of alcohol and other drugs, reduce the incidence of mental illness, suicide and suicide attempts and, promote positive mental health in the Western Australian community.

- 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 well-being.

- 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 and carers, and families are better supported.

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

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

- Expand the availability of a range of high quality, effective and efficient specialised state-wide services to meet demand (e.g. Aboriginal mental health services, eating disorders, transcultural and neuropsychiatry).

- Build a comprehensive, responsive, effective and efficient forensic service system that will prevent and reduce the impacts of mental illness and alcohol and other drugs on offending individuals and help reduce recidivism, whilst providing increased safety for Corrective Services staff and the general community.

- Implement a range of system-wide improvements and new initiatives to support the transformation of the mental health, alcohol and other drug service system.

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What will happen if we don't change?

The Stokes Review details the impact on consumers and families if the mental health system does not undergo substantial change. If we do not change the system, there will be a continuation of:

- extended lengths of stay and more frequent admissions and readmissions to mental health 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;
- continued difficulty in navigating and accessing the system (people falling through the gaps);
- continued high level of recidivism and involvement in the justice system for people with mental health, alcohol and drug problems; and
- delays in access to treatment causing mental health, alcohol and drug problems to worsen (leading to the need for higher cost treatment).

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% of the target population.[2] Over the life of the Plan, a minimum of $498 million can be saved if the proposed transition articulated in the Plan occurs. Over the modelled 12 years, this translates to a 7.3% saving in operational expenditure.

People with severe mental illnesses make up 3% 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, they can jeopardise their housing, employment and relationships.

Community expectations surrounding the treatment and care for people with severe physical health conditions are that there are adequate services available. The expectations regarding people with severe mental illnesses should follow.

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

The Plan provides a clear way forward.

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1   INTRODUCTION

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan) has been developed in partnership between the Mental Health Commission, the Drug and Alcohol Office and the Department of Health. The Department of Corrective Services has been involved in the development of the forensic component of the Plan. The Plan also has incorporated substantial input from peak bodies, consumers, carers, families and service providers. It presents a long term direction for the development of mental health, alcohol and other drug services in Western Australia.

The development of the Plan was the principal recommendation of the 2012 report by Professor Bryant Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* (the Stokes Review).

Our vision (see page 5) is consistent with the *Mental Health 2020: Making it personal and everybody's business* (Mental Health 2020) and the *Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015* (Interagency Strategic Framework).

1.1   What we have achieved in recent years

Western Australia was one of the first in Australia, to establish a dedicated Ministerial portfolio for Mental Health in 2008, to ensure mental health continued as a priority for Western Australia.

The establishment of the Western Australian Mental Health Commission in 2010 paved the way towards creating a modern and effective mental health system that puts the individual and their family at the centre of its focus.

Progress has already been made with a record mental health, alcohol and other drug budget increase of 68% since 2008.[3] This has resulted in an increase in public mental health, alcohol and other drug service capacity and the introduction of a range of new programs such as:

- expanding public mental health services;

- services for Aboriginal people with mental illness;

- expanding community-based subacute care facilities;

- youth and adult court diversion services;

- state-wide suicide prevention;

- development of the Mental health Bill 2013; and

- expansion of drug and alcohol services.

1.2   The modelling

The Plan is based on agreed national models and frameworks: the *National Mental Health Service Planning Framework* (adapted for Western Australia, see Appendix D); and the *National Drug and Alcohol Service Planning Model*. Our priorities are separated into sections as follows:

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- prevention and mental health promotion;

- community support services;

- community treatment services;

- community bed based services;

- hospital based services;

- specialised state-wide services; and

- system improvement and supporting change.

Each section provides information regarding services, programs and funding of the current system, the service requirement in 2025 and what strategies and actions we will aim to implement to achieve the required mix of services. The initiatives contained in the Plan are provider and funder neutral, that is, the Plan articulates the services and programs required in the system but not who should fund or provide such services.

Furthermore, the national model's output is based on hours of service, hours of support or bed numbers required to deliver the optimal mix of services. This type of output does not pre-empt service models but is considered a proxy for the level of service required (see Appendix D and E for more information).

Importantly, not everything can or should occur immediately. System development and growth will happen in three phases: short term to the end of 2017, medium term to the end of 2020, and long term to the end of 2025. Our main emphasis in the short term is to build on the changes and developments that are already under way and doing what is achievable and affordable as soon as possible.

Failing to implement change will come at a high financial cost for the community, particularly if the mental health system remains skewed towards highest cost acute settings. Without effective strategic action, we are likely to continue to see demand for services being unmet and increasing costs to the system due to an inappropriate and inefficient mix of service delivery.

Resource projections will therefore be recast with population updates every two years to reflect system changes over time. We will continue to consult with key stakeholders and the community for periodic updates, reviews and evaluation of the Plan.

1.3 Principles

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

- Recovery oriented practice[i] is central to the development of mental health services.

- Consumer, families, and carers are fully involved in co-planning, co-designing, co-delivery and co-reviewing of policies and services.

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[i] Recovery-oriented practice ensures that services are delivered in a way that supports each person's recovery. This practice promotes a partnership between people accessing services and professionals who provide services, whereby people with lived experience are considered experts on their lives and experiences while the professionals are considered experts on available interventions and services. (Department of Health, Victoria)

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- A primary focus is on rebalancing services between hospital based and community based, moving services to the community where clinically appropriate.

- Services expanding in the regions and in locations where they are most required, and closer to where people live.

- State funded mental health services (as described in the Plan) treat individuals with severe mental health issues only. 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.

- The system must be developed so that it provides the right level and type of service depending on the needs of an individual.

- An appropriate mix of supports and services will be established that best meet 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.

- The development of all services must be premised on a whole-of-life, holistic approach that incorporates an understanding of the social determinants of life such as housing, education, employment and health.

- Improved system navigation, collaboration and integration is a priority to ensure people are supported to get to the 'right place'.

- Individuals in contact with the criminal justice system have the right to receive the same access and quality of care as the general population.

1.4 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 numbers of people developing mental health, alcohol and other drug problems and reduced attempts and rates of suicide.

- 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 moving hospital and community services to outer metropolitan and regional locations wherever possible.

- Greater involvement of consumers, families, and carers in the planning, design and review of services.

- Services that are more connected, high quality, and person centred.

- Improved social and economic participation for people living with mental health, alcohol and other drug problems.

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- 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 a balance of service options outside a hospital setting.

- Graylands Hospital will be closed and replaced by contemporary services across the State.

- Improved transition for people moving between services including between bed based and other community 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 by increasing the availability of community services and implementing initiatives to improve the efficiency and effectiveness of the current system.

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2   THE NEED FOR CHANGE

Mental Illness

- One in five Australians will be affected by a mental health disorder each year.[4]

- Severe mental health disorders are experienced by approximately 3% of the Australian population.[5]

- 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.[6]

- Internal modelling suggests that 59% of the adult prison population, and 65% of the juvenile prison population in Western Australia has a mental illness, almost three times the prevalence of the general population.[7]

- Ten percent of homicides are committed by 1% of the population suffering from severe mental illness and most commonly involves death of family members.[8]

Suicide

- Western Australia's suicide rate was 36% higher than the national average in 2012 and has been consistently higher than the national average since 2006.[9]

- Male's 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).[10]

- Globally, for every suicide, there are approximately 20 suicide attempts.[11]

- Suicide is the underlying cause of 17% of deaths among persons aged 25–44 and 24% of deaths among those aged 15–24.[12]

- Suicide rates in the Kimberley region are 2.5 times the State average and more than 3.5 times the national average.[13]

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.[14]

- Around 1 in 4 Western Australians over 14 years of age are drinking at risk of lifetime harm and about 1 in 5 recently used illicit drugs.[15]

- In Western Australia, more than half of all domestic and over a third of all non-domestic assaults are alcohol related.[16]

- 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 (2.8 times higher in the Kimberley region).[17]

- Based on various national and international studies[18, 19, 20], it is estimated that at least 30-50% 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 suicide. Western Australia 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.[21]

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Statistics in Figure 2 show that mental disorders were the leading cause of disability among the 15-24 year age cohort. High percentages are also shown for children (0-14 years) and adults (25-64 years). This coupled with information showing an inefficient mental health system and unmet demand calls for significant action to improve the system.

Figure 2: Causes of disability in the Australian population[22]

Years lost to disability (YLDs)

	0%	50%	100%

Children (0-14)

Youth (15-24): 61% | 23% | 16%

Adult (25-64): 27% | 46% | 27%

Older Adult (65+): 39% | 60%

Mental disorders

Other causes

Cardiovascular, Chronic respiratory, Nervous system
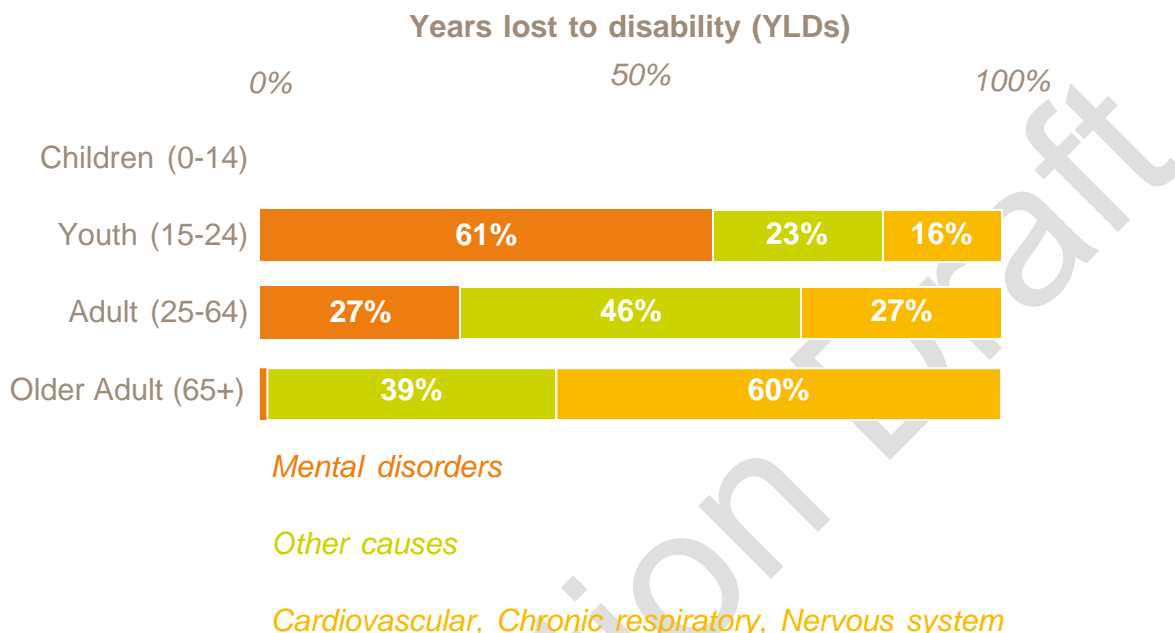
At present, expenditure on mental health, alcohol and other drug services in Western Australia is heavily concentrated on clinical services at the acute end of the service spectrum. Figure 3 below shows the current level of services compared to the level required to meet 100% of demand in 2014. The graph clearly displays that there is a higher degree of underinvestment in community services compared to hospital services.

Figure 3: Progress towards meeting demand in 2014 for mental health, alcohol and other drug services

Community Support: 78%
Community Beds: 51%
Community Treatment: 40%
Hospital Beds: 25%

■ 2014 Actual Services ■ 2014 Demand

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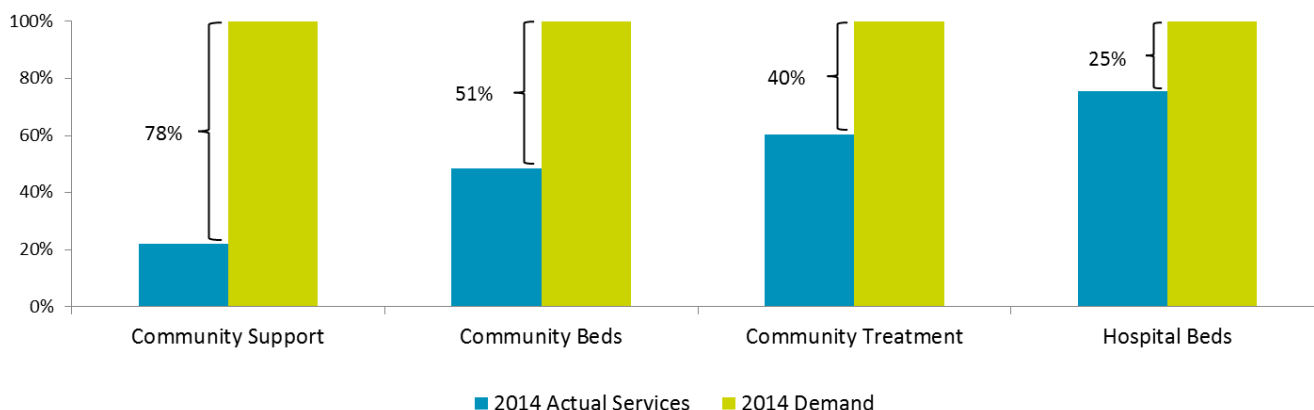
In 2012-13, 85% of the $878 million expended on mental health, alcohol and other drug services in Western Australia funded clinical services.[23] The below figure (Figure 4) shows that 61% of expenditure was for State delivered services, 23% of expenditure was for non-government delivered services, and 16% of expenditure was for Commonwealth delivered services (such as the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS)).[24]

Figure 4: Mental health, alcohol and other drug funding by service provider, 2012-13[ii]

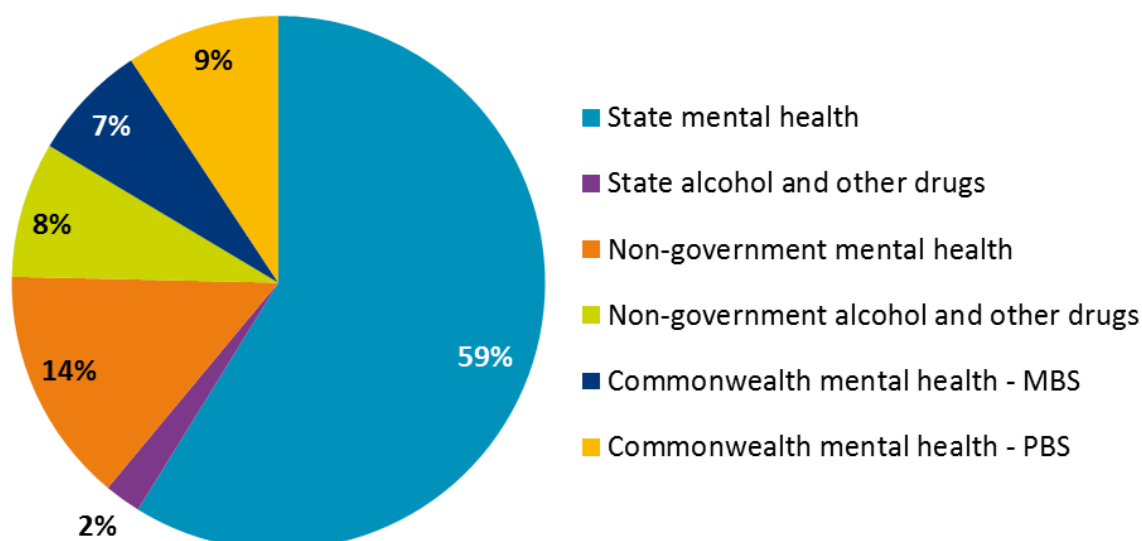Inadequate investment in prevention and mental health promotion programs, primary care services, and community based mental health, alcohol and other drug services puts pressure on other parts of the system. Lack of access to community services makes it more difficult for inpatient services to safely 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 over 40% of individuals occupying mental health inpatient beds at any given time could be discharged if appropriate community services were available.[25]

Recent reports indicate that in Western Australia, Commonwealth subsidised specialised mental health services, and particularly psychiatrist services, are provided at a lower rate than the national average.[26] This has an impact on state funded services as individuals with a mental health problem have no choice but to access higher cost secondary and tertiary 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.

Until now, these issues have been broadly understood but difficult to quantify and thus easy to avoid. We now fully understand the gaps in the system, therefore this Plan provides us with a detailed pathway to develop and grow the system to reach the optimal mix of services over ten years to 2025.

[ii] Commonwealth funding for Alcohol and Other Drug services is not included.

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3   IF WE DO NOT CHANGE THE SYSTEM

The Stokes Review goes into detail regarding the impact on consumers and families if the mental health system does not undergo substantial change. The following impacts on consumers, carers and families will continue if we do not change the system:

- Extended lengths of stay and more frequent admissions and readmissions to mental health inpatient units.
- Continued 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.
- 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 drug problems.
- Delays in access to treatment causing mental health, alcohol and drug problems to worsen (leading to the need for higher cost treatment).

The remainder of this section focuses on the financial inefficiencies in the current mental health system and the implications if we do not invest in the right services and progress system transformation.

Internal modelling shows that in 2012-13 the mental health system met approximately 65%[27] of the target population. This is inclusive of both hospital and community treatment services only, and refers to the population with a severe mental illness only (approximately 3% of the State's population). The modelling excludes mental health community support services, prevention, community beds, and alcohol and other drug services. The dollars are an estimate, and are reported in 2012-13 terms (unadjusted for inflation). Modelling different scenarios has identified varied costs:[iii]

- Actual annual spend in 2012-13 was $367m (which is meeting demand for 65% of the target population).
- If we are to continue to deliver services in the same inefficient system, by 2025 the annual cost will grow to $716m (which will meet 100% of demand).
- If we move to an efficient system and meet 100% demand, by 2025 the annual cost will be $625m (12.7% or $91m less than in an inefficient system).

Figure 5 (below) shows that value for money can be achieved through a reconfiguration of mental health services. If change does not occur, costs to the system will escalate significantly. The figure below identifies the cumulative net impact of moving from an inefficient to an efficient system in 2012-13 terms, for mental health services in community treatment and hospital based services only.

[iii] Figures based on 2012-13 prices, community treatment and hospital services only (forensics is included).

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Figure 5: Cumulative net impact of moving from an inefficient to an efficient system[iv].
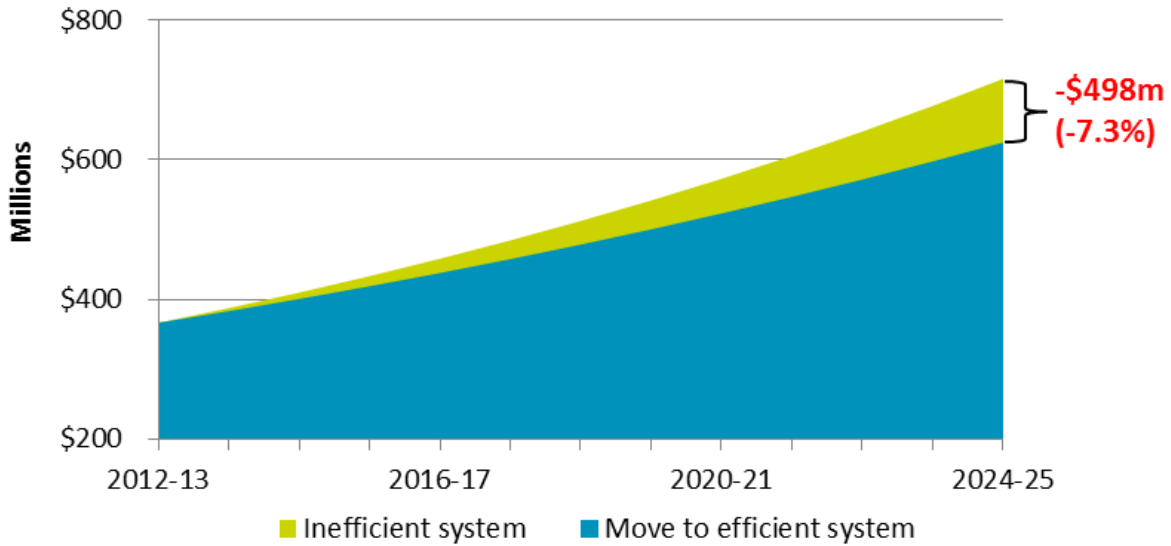
Over the life of the Plan, a minimum of $498 million can be saved if the proposed transition articulated in the Plan occurs. Over the modelled 12 years, this translates to a 7.3% saving in operational expenditure for community treatment and hospital services only.

Improved cost efficiencies to the system will also promote the best outcomes for consumers and their families as treatment will be offered in the most appropriate care setting.

[iv] Figures based on 2012-13 prices, community treatment and hospital services only (forensics is included).

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4 HOW WE WILL PROGRESS

The magnitude of transformation is substantial and requires a phased approach. This allows for effective implementation, evaluation, and adjustments to actions over the life of the Plan. 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. It should be noted 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.

The Mental Health Commission will lead the process of transition, working with key government and non-government organisations, and people with mental health, alcohol and other drug problems, carers, and their families wherever relevant.

The following principles underpin the prioritisation and timing of the system transition:

System transition principles:

- prioritisation of investment considers the areas and services of greatest need, first;

- clinical safety is the highest priority (i.e. some services need to be opened before others can be reconfigured or closed);

- sufficient planning time must be allocated for all projects, including thorough options analysis;

- achievable timeframes should be established for all initiatives;

- interdependencies between actions must be considered;

- where practical, remodelling and improvement of existing services must be undertaken prior to focusing on additional investment;

- economies of scale need to be considered when implementing small programs and programs in areas of small populations; and

- transparency and accountability is vital in relation to decision making, and the delivery of the actions and outcomes of the Plan.

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. Consultation and working groups are required to ensure co-design and prioritisation of services and programs with consumers, carers, and their families.

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 2025 and keep the Plan current and relevant. This will confirm whether the planned changes for 2025 remain appropriate and achievable.

The transition strategy has been developed in three stages (Figure 6):

EXHIBIT 315   COI.017.0001.0021

Figure 6: Timeline for implementing

From now until the end of 2017, we need to prepare for the future by:

- 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; and

- evaluating, redesigning, remodelling and reconfiguring existing services – including specifying logistics in relation to facilities, workforce/recruitment, and patient transfers.

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; and

- the provision of a progress report to Government in 2020.

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COI.017.0001.0022

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; and

- the provision of a progress report to Government in 2025.

EXHIBIT 315

COI.017.0001.0023

5 THE PLAN MATRIX

Predicated on the national demand 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 2025. These requirements have been further prioritised by the end of 2017, 2020 and 2025, demonstrating which services are expected to come on line in which time-period (further detail on the prioritisation process is included in Section 4: *How we will progress*). Exact locations and distributions will be determined by a combination of consultation processes and the assessment of relative feasibility to deliver the service.

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. It is not intended to specify the model of service or the service provider. This will be determined as part of the development of individual business cases. Further detail on each of the service types is contained in the sections following the Plan Matrix.

EXHIBIT 315

COI.017.0001.0024

Service Type	Unit	State Total				State-wide Services				Graylands				North Metropolitan				South Metropolitan				Northern and Remote Total				Goldfields	Kimberley	Pilbara	Midwest	Southern Country Total				Great Southern	Southwest	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 and Promotion																																				
MH *	Percentage	1%	2%	3%	5%	1%	2%	3%	5%																											
AOD	Hours ('000)	66	108	192	208	52	59	112	122						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	1,515	3,215	5,231	2	2	2	2						470	1,122	2,074		460	1,079	1,940	154	247	416	513	115	115	124	159		336	597	703	133	407	163
	Beds (total)	168	178	205	205									14	14	17	17			12	12	154	164	176	176	18	84	46	28							
MH	Hours ('000)	842	1,489	2,977	4,962										460	1,027	1,966		452	994	1,843		242	386	483	108	108	117	150		335	570	670	126	388	156
AOD (Harm reduction and personal support)	Hours ('000)	5	5	201	217	2	2	2	2					2	2	80	87	2	2	72	79			23	23	5	5	5	7			24	26	5	16	5
AOD (Post Residential Rehabilitation)	Hours ('000)	12	21	37	52									4	8	14	21	3	6	13	18	5	6	6	7	2	2	2	2		1	3	6	1	4	1
AOD (Safe places for intoxicated people)	Beds	168	178	205	205									14	14	17	17			12	12	154	164	176	176	18	84	46	28							
Community Treatment Services	Hours ('000) (total)	2,713	3,149	4,101	5,457									1,235	1,361	1,667	2,181	901	1,102	1,461	2,024	288	346	449	554	123	128	142	161	290	339	524	697	128	408	161
MH Infant, Child and Adolescent	Hours ('000)	373	729	1,094	1,459									149	286	429	572	149	272	408	544	32	81	121	161	36	39	41	45	43	91	136	181	32	107	42
MH Youth	Hours ('000)	339	380	415	426									161	173	173	173	121	138	160	160	26	32	38	42	9	10	11	12	31	37	44	50	9	30	11
MH Adult	Hours ('000)	1,200	1,143	1,143	1,142									495	467	467	467	436	419	419	419	124	118	118	118	26	27	32	32	145	139	139	139	25	82	32
MH Older Adult	Hours ('000)	236	254	320	498									114	120	143	182	97	107	129	192	8	8	15	37	8	7	4	17	18	19	35	87	18	48	21
AOD - All (non-residential treatment)	Hours ('000)	565	642	1,127	1,932									316	315	454	787	97	166	346	710	98	107	157	196	43	45	53	55	54	54	170	239	43	141	55
Community Bed Based Services	Beds (total)	639	790	1,034	1,627									300	342	415	630	205	243	341	592	98	144	159	188	38	61	36	53	36	61	119	217	41	124	53
MH Community Based Beds	Beds	281	382	526	854									131	163	233	334	100	120	168	320	14	38	48	77	17	16	17	27	36	61	77	123	24	71	29
AOD - Low Medical Withdrawal	Beds	14	14	35	49									14	14	17	20			7	18			5	5	1	1	1	2			6	6	1	1	4
AOD - Residential rehab	Beds	344	394	473	724									155	165	165	276	105	123	166	254	84	106	106	106	20	44	18	24			36	88	16	52	20
Hospital Based Services	Beds (total)	696	782	856	1,090	26	38	38	43	176	149	103	0	187	217	268	426	243	282	303	378	21	47	80	102	22	22	26	32	43	49	64	142	26	82	34
	Hours ('000) (total)	218	256	273	290	35	26	26	26					63	82	93	103	117	95	95	95	3	23	26	29	6	7	7	8		30	34	37	7	22	9
MH Infant, Child and Adolescent	Beds	26	21	22	26	26	20	20	21														1	2	2				2				3		2	1
MH Youth Acute	Beds	0	32	36	78										15	15	32						3	6	8	2	2	2	2				9	1	6	2
MH Youth Subacute	Beds	0	14	15	17		14	14	14															1	1		1		1				2		1	2
MH Adult Acute	Beds	384	372	366	383					54	34	19	0	103	97	97	157	163	171	171	141	21	27	36	39	9	9	11	11	43	43	43	47	8	28	11
MH Adult Subacute	Beds	102	88	72	81					82	65	43	0			3	33	20	20	20	30		3	5	8	2	2	2	2			1	10		10	2
MH Older Adult Acute	Beds	144	84	77	74					32	26	17	0	52	27	27	27	60	28	28	28		3	4	5	1	1	1	3		1		13	1	13	3
MH Older Adult Subacute	Beds	0	62	65	108										25	25	39		32	32	41		5	6	8	2	2	1	4		2		19	4	10	5
MH HITH **	Beds	12	70	116	183					8	24	24	0	4	18	36	72		17	34	67		5	9	18	4	4	5	6		6	13	26	5	15	6
Mental Health Observation Area (MHOA)	Beds	6	17	21	29		4	4	8					6	13	13	13				8															
MH Private ^	Beds	231	231	231	231																															
AOD (High/Complex Medical Withdrawal)	Beds	22	22	66	110									22	22	52	52				33			11	11	3	2	3	3			3	14	3	8	3
AOD Private ^	Beds	19	19	19	19																															
MH/AOD Consultation Liaison	Hours ('000)	218	256	273	290	35	26	26	26					63	82	93	103	117	95	95	95	3	23	26	29	6	7	7	8		30	34	37	7	22	9
Specialised State-wide Services (inpatient) ***	Beds (total)	8	40	54	70	8	40	54	70																											
Eating Disorders	Beds	0	24	34	44		24	34	44																											
Perinatal beds	Beds	8	16	20	26	8	16	20	26																											
Forensic Services	Beds (total)	38	38	38	92				92	38	38	38	0																							
	Hours ('000) (total)	82	133	206	302	33	84	112	140						9	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	0																							
MH Subacute Hospital	Beds	8	8	8	30				30	8	8	8	0																							
MH Community	Hours ('000)	33	84	112	140	33	84	112	140																											
AOD Community (Diversion)	Hours ('000)	49	49	94	163										9	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)	0	70	70	70		70	70	70																											
In-prison MH/AOD beds	Beds	0	70	70	70		70	70	70																											

NOTES

* Percentage of total MHC budget.

** HITH beds are a substitution for both acute and subacute hospital beds.

***Specialised State-wide 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.

Note: some total columns may not add, due to rounding.

Note: Exact locations and distributions will be determined by a combination of consultation process and the assessment of relative feasibility to deliver the service.

Note: All hours are reported as "hours of service". Community support is to only exception, with the hours represented as "hours of support".

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COI.017.0001.0025

Service Type		State-wide Services				Graylands				North Metropolitan									South Metropolitan							
										North Metropolitan				City	Joondalup-Waneroo	Lower West	Stirling-Osborne Park	Swan and Hills	South Metropolitan				Armadale	Bentley	Fremantle	PARK
		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)									300	342	415	630	110	140	80	114	186	205	243	341	592	178	126	89	199
MH Community Based Beds	Beds									131	163	233	334	42	88	60	65	79	100	120	168	320	80	90	60	90
AOD - Low Medical Withdrawal	Beds									14	14	17	20	14	3			3			7	18	3	3	3	9
AOD - Residential rehab	Beds									155	165	165	276	54	49	20	49	104	105	123	166	254	95	33	26	100
Hospital Based Services	Beds (total)	26	38	38	43	176	149	103	0	206	236	268	425	85	105	54	81	100	243	282	303	377	66	121	103	87
MH Infant, Child and Adolescent	Beds	26	20	20	21																					
MH Youth Acute	Beds										15	15	32		17			15		14	14	29			14	15
MH Youth Subacute	Beds		14	14	14																					
MH Adult Acute	Beds					54	34	19	0	103	97	97	157	24	42	36	30	25	163	171	171	141	25	60	36	20
MH Adult Subacute	Beds					82	65	43	0			3	33		10		13	10	20	20	20	30	8	12		10
MH Older Adult Acute	Beds					32	26	17	0	52	27	27	27				11	16	60	28	28	28	8	10		10
MH Older Adult Subacute	Beds										25	25	39		12		13	14		32	32	41	4	16	16	5
MH HITH *	Beds					8	24	24	0	4	18	36	72	14	16	14	14	14		17	34	67	17	17	16	17
Mental Health Observation Area (MHOA)	Beds		4	4	8					6	13	13	13		5	4		4			4	8	4		4	
AOD (High/Complex Medical Withdrawal)	Beds									41	41	52	52	47	3			2				33		2	21	10
Specialised State-wide Services (inpatient) **	Beds (total)	8	40	54	70																					
Eating Disorders	Beds		24	34	44																					
Perinatal beds	Beds	8	16	20	26																					
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																					
In-prison MH/AOD Beds	Beds			70	70																					

NOTES

* HITH beds are a substitution for both acute and subacute hospital beds

**Specialised State-wide 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).

Note: some total columns may not add, due to rounding.

Note: Exact locations and distributions will be determined by a combination of the consultation process and the assessment of relative feasibility to deliver the service.

EXHIBIT 315

COI.017.0001.0026

6 PREVENTION AND PROMOTION

6.1 Overview

A major five-year study, funded by the National Health and Medical Research Council (NHMRC), found that investing in prevention strategies for mental health, alcohol and other drugs is highly cost effective.[28] Our intention is to enhance the delivery of evidence-based whole of population and targeted prevention strategies.

Alcohol and other drug, mental illness and suicide prevention, and mental health promotion necessitates a long-term strategic approach. Effective prevention programs range from mass-reach programs to the whole population, such as existing alcohol and other drug social marketing programs (e.g. *Alcohol.Think Again and Drug Aware)*, to targeted programs for specific populations and target groups.

6.2 Aim

Establish a range of evidence based prevention and promotion programs, strategies and initiatives that will prevent and reduce the harmful effects of alcohol and other drugs, reduce the incidence of mental illness, suicide and suicide attempts, and promote positive mental health in the Western Australian community.

6.3 Current services

In 2013-14, approximately 1% of the Mental Health Commission budget (or $7.3 million) was spent on mental health illness prevention and mental health promotion. In the same year $10.5 million was dedicated to alcohol and other drug prevention which represents 12.9% of the Drug and Alcohol Office's annual budget.

A range of prevention and mental health promotion programs are already implemented by the Mental Health Commission and the Drug and Alcohol Office. Examples include the funding provided to the Act, Belong Commit program; the Music Feedback program to reduce stigma relating to mental health problems; internationally recognised alcohol and other drug mass reach campaigns; 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 reduce the risk of harm from alcohol and drugs in high risk venues.

6.4 What the Modelling Tells Us

The Western Australian Mental Illness Prevention and Mental Health Promotion Consultation Group, which was comprised of a range of experts, recommended funding should increase to at least 5% of the Mental Health Commission budget over the life of the Plan. This equates to $62 million in 2025 (reported in 2012-13 terms).

> **71.5% of respondents to the community feedback survey found there were insufficient prevention programs for people at risk of mental illness.**
>
> *"Preventative mental health programs are severely lacking at the moment but are essential in the prevention of costly hospital admissions. Take the step and properly resource preventative measures for longer term cost savings and better mental health in Western Australia[29]."*
>
> *"Reducing the social and cultural acceptability of harmful alcohol and drug use in WA is important. Alcohol is widely available and accessible.[34]"*
>
> *"...community development activities and programs are considered integral...[35]"*

EXHIBIT 315   COI.017.0001.0027

An alcohol and other drug prevention expert reference group estimated the hours of service on alcohol and other drug prevention strategies in 2024-25 should be 208,000, which along with other evidence based prevention strategies (such as mass reach education), would represent approximately 10.5% of the budget for alcohol and other drugs.

Further detail on the modelling for prevention and promotion is contained in Section 5: *the Plan Matrix.*

6.5 Strategies

6.5.1 Further enhance prevention capability within the Mental Health Commission upon amalgamation with the Drug and Alcohol Office.

To increase the emphasis on and to continue to enhance prevention, and mental health promotion, the newly amalgamated organisation will be strengthened in its approach with the Drug and Alcohol Office expertise and experience. The amalgamated organisation will:

- lead the development of a detailed prevention plan for mental health, alcohol and other drugs;

- expand partnerships between government, non-government, the private sector and the Western Australian community; and

- deliver programs, services and initiatives that are culturally responsive, youth-friendly and accessible, in order to reach priority groups and people with intersecting needs.

6.5.2 Closely monitor suicide rates and develop programs and initiatives to decrease the suicide rate.

The Western Australian Suicide Prevention Strategy 2009-2013 aimed to build community awareness and capacity to prevent and reduce suicides.

The new multi-year Strategy is aligned with the World Health Organization 2014 reports on suicide prevention and social determinants for mental health. Its development is informed by expertise from the Ministerial Council for Suicide Prevention; current data and best practice; and evaluations and reports on the *Western Australian Suicide Prevention Strategy 2009-2013*.

In Western Australia 1 person died by suicide every day in 2012 (366 people)

Key outcomes of the new strategy include:

- 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 healthy workplaces;

- increased suicide prevention training; and

- timely data and evidence to improve responses and services.

EXHIBIT 315   COI.017.0001.0028
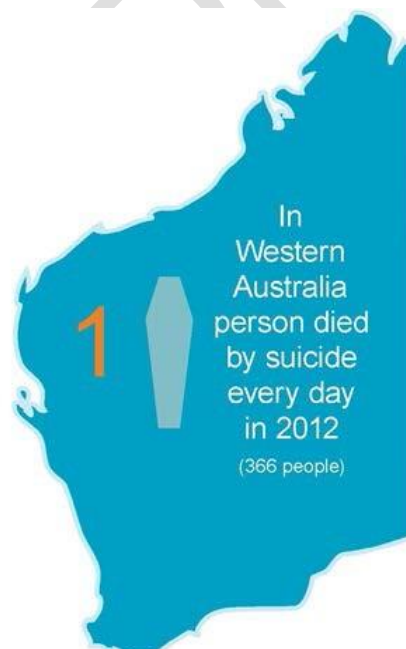
It is intended that additional initiatives will operate alongside the Strategy, including counselling and early intervention, crisis lines, postvention[1], and national initiatives such as *beyondblue.*

6.5.3   Expand current evidence based alcohol and drug prevention programs.

A range of evidence based programs are currently implemented by the Drug and Alcohol Office and over the next ten years these programs will expand across the State. Programs include mass reach prevention campaigns, community action as well as initiatives to reduce risk of harm in high risk venues.

IN WESTERN AUSTRALIA

Alcohol is the most prevalent drug and causes the MOST drug related harm*

More than **50%** of all domestic assaults and over **30%** of all non-domestic assaults are alcohol related

More than **30%** of males and **25%** of females who died by suicide had alcohol and other drug use issues noted three months prior to their death

19% of people over 14 years of age recently used illicit drugs

23% of people over 14 years of age are drinking at risk of lifetime harm

* excluding tobacco

6.5.4   Develop a range of complementary prevention strategies to promote social inclusion and create supportive environments.

Building on work to create mentally healthy communities will be a priority, alongside enhancing activity to create environments that de-normalise harmful alcohol use and support a reduction in harmful alcohol and other drug use.

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. Similarly, research is being conducted in the alcohol and other drug sector to inform strategies to reduce alcohol and drug related stigma.

6.5.5   Further progress a range of initiatives that will reduce the physical health gap.

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.[31] Alarmingly, 70% of people with a serious mental illness die from cardiovascular disease compared with 18% of the general population and approximately 60% of people with a serious mental illness smoke compared to 17% of the general population.[32]

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 engaging with the primary healthcare sector.

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[1] Postvention is an intervention after a suicide, to support individuals and communities impacted by the death. It aims to assist people who are bereaved (family, friends, professionals and peers) to recover from major stressors, grief and loss. Debriefing and support for survivors of suicide is a critical part of suicide prevention for vulnerable people

EXHIBIT 315   COI.017.0001.0029

6.5.6 Establish infant, child, adolescent and youth programs to reduce the incidence of mental illness and prevent harmful impacts of alcohol and other drugs.

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. Examples include reducing the impact of alcohol on a baby during pregnancy (preventing foetal alcohol spectrum disorders) and school based education programs.

Evidence indicates that 75% of mental illness emerges by the age of 25.[33] Individuals may also commence alcohol and other drug use by this age. Early and effective intervention, targeting young people, is critical for future mental health, alcohol and other drug use service outcomes.

6.6 Actions

Implementing Existing Commitments:

6.6.1   complete the development, and commence implementation of a new suicide prevention strategy; and

6.6.2   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:

6.6.3   increase the proportion of the Mental Health Commission budget spent on prevention and promotion from 1% to 2% and increase the hours of service dedicated to alcohol and other drug prevention from 66,000 to 108,000 hours;

6.6.4   identify opportunities to enhance school based programs to incorporate mental health, alcohol and other drug education, and resilience building; and

6.6.5   develop a comprehensive prevention plan for mental health, alcohol and other drugs which will include a range of evidence based strategies.

By the end of 2020, to rebalance the system there is a need to:

6.6.6   increase the proportion of the Mental Health Commission budget spent on mental illness prevention and mental health promotion from 2% to 3%, and increase the hours of service dedicated to alcohol and other drug prevention from 108,000 to 192,000 hours;

6.6.7   increase the level of evidence-based prevention activity taking place at the state, regional and local level through enhancing the capacity of the workforce;

6.6.8   improve access to web-based/on-line strategies and interventions;

6.6.9   expand current public education campaigns targeting harmful alcohol and other drug use; and

6.6.10 promote the adoption of evidence based mental health 'first aid' training throughout the community.

EXHIBIT 315   COI.017.0001.0030

By the end of 2025, to continue the reform, modelling identifies the requirement to:

6.6.11 complete the rollout of school based education programs on mental health, alcohol and other drugs, and resilience building until available in all schools;

6.6.12 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; and

6.6.13 reach the target of 5% of the Mental Health Commission budget allocated to mental illness prevention and mental health promotion, and 208,000 hours of service dedicated to alcohol and other drug prevention.

6.7 Summary of the Plan Matrix

State Total	Measure	Current	2017	2020	2025
Prevention and Promotion					
MH[v]	Percentage	1%	2%	3%	5%
AOD	Hours ('000)	66	108	192	208

[v] Percentage of total Mental Health Commission budget

EXHIBIT 315   COI.017.0001.0031

7 COMMUNITY SUPPORT SERVICES

7.1 Overview

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 programs include peer support, personalised support programs, home in-reach, family and carer support and respite (including young carers), recovery programs and harm reduction programs.

Harm reduction strategies are a long standing, community support response for people with alcohol and other drug problems and include needle and syringe provision, overdose prevention and safe places for intoxicated people (often known as sobering up centres). Personalised support programs in the alcohol and other drug sector are a relatively new concept but their importance is growing internationally. These programs involve the provision of wrap around, personalised support for people to identify and meet their personal goals (which may be in the area of housing, employment, education and so on).

We recognise that strengthening community support services alongside community treatment and community bed based services, and improving the ability of consumers to navigate the system is important. Through building the capacity of the system and improving coordination, 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.

Best practice in recovery is for support services to be designed and delivered as part of a personal recovery journey, whereby the individual creates or rebuilds a satisfying, hopeful and contributing life.[34] This requires mental health staff and practitioners to support consumers and their families to decide on the services they access.

> *"More support for families/carers, more options to support people in re-engaging in educational pursuits, more supported housing for people with mental health issues."*
>
> *"Programmes that are inclusive of relatives and friends."* [29]

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.

Housing and Accommodation

Research indicates that mental health, alcohol and other drug problems are contributing factors to a person becoming homeless.[35] To improve services for people who are homeless we intend to improve in-reach into homelessness services and work with housing providers to increase access to available housing. This will 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.

7.2 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 well-being.

EXHIBIT 315

COI.017.0001.0032

7.3 Current services

It has been estimated the Mental Health Commission and the Commonwealth funded approximately 842,000 hours of mental health community support in 2012-13 (with the Commonwealth and State funding approximately 50% each). For alcohol and other drug community support services, the State Government funded 17,000 hours of support and 168 beds. There is a range of non-government organisations contracted to provide community support services, examples of programs are provided below.

The Individualised Community Living Strategy[vi] (ICLS) is a Mental Health Commission program that utilises individualised funding as a strategy to provide personalised support to people to live a good life in their own home in the community. As at 2013-14,115 houses have been purchased and 138 people supported by the program. The ICLS is currently being evaluated.

The Mental Health Commission also 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 focussed community based support services are important for people living in hostels.

In relation to alcohol and other drugs, community support services include harm reduction strategies. Current programs include needle and syringe provision, overdose prevention programs and safe places for intoxicated people (also known as sobering up centres).

The Transitional Housing and Support Program (THASP) was introduced as a pilot in 2011-12 and provides in-reach support for people staying in short term accommodation following residential alcohol and other drug treatment. There are currently 15 THASP houses operational across the State. A 2013 evaluation of the program has demonstrated a range of positive outcomes including reductions in relapse rates, improvements in well-being, increased life and independent living skills and reduced levels of homelessness.

7.4 What the modelling tells us

Modelling shows that the hours of support for mental health is required to increase from 842,000 currently to 4.96 million hours by 2025. The modeling shows that hours of support for alcohol and other drugs is required to increase from the current 17,000 hours to 269,000 hours (see Figure 7).

[vi] The Individualised Community Living 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.

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Figure 7: Mental health, alcohol and other drug community support services: hours of support in millions of hours
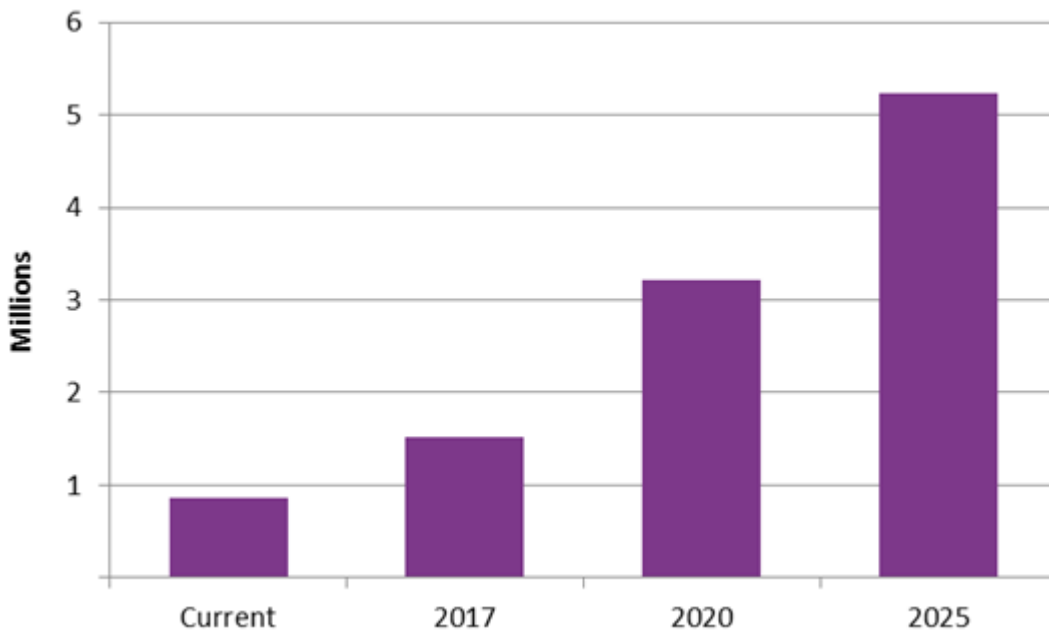
Further, the bed numbers for safe places for intoxicated people is required to increase from the current 168 beds to 205 beds by 2025 (see Figure 8).

Figure 8: Alcohol and other drug community support services: beds (safe places for intoxicated people)

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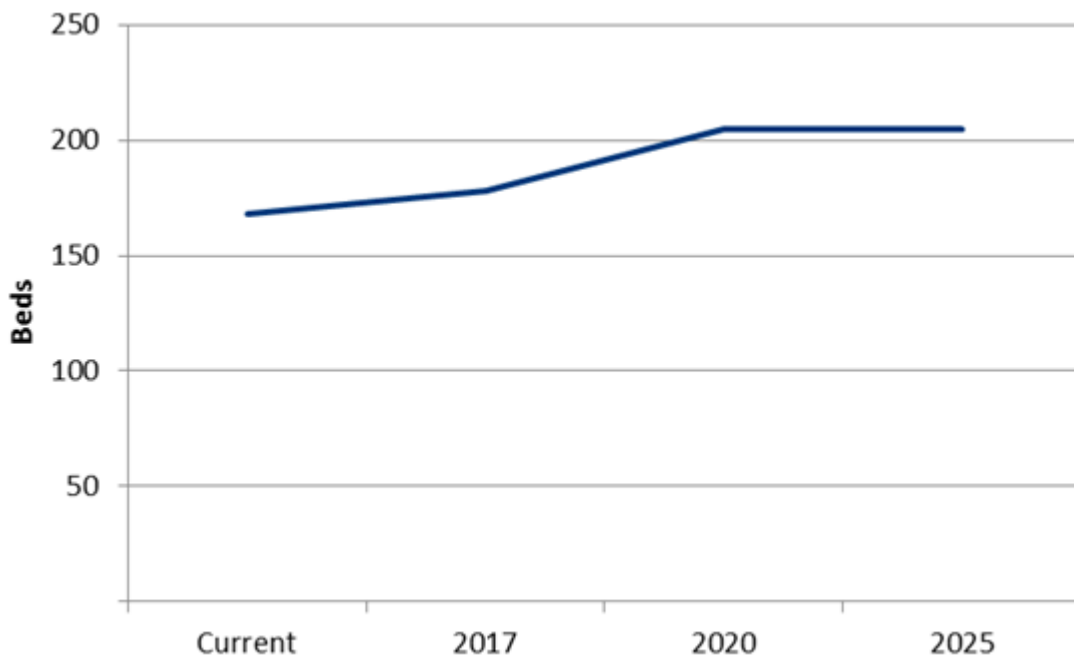
7.5 Strategies

7.5.1 Contribute to the piloting of the National Disability Insurance Scheme (NDIS) and My Way trials.

The National Disability Insurance Scheme (NDIS)[vii] and My Way trial sites have commenced. Evaluation and findings from the trial sites will inform our future investment. 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.

7.5.2 Expand family and carer 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. 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. Over the next ten years we intend to expand access to information, support and importantly flexible respite.

7.5.3 Promote the expansion of recovery focused mental health services.

Expanding the availability of personal recovery oriented support services is a common theme within the Plan. Service expansion and development will be centred on enabling greater choice of service provider for individuals with mental health problems, their families and carers. Over the lifetime of the Plan we intend to make available a variety of recovery oriented community support services, including supporting the growth of the peer workforce.

7.5.4 Further expand access to alcohol and other drug community support services.

Current alcohol and 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.

Personalised support services are an emerging area in the alcohol and drug sector which provide individualised wrap around support for people to address their holistic needs (including housing, employment, education and so on). Often this support is provided by peer workers. The potential for delivery of individualised funding and personalised 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.

[vii] 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 trialed: the Commonwealth's NDIS (run by the National Disability Insurance Agency) and the State Government's WA NDIS My Way (run by the State Government).

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7.5.5 Expand mental health, alcohol and other drug service in-reach to homelessness services and work with housing providers to increase access to housing for people with mental health, alcohol and other drug problems.

A system-wide multiagency accommodation strategy to address the broad accommodation needs of individuals with mental health, alcohol and other drug problems is essential. It would include the specification of housing and support needs of people currently living in psychiatric hostels.

People exiting alcohol and other drug treatment programs often experience difficulties in finding and sustaining suitable accommodation. The continued work with housing providers to identify appropriate locations for additional Transitional Housing and Support Program properties and provide in-reach treatment and support is required.

In addition to the above, specialised homelessness services are required to expand, to increase consultation and liaison to mainstream services and in-reach into homelessness services (further detail provided in Section 11: *Specialised State-wide Services*).

7.6 Actions

The actions in the area of community support services are detailed below. For further information refer to Section 5: *The Plan Matrix.*

Implementing Existing Commitments:

7.6.1   evaluate the Individualised Community Living Strategy and implement improvements.

By the end of 2017, to prepare for the future we aim to:

7.6.2   double the state provision of community support services from 444,000 hours of support to 888,000 hours of support, with a particular focus on rural and remote areas and youth;

7.6.3   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 on recovery;

7.6.4   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;

7.6.5   in collaboration with key stakeholders, develop an accommodation strategy to address the housing needs of people with mental health, alcohol and other drug problems which will include working with housing providers to increase access to suitable housing options for people with mental illness;

7.6.6   continue to provide alcohol and other drug support services for residents within existing Transitional Housing and Support Program houses in: North Metropolitan; South Metropolitan; the Goldfields; the Midwest; and the Kimberley; and

7.6.7   in consultation with housing providers, establish new Transitional Housing and Support Program houses and commission in-reach treatment and support[viii] (expand

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[viii] Referred to in Section 5: *The Plan Matrix* as "post residential rehabilitation".

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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.

By the end of 2020, to rebalance the system there is a need to:

7.6.8   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;

7.6.9   commission in-reach and out-reach support[ix] (approximately 17,500 hours of support) in the metropolitan area for people in crisis accommodation with alcohol and other drug problems;

7.6.10 develop and commission a personalised support services[x] for people with alcohol and other drug problems (approximately 175,000 hours of support), which would include peer workers;

7.6.11 in consultation with housing providers, continue the expansion of the number of houses with support available in the Transitional Housing and Support Program (expand the total by approximately 15,900 hours of support) across the North Metropolitan (6,600 hours), South Metropolitan (6,900 hours), Pilbara (600 hours), South West (1,200 hours), Wheatbelt (400 hours); and

7.6.12 expand mental health community support services across the state from approximately 1.5 million hours of support to approximately 3 million hours of support.

By the end of 2025, to continue the reform, modelling identifies the requirement to:

7.6.13 expand community mental health support services across the State from approximately 3 million hours of support to approximately 5 million hours of support; and

7.6.14 in consultation with housing providers complete delivery of houses and support available in the Transitional Housing and Support Program with a further 15,700 hours of support (approximately 52,500 total hours of support).

[ix] Referred to in Section 5: *The Plan Matrix* as "harm reduction and personal support".

[x] Referred to in Section 5: *The Plan Matrix* as "harm reduction and personal support".

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7.7 Summary of the Plan Matrix

State Total	Measure	Current	2017	2020	2025
Community Support Services	Hours ('000) (total)	859	1,515	3,215	5,231
	Beds (total)	168	178	205	205
MH	Hours ('000)	842	1,489	2,977	4,962
AOD (Harm reduction and personal support)	Hours ('000)	5	5	201	217
AOD (Post Residential Rehabilitation)	Hours ('000)	12	21	37	52
AOD (Safe places for intoxicated people)	Beds	168	178	205	205

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8 COMMUNITY TREATMENT SERVICES

8.1 Overview

Community treatment provides clinical care in the community for individuals with mental health, alcohol and other drug problems. Community treatment services generally operate with multidisciplinary teams, and include specialised and forensic community clinical services. Services provided to individuals are non-residential, and can be intensive, acute or ongoing. Alcohol and other drug community treatment services include pharmacotherapy programs, screening and assessment programs, and counselling.

> **More than 87% of those surveyed indicated there are not sufficient clinical services in the community to meet demand.**
>
> *"(We need) less of the hospital "illness based" programs and more whole-of-community recovery-based programs."* [29]
>
> *"Assertive linkages should be established between the specialist alcohol and drug sector and other health, social and welfare services."* [42]

As with the expansion of community support services, expanding 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 translate to efficiencies in the public hospital system. Such efficiencies will alleviate inappropriate demand for acute beds, thereby improving access to treatment for individuals with acute illness.

Primary Care and Pharmacy

Effective primary care services have the capacity to prevent and reduce the severity of mental health, alcohol and other drug problems. Primary health services (including General Practitioners (GPs)) can identify problems early, treat and support many people in the community, and provide appropriate and timely referral to other services. Improving access to primary care services will help to ease pressure on other parts of the system. Pharmacies can also become more involved in the provision of services to individuals with mental health, alcohol and other drug problems.

Western Australia receives a lower per capita Australian Government expenditure on Medicare subsidised mental health services compared to the national per capita expenditure.[36] For example, Western Australia 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)[37];

- 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)[38];

- rates of GPs per capita (183.5 per 100,000 persons)[39]; and

- rate of prescription medications for mental health problems.[40]

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.

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

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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.

8.2 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 and carers, and families are better supported.

8.3 Current Services

In 2014, approximately 2.1 million mental health, and 566,000 alcohol and other drug community treatment hours of service 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.

8.4 What the modelling tells us

The modelling indicates a requirement for community treatment services to increase from 2.1 million to 3.5 million hours of service for mental health, and from 566,000 to 1.9 million hours of service for alcohol and other drugs by 2025. Hours of service to deliver the optimal level of community treatment services is shown in Figure 9 below and in Section 5: *The Plan Matrix.*

Figure 9: Mental health, alcohol and other drugs community treatment hours of service
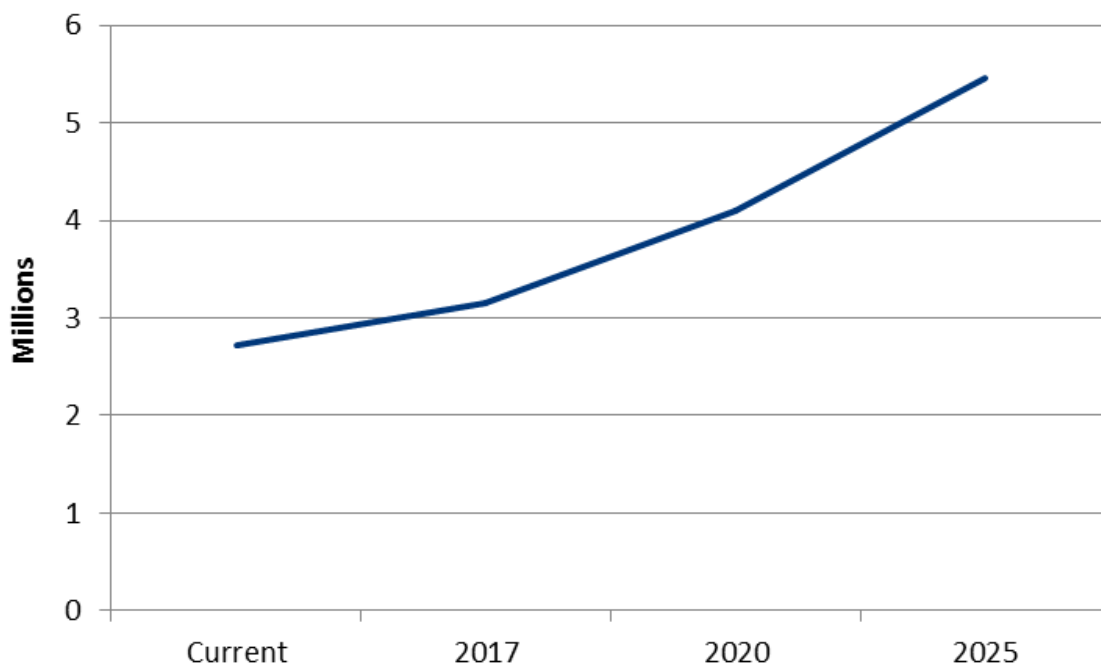
The gap in public infant, child and adolescent community treatment mental health services is substantial and requires urgent resources. According to the optimal service mix, there is an

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excess of 57,000 hours of service being provided for adult mental health, provided that other service elements are operating at the optimal mix and are resourced adequately. However, unless other elements of the system are delivering at adequate levels, there will be a continuing high demand for these services that is challenging to meet. There is an overall requirement for alcohol and other drug community treatment hours of service to grow by over 300% by 2025. Figure 10 below shows the current services mapped against the 2025 demand according to the optimal mix of services.

Figure 10: Mental health, alcohol and other drugs community treatment hours of service
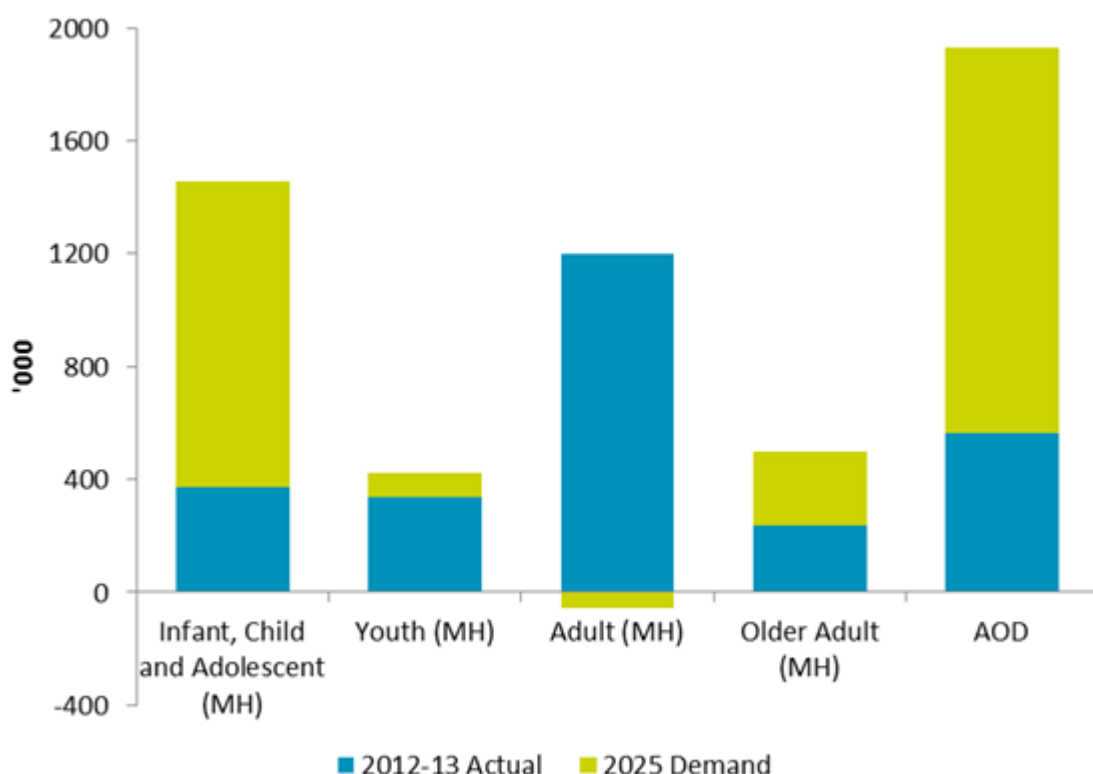
8.5 Strategies

8.5.1 Deliver mental health community treatment services through three key service types: Acute Services, Intensive Community Treatment Services and Continuing Intervention Services.

To address the full continuum of need in mental health community treatment settings, our focus will be on three key service types:

- **Acute services:** which will 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 24/7 that 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. Some instances of crisis require attendance by the Police, and it is necessary for Police to have the skills and immediately available clinical advice to address the situation.

- **Intensive Community Treatment services:** provide assessment, pro-active treatment and interventions, delivered within a recovery oriented context that supports individuals,

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families and carers to manage the illness and improve their quality of life. Services are delivered via mobile outreach by multidisciplinary teams.

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

8.5.2 Realign the current mental health community teams to new age streams.

It is intended that current mental health community teams be realigned to new age streams. This translates into new age cohorts: infant, child and adolescent mental health services will treat those up to the age of 16 years; youth services will treat those aged 16 to 24 years; adult services will be for those aged 25 to 64 years; and older adult for those aged 65 years and over. The creation of the youth stream will be achieved predominantly through reconfiguration of the adult stream. These changes will be implemented gradually but will ensure more age appropriate responses can be delivered.
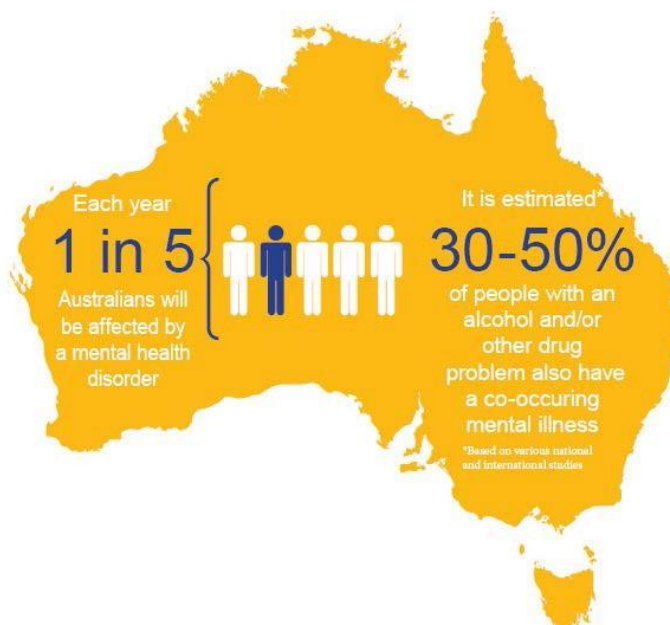
8.5.3 Expand alcohol and other drug treatment services to meet the needs of the growing population.

Alcohol and other drug community based treatment services are predominantly in the community managed sector. The main model for 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 and the Drug and Alcohol Office Next Step clinical service. The integrated services model offers a multidisciplinary approach including medical, nursing, clinical psychology and counselling services. These services are required to expand across the state to improve links with other health, justice and community services. Improvement of services for people with co-occurring mental health, alcohol and other drug problems is a continued focus.

8.5.4 Establish a Police co-response program.

When 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 as program will improve community perceptions regarding the role of 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

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additional staff requirement). The Police resource requirement for the co-response program is not included within the modelled community treatment hours of service.

8.5.5 Continue to work with the Department of Health to improve the 24 hour mental health crisis and emergency response, triage, assessment, and treatment services to be effective and efficient, and valued by consumers and carers.

The need for improved mental health crisis and emergency responses services has been identified by a range of stakeholders, including consumers, carers and families. Services are currently being remodelled to align with best practice so that consumers and families have access to a service that has a single point of access, is responsive and effective. The service will also provide training to relevant front line staff (e.g. Police, Ambulance Officers, GPs,) in how to respond to people with a mental illness in an emergency situation. This service may also have a role in system navigation and a broader role to deliver future training needs as the mental health system develops.

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 the alcohol and other drug helpline and to map synergies in relation to system navigation, helpline function and future service delivery models.

8.5.6 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. Pharmacies have begun to play a greater role in providing services to people with a mental health, alcohol and other drug problems and opportunities to expand this, such as through increasing the use of Nurse Practitioners in pharmacies, is an area that will be explored.

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

8.6 Actions

The actions in the area of community treatment services are detailed below. For further information refer to Section 5: *The Plan Matrix*.

By the end of 2017, to prepare for the future we aim to:

8.6.1   boost infant, children and adolescent community treatment services by doubling the provision of community treatment hours of service across the state from 373,000 hours to 729,000 hours;

8.6.2   build on current youth services through commissioning dedicated public mental health youth services across the state for 16 to 24 year olds, predominantly through a reconfiguration of existing adult services;

8.6.3   establish two new integrated alcohol and other drug treatment services (Joondalup and Mandurah);

8.6.4   develop another community alcohol and other drug service hub in the Midwest (Meekatharra);

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8.6.5   work with Police to develop and commission a mental health Police co-response program;

8.6.6   establish an effective 24 hour mental health crisis and emergency response service, that provides triage, assessment, and treatment services. The service will also provide relevant frontline staff with training;

8.6.7   work with the Commonwealth Government to establish clear referral pathways and system navigation support to ensure access to services occurs at the earliest point of contact and is seamless for individuals, families, carers, service providers and General Practitioners; and

8.6.8   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.

By the end of 2020, to rebalance the system there is a need to:

8.6.9   increase the total mental health community treatment hours of service across the State from 2.5 million hours to approximately 3 million hours with a priority on developing telepsychiatry, 'after hours' services and expanded clinical services for the South West;

8.6.10   expand metropolitan alcohol and other drugs integrated treatment services to provide outpatient withdrawal, pharmacotherapy maintenance and specialist counselling and support. Rockingham, Midland, Armadale and the Perth Central Metropolitan area are identified as priority areas;

8.6.11   expand the number of regional alcohol and other drug service hubs and 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; and

8.6.12   expand training and engagement of General Practitioners and other primary care providers to:

- expand the Community Program for Opioid Pharmacotherapy across the State, particularly regional areas; and

- increase screening, brief interventions, early interventions, and referrals for mental health, alcohol and other drug problems in all regions.

By the end of 2025, to continue the reform, modelling identifies the requirement to:

8.6.13   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 from approximately 1 million hours to 1.9 million hours of support (including establishing smaller hub sites in 18 non-metropolitan locations); and

- increasing the total mental health community treatment hours of service across the State from approximately 3 million hours to approximately 3.5 million hours.

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8.6.14   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.

8.7 Summary of the Plan Matrix

State Total	Measure	Current	2017	2020	2025
Community Treatment Services	Hours ('000) (total)	2,713	3,149	4,101	5,457
MH Infant, Child and Adolescent	Hours ('000)	373	729	1,094	1,459
MH Youth	Hours ('000)	339	380	415	426
MH Adult	Hours ('000)	1,200	1,143	1,143	1,142
MH Older Adult	Hours ('000)	236	254	322	498
AOD - All (non-residential treatment)	Hours ('000)	565	642	1,127	1,932

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9 COMMUNITY BED BASED SERVICES

9.1 Overview

Community bed based services are focused on providing recovery oriented services in a residential style setting (in the case of mental health services) and residential rehabilitation for people with an alcohol and other drug problem. 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 over 40% of individuals occupying mental health inpatient beds at any given time could be discharged if appropriate community services were available.[41] 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.

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.

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

$1,234 in a hospital

$453 in a community based subacute centre

9.2 Aim

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

9.3 Current Services

In 2012-13, there were a total of 281 community beds for mental health services, and 358 for alcohol and other drug services.The Government has commenced investing in community bed based services with the first subacute service opening with 22 beds at Joondalup in 2013.

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 Section 7: *Community Support Services*.

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9.4 What the modelling tells us

There are five 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 often delivered in home-like cluster style facilities and are staffed 24 hours per day, 7 days per week. For mental health, the services are:

- **Subacute community short-stay (Adult):** The average length of stay is 14 days with an expected maximum of 30 days. Short-term residential care, which involves intensive clinical treatment and support, is provided. 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, provide consumers an early discharge from acute care through the provision of an intensive safe and supportive residential community residential program (step down).

- **Subacute community short-stay (Youth):** The average length of stay is 28 days. The service for youth mirrors that of the adult service (outlined above).

- **Subacute community medium-stay (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 to deliver recovery oriented psychosocial rehabilitation programs.

- **Subacute community long-stay (Adult and Older Adult):** The average length of stay is 365 days. The functions of this service mirror that of the 'rehabilitation service' (above). The two services differ in their length of stay.

- **Subacute 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:

- **Low medical withdrawal:** The average length of stay is five to seven days. This type of service provides 24 hour supervised alcohol and other drug detoxification or withdrawal programs from a psychoactive drug of dependence.

- **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.

To meet 100% of demand, modelling indicates that community bed numbers for mental health are required grow to from 281 to 854, and for alcohol and other drugs are required to grow from 358 to 773 by 2025 (see Figure 11 and Section 5: *The Plan Matrix*).

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Figure 11: Mental health, alcohol and other drugs (AOD) community beds
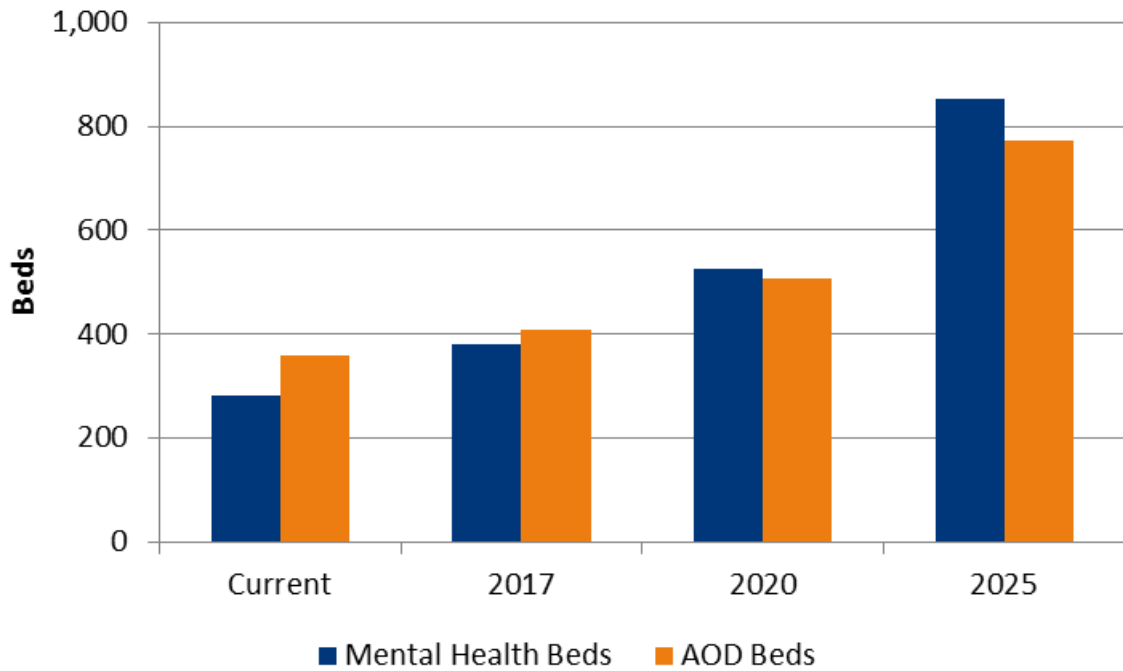
For mental health community beds, the greatest expansion is required in the long-stay beds. For alcohol and other drug community beds, the residential rehabilitation beds require the greatest growth, in order to meet the optimal service mix in 2025 (see Figure 12).

Figure 12: Mental health, alcohol and other drugs (AOD) community beds by bed type

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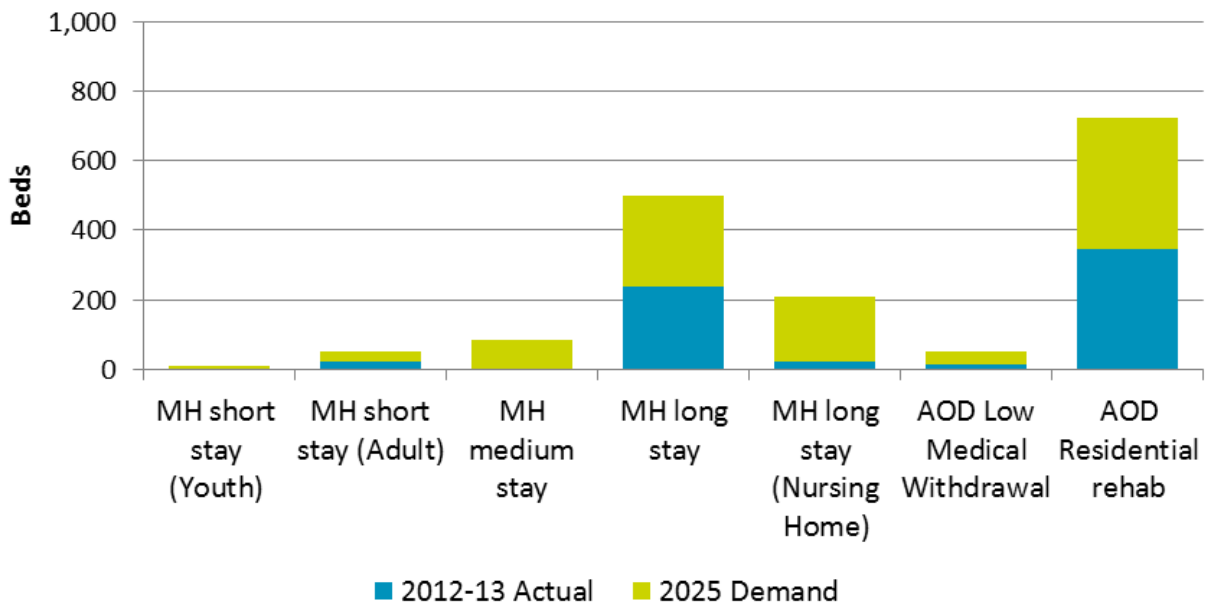
9.5 Strategies

9.5.1 Expand the number of mental health community bed based services, particularly in the regions.

We will progress the commissioning of community bed based services over the next ten years (see Section 5: *The Plan Matrix* for details of the number, type and location). The Government has committed to building a number of subacute services in areas such as Rockingham, Kalgoorlie, Karratha, Bunbury and Broome.

9.5.2 Increase the availability of older adult services.

With an ageing population, more focus and investment will occur in the area of older adult services, particularly subacute community long stay services.

9.5.3 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 no residential rehabilitation services in the southern region of the State.

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.

The modelling shows that a strong emphasis in boosting the availability of residential rehabilitation beds is required, to ensure consumers with an alcohol and other drug problem are able to access timely, personalised services, as close as possible to where they live.

9.6 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 Section 5: *The Plan Matrix*.

Implementing Existing Commitments:

9.6.1   open new community bed based services approved by Government:

- Rockingham (Peel - 10 beds);
- Broome (Kimberley - 6 beds);
- Kalgoorlie/Boulder (Goldfields - 6 beds);
- Karratha (Pilbara – 6 beds); and
- Bunbury (South West – 10 beds).

By the end of 2017, to prepare for the future we aim to:

9.6.2   increase the subsidy provided for subacute 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, 6 places in Northern and Remote, and 15 Places in Southern Country);

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9.6.3   expand existing alcohol and other drug residential treatment and rehabilitation services by 50 beds (10 beds in North metropolitan, 18 beds in South Metropolitan, 12 beds in Geraldton and 10 beds in Kalgoorlie);

9.6.4   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 Southern region of the State; and

9.6.5   commence the development and implementation of a new alcohol and other drug residential treatment and rehabilitation service in the Southwest (36 beds).

By the end of 2020, to rebalance the system there is a need to:

9.6.6   increase the total number of mental health community beds by 103 beds (including in the North Metropolitan, South Metropolitan, Northern and Remote, and Southern Country areas);

9.6.7   deliver a new service specifically designed for youth alcohol and other drug treatment and rehabilitation (with an additional 13 beds) in the metropolitan area;

9.6.8   expand low medical alcohol and other drug withdrawal services in the metropolitan area by 11 beds, Northern and Remote country by 5 beds and Southern Country by 6 beds on existing residential rehabilitation sites; and

9.6.9   increase the subsidy provided for subacute long-stay (nursing home) places for older adults with mental illness by an additional 41 beds - North Metropolitan (14 beds), South Metropolitan (16 beds), Northern and Remote (4 beds), and Southern Country (7 beds).

By the end of 2025, to continue the reform, modelling identifies the requirement to:

9.6.10   further expand alcohol and other drug residential treatment and rehabilitation in the North Metropolitan area (111 beds), Southern Metropolitan (88 beds) and Southern Country (52 beds);

9.6.11   complete delivery of low medical withdrawal beds in the metropolitan area (14 beds); and

9.6.12   increase the number of mental health community beds across the State (all metropolitan and regional areas) from 526 beds to deliver the modelled target of 854 beds.

9.7 Summary of the Plan Matrix

State Total	Measure	Current	2017	2020	2025
Community Bed Based Services	Beds (total)	639	790	1,034	1,627
MH Community Based Beds	Beds	281	382	526	854
AOD - Low Medical Withdrawal	Beds	14	14	35	49
AOD - Residential rehab	Beds	344	394	473	724

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10 HOSPITAL BASED SERVICES

10.1 Overview

Hospital based services include acute and subacute inpatient units, emergency departments, consultation and liaison services, and mental health observation areas.

Detailed analysis in 2009 has revealed that over 40% of mental health patients in acute hospital beds do not need to be in acute care if appropriate community services were available.[43] 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.

10.2 Aim

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

10.3 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 13 shows in some cases current bed numbers as a percentage of 2014 demand is greater than 100% - suggesting we have more beds than modelling indicates we currently require in some areas. 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 in 2015. These include 20 beds at the Perth Children's Hospital, 30 beds at the Fiona Stanley Hospital, 30 beds at Sir Charles Gairdner Hospital, and 56 beds at the Midland Hospital.

10.4. What the Modelling Tells Us

For mental health, the main 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 hospital short stay:** 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.

- **Subacute hospital long stay:** 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

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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. Average length of stay is 365 days.

- **Mental Health Observation Areas:** Mental Health Observation Areas (MHOA) 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.

- **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 telemedicine services to support smaller 'satellite' hospitals. Consultation and liaison services can be provided in hospitals, and emergency departments.

Alcohol and other drug specific beds include:

- **High medical withdrawal services:** are medical inpatient withdrawal services that provide medically supervised alcohol and other drug withdrawal, 24 hour staffed 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:** are medical inpatient withdrawal services that provide medically supervised alcohol and other drug withdrawal, 24 hour staffed 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) within a hospital. Complex medical inpatient withdrawal is for clients with withdrawal symptoms that are moderate to severe, there is polydrug use, complicating medical or mental health issues and/or a history of complicated withdrawals.

Figure 13 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 – shown as a negative in Figure 13) and a proportionate increase in other bed types that are currently undersupplied (e.g. youth 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 the hospital beds cannot be realigned without substantial investment and expansion of the community based services.

Figure 14 shows that only a minimal increase in hospital beds is required by 2020, with a sharp increase between 2020 and 2025. This is in line with the focus of investment being in community services first, as that is where the greatest need is (see Section 5: *The Plan Matrix* for further detail).

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Figure 13: Mental health, alcohol and other drug hospital beds by bed type
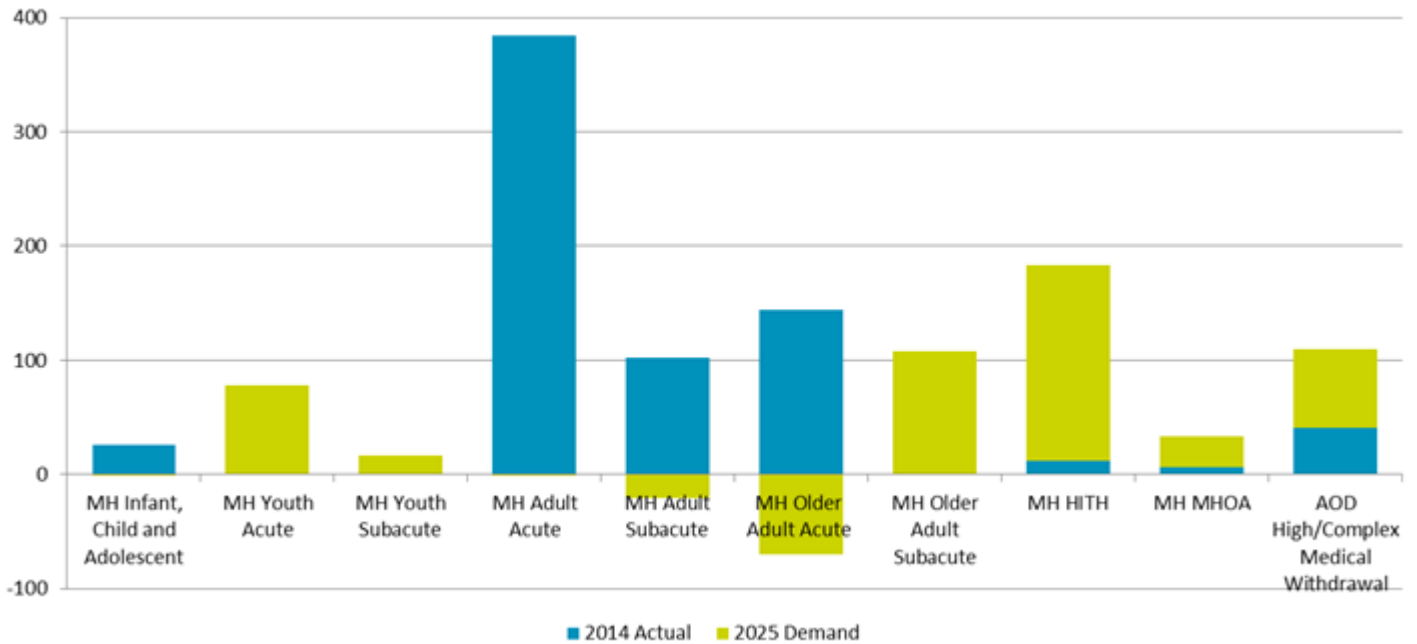
Figure 14: Mental health, alcohol and other drug hospital beds
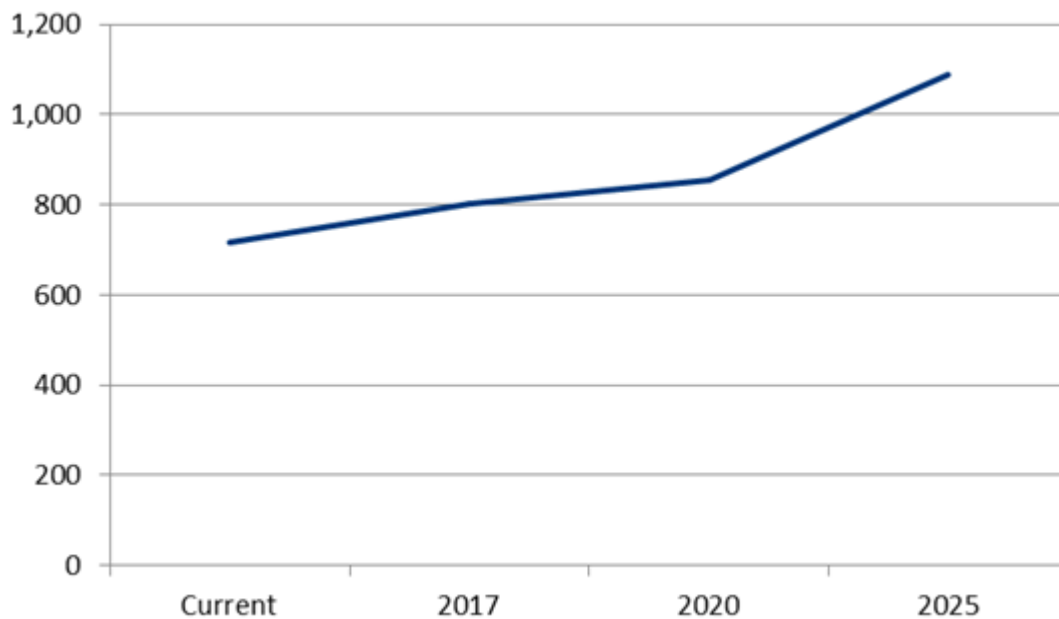
Currently, there are a total of 231 mental health beds located in private hospitals throughout Western Australia. However, at this time, the number of individuals seen by private providers, who have a severe condition, cannot be comprehensively quantified; therefore have not been counted in the 'current 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.

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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 290,000 hours of service by 2025.

10.5 Strategies

10.5.1 Realign the type, quantity and location of hospital beds.

Realignment of bed based services requires the right types of bed, 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 treatment for individuals with a serious mental illness 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 Section 5: *The Plan Matrix*, 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.

10.5.2 Continue to expand the Hospital in the Home (HITH) program.

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

10.5.3 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. Acute mental health inpatient services were developed within general hospitals, and non-acute services were developed in community based settings. Stand-alone psychiatric institutions were built based on a Victorian era asylum model, and most of the campus buildings are now unsuitable for the delivery of modern health care.

In Western Australia, the Swanbourne Hospital was closed in 1985 and the Heathcote Hospital was closed in 1994, leaving Graylands Hospital and Selby Older Adult Unit as the remaining stand-alone mental health hospitals. The full divestment of mental health services from Graylands Hospital and Selby Older Adult Unit will be progressed over the lifetime of the Plan. 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. A significant part of the reform of Western Australia's mental health system is to redistribute existing services provided at Graylands Hospital and Selby Older Adult Unit

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[xi] Based on the results of a 2000 Cochrane Systematic Review, it is estimated up to 55% 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.

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(acute and subacute) to existing or new services across the State – including HITH, general hospitals, and in the regions.

A carefully planned and phased closure of Graylands Hospital is essential. Certain services will need to be established before the phased closure of Graylands Hospital can commence. 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 of the sale of the Graylands property, which can be used as a source of funding for further investment into the mental health system.

Phased closure of Graylands Hospital:

The full divestment of Graylands Hospital would ideally eventuate by the end of 2025. As shown in Section 5: *The Plan Matrix*, Graylands Hospital beds and Selby Older Adult Unit beds are closing in three phases, as HITH beds are opened. The proposed new HITH beds can operate from various sites, which would be determined by demand. During stage 3, the majority of inpatient beds expansion would occur. Some inpatient beds can also replace the beds at Graylands Hospital during this period. Figure 15 below shows the closure of Graylands Hospital:

Figure 15: Staged closure of Graylands
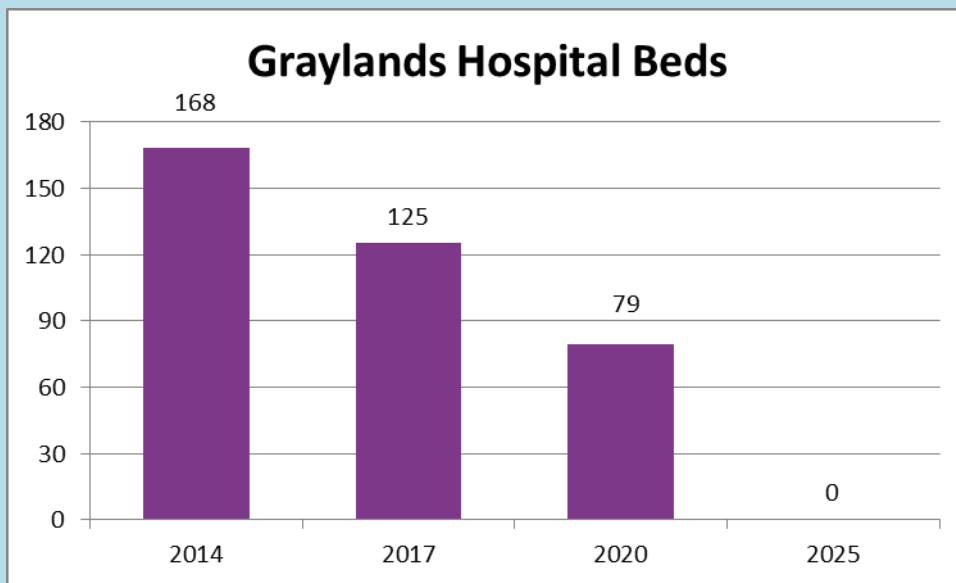
Between 2014 and 2017, it is planned that 34 beds close at Graylands Hospital with the expansion of HITH. There will also be a further closure of 9 beds at Graylands Hospital, which will be replaced with 9 youth beds at Midland Hospital.

Between 2017 and 2020, it is proposed that HITH expands by a further 46 beds, and the corresponding beds close at Graylands Hospital.

Between 2020 and 2025 it is proposed that HITH expands by a further 68 beds, and that youth, adult and older adult inpatient units across Western Australia grow by 110 beds. A combination of HITH and physical inpatient beds would be used to replace the beds at Graylands Hospital.

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10.5.4 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 telemedicine services to support smaller 'satellite' hospitals.

We will aim to progress the establishment of dedicated Mental Health Observation Areas (MHOA) 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.

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 ward. When applying this rationale in the Western Australian context, consideration has been given to hospitals that have a high rate of presentations in emergency departments (regardless of bed numbers in the hospital).

Consideration was also given to those hospitals which are the sole provider of speciality tertiary services such as the Perth Children's Hospital and King Edward Memorial Hospital. This may also apply to highly-populated rural areas where presentations are high but the number of beds may not fit the *National Mental Health Service Planning Framework* criteria.

10.5.5 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 for alcohol and other drugs 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 health issues

The Plan articulates that Next Step Inpatient Withdrawal Service needs to expand to provide supervised medical inpatient withdrawal for individuals across the State. Individuals who require residential withdrawal, but do not have the need for specialist medical support, would have access to co-located services and beds within existing residential rehabilitation services to promote smooth transition and continuing care.

10.5.6 Continue to commission a transport service for people requiring transfer under the Mental Health Act.

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

10.5.7 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.

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Readmissions to an acute specialised 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 2013-14, readmissions to acute public mental health inpatient facilities within Western Australia within 28 days of discharge was 13%.[44]

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.

10.6 Actions

The actions for the hospital based services are detailed below. For further information, particularly on the location of services, refer to Section 5: *The Plan Matrix*.

Implementing Existing Commitments:

10.6.1 Open 36 new and 100 replacement mental health inpatient services at:

- Perth Children Hospital - 20 bed acute mental health unit for children up to 16 years (6 new beds, and 14 replacement beds (6 Bentley Hospital, 8 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), 9 replacement beds from Graylands Hospital and 6 replacement beds from Sir Charles Gairdner Hospital (to become 15 youth beds); and

- Fiona Stanley Hospital - 30 bed acute mental health unit, including 8 new mother and baby (perinatal) beds, 14 new youth beds, and 8 new mental health assessment beds (short stay).

By the end of 2017, to prepare for the future we aim to:

10.6.2 commence the process of divestment of services on the Graylands and Selby hospital campuses;

10.6.3 convert the Bentley Adolescent Unit into a state-wide 14 bed subacute service for youth;

10.6.4 open 21 inpatient beds in Geraldton;

10.6.5 expand Mental Health Observation Areas across the State to deliver an additional 11 beds (Midland Hospital, Joondalup Health Campus, Perth Children's Hospital);

10.6.6 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;

10.6.7 increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 218,000 to 256,000 hours of service;

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10.6.8 increase capacity for Telehealth links (i.e. telepsychiatry and specialised services) into small hospitals in rural and remote regions; and

10.6.9 expand HITH beds to meet the target of approximately 5% of inpatient mental health beds to be delivered as HITH.

By the end of 2020, to rebalance the system there is a need to:

10.6.10 open new mental health inpatient units in Pilbara (16 beds);

10.6.11 expand the Next Step Inpatient Withdrawal Service, in the inner city area, to provide greater capacity for high medical withdrawal (increase from 17 to 28 beds);

10.6.12 expand the capacity of country hospitals by 14 beds across the Goldfields, Great Southern, Kimberley, Midwest and Pilbara to provide medically supervised alcohol and other drugs withdrawal;

10.6.13 increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 256,000 to 273,000 hours of service;

10.6.14 expand Mental Health Observation Areas across the State to deliver an additional eight beds (Royal Perth Hospital);

10.6.15 continue the closure of Graylands wards in a staged process as HITH and new hospital wards become operational across the State; and

10.6.16 expand HITH beds to meet the target of approximately 10% of inpatient mental health beds to be delivered as HITH.

By the end of 2025, to continue the reform, modelling identifies the requirement to:

10.6.17 expand Mental Health Observation Areas by an additional eight beds (Armadale Hospital, King Edward Memorial Hospital);

10.6.18 increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 273,000 to 290,000 hours of service;

10.6.19 continue the expansion of high medical withdrawal beds by 44 beds (South Metropolitan, Southwest and the Wheatbelt);

10.6.20 complete the closure of the existing Graylands facilities, with final transition from the site by 2025; and

10.6.21 expand HITH beds to meet the target of approximately 20% of inpatient mental health beds to be delivered as HITH.

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10.7 Summary of the Plan Matrix

State Total	Measure	Current	2017	2020	2025
Hospital Based Services	Beds (total)	696	782	856	1,090
	Hours ('000) (total)	218	256	273	290
MH Infant, Child and Adolescent	Beds	26	21	22	26
MH Youth Acute	Beds	0	32	36	78
MH Youth Subacute	Beds	0	14	15	17
MH Adult Acute	Beds	384	372	366	383
MH Adult Subacute	Beds	102	88	72	81
MH Older Adult Acute	Beds	144	84	77	74
MH Older Adult Subacute	Beds	0	62	65	108
MH HITH	Beds	12	70	116	183
Mental Health Observation Area (MHOA)	Beds	6	17	21	29
MH Private ^	Beds	231	231	231	231
AOD (High/Complex Medical Withdrawal)	Beds	22	22	66	110
AOD Private ^	Beds	19	19	19	19
MH/AOD Consultation Liaison	Hours ('000)	218	256	273	290

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11   SPECIALISED STATE-WIDE SERVICES

11.1 Overview

Specialised state-wide 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.

Specialised state-wide services include services for: eating disorders; neuropsychiatry and neurosciences; perinatal; Attention Deficit Hyperactivity Disorder (ADHD); co-occurring intellectual disability and Autism Spectrum Disorders; children in care; gender, sex and sexuality diverse people; Aboriginal people; culturally and linguistically diverse people; people who are hearing and vision impaired; and people who are homeless.

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

11.2 Aim

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

11.3 Current Services

Current community specialised state-wide services include transcultural mental health services; perinatal services; and homelessness services. Specific specialised state-wide 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 state-wide 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 8 dedicated specialised state-wide inpatient beds for mothers and babies (perinatal).

11.4 What the Modelling Tells Us

The modelling shows a requirement for eating disorder and perinatal inpatient beds to increase (see Figure 16). Dedicated eating disorder beds are required to grow by 44 beds over ten years. Perinatal beds are required to grow by 18 beds over the same period (from the current 8 beds at King Edward Memorial Hospital, to a total modelled need of 26 beds).

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Figure 16: Specialised state-wide services: dedicated inpatient beds
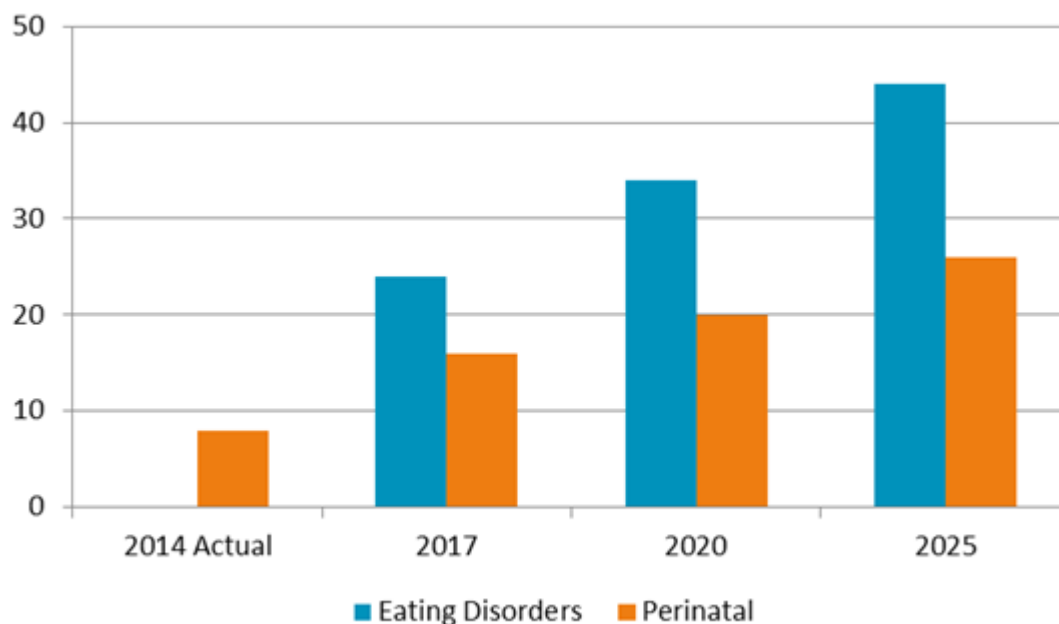
There is a need for dedicated beds for neuropsychiatry and neurosciences. This requirement can be met through a realignment of the existing bed stock, and are within the overall modelled inpatient beds estimated for 2025. There is also a requirement for expansion or establishment of specialised state-wide community treatment services which includes:

- Aboriginal Mental Health Services;

- Transcultural Services;

- Children in Care Program;

- Hearing and Vision Impaired;

- Homelessness Program;

- Eating Disorder Services;

- Perinatal Services;

- Neuropsychiatry and Neurosciences;

- Sexuality, Sex and Gender Diversity Service;

- Attention Deficit Hyperactivity Disorder (ADHD); and

- A Co-occurring Intellectual Disability and Autism Spectrum Disorders Service.

11.5 Strategies

11.5.1 Maintain and strengthen an appropriate Aboriginal mental health service.

The Aboriginal population represents 3.8%[45] of Western Australia's population. According to Australian Bureau of Statistics, Aboriginal and Torres Strait Islander people aged 18 years and over were two and a half times more likely than non-Indigenous people to have experienced high/very high levels of psychological distress.[46]

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Government's response to the findings of the Stokes Review included the expansion of the State-wide Specialist Aboriginal Mental Health Service (SSAMHS). SSAMHS increases the accessibility and responsiveness of mainstream public mental health services for Aboriginal and Torres Strait Islander peoples with severe and persistent mental illness. The SSAMHS model delivers whole-of-life mental health care, which involves the family and also engages traditional healers, identified by individuals and their families through community networks.

A further three years of investment in SSAMHS was included in the 2014-15 State Budget. The implementation of the next phase of the SSAMHS program will commence in 2014-15. The evaluation of the SSAMHS program is an early priority that will be progressed.

SSAMHS will have a fundamental role in ensuring compliance with particular provisions and requirements of the new Mental Health Bill that impact on Aboriginal people.

The Aboriginal community treatment hours of service are included in the total modelled community treatment hours of service (Section 8: *Community Treatment Services*).

> *"We need mental health treatment and support services specific to and appropriate for Aboriginal and Torres Strait Islander people."*
>
> *"The SSAMHS is a very good program because the Aboriginal staff do community development providing educational programs and makes connection to the community and they also have clinical roles which provide cultural safety for Aboriginal clients."* [29]

11.5.2 Further develop transcultural mental health services.

Western Australia's population includes 15% 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 expansion of the West Australian Transcultural Mental Health Centre. This service would increase 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.

Transcultural community treatment hours of service will be in addition to those modelled in the total modelled community treatment hours of service (Section 8: *Community Treatment Services*).

11.5.3 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 and neglect. 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

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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 Children in Care Program requires resources in addition to the total modelled community treatment hours of service (Section 8: *Community Treatment Services*).

11.5.4 Establish a Hearing and Vision Impaired service.

Individuals with hearing and vision impairment are recognised to experience mental health problems[48] 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.

The hearing and vision impaired service is modelled in the total modelled community treatment hours of service (Section 8: *Community Treatment Services*).

11.5.5 Expand specialised homelessness service capability.

As mentioned in Section 7: *Community Support Services*, research indicates that mental health, alcohol and other drug problems rank high in factors related to homelessness.[49] The Plan articulates that capacity to meet the needs of people who are homeless is an early priority 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 (Section 8: *Community Treatment Services*).

11.5.6 Enhance youth and adult eating disorders services.

Eating disorders are the 12th leading cause of mental health hospitalisation costs within Australia.[50] 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% of individuals treated for eating disorders in Western Australian public hospitals are aged 16 to 25.[51] The majority of these individuals access adult mental health services.

"We need more eating disorder services - particularly public inpatient beds, and a multidisciplinary team for adults with eating disorders and more clinical psychologists in the public specialist services."[29]

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.

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The modelling shows a requirement of 44 eating disorder beds by 2025. The eating disorder community treatment hours of service are included in the total modelled community treatment hours of service (Section 8: *Community Treatment Services*).

11.5.7 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) service that provides inpatient and outpatient services, as well as the new Fiona Stanley Hospital 8 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 26 perinatal inpatient beds by 2025. The perinatal community treatment hours of service are included in the total modelled community treatment hours of service (Section 8: *Community Treatment Services*).

11.5.8 Establish appropriate neuropsychiatry and neurosciences specialised services.

Specialised neuropsychiatric treatment services are limited in Western Australia. The Plan requires that a dedicated state-wide 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 state-wide community service. Neuropsychiatry and neurosciences inpatient beds are modelled in the total hospital bed numbers (Section 10: *Hospital Based Services*) and neuropsychiatry and neurosciences community treatment hours of service are included in the total modelled community treatment hours of service (Section 8: *Community Treatment Services*).

11.5.9 Establish a Sexuality, Sex and Gender Diversity Service[xii].

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

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[xii] National LGBTI 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

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infant, child and adolescent team, these teams offer services and support to people with gender identity issues (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.

The Sexuality, Sex and Gender Diversity Service requires resources in addition to the total modelled community treatment hours of service (Section 8: *Community Treatment Services*).

11.5.10 Expand access to publicly funded Attention Deficit and Hyperactivity Disorder (ADHD) 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 state-wide 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 (Section 8: *Community Treatment Services*).

11.5.11 Establish a specialised service to meet the needs of people with co-occurring mental illness and intellectual and developmental disability, including autism spectrum.

Children with intellectual disability have three to four times higher rates of mental illness compared to other children.[52] Some mental illnesses may present in a different way than in people without intellectual disability. The optimal mix includes a state-wide intellectual 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 state-wide service is modelled in the total modelled community treatment hours of service (Section 8: *Community Treatment Services*).

11.6 Actions

The actions for the specialised state-wide services are detailed below.

Implementing Existing Commitments:

11.6.1 continue the implementation of the Government's 2013 election commitment for Specialised Aboriginal Mental Health Services including specific strategies to enhance access for Aboriginal children and families.

By the end of 2017, to prepare for the future we aim to:

11.6.2 establish and continue to develop specialised state-wide inpatient services for:

- Eating Disorders (24 beds);
- Perinatal (8 beds); and
- Neuropsychiatry and Neurosciences disorders.[xiii]

[xiii] Bed number to be confirmed during business case development.

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11.6.3 commence establishment or enhancement of community based specialised state-wide services including:

- Transcultural services;
- Children in Care Program;
- Hearing and Vision Impaired service;
- Homelessness services;
- Eating Disorders service;
- Perinatal services;
- Neuropsychiatry and Neurosciences service;
- Sexuality, Sex and Gender Diverse service;
- ADHD service; and
- Co-occurring Mental Illness and Intellectual and Developmental Disability service.

By the end of 2020, to rebalance the system there is a need to:

11.6.4 continue to develop specialised state-wide inpatient services for:

- Eating Disorders (10 additional beds);
- Perinatal (4 additional beds); and
- Neuropsychiatry and Neurosciences disorders.[xiv]

By the end of 2025, to continue the reform, modelling identifies the requirement to:

11.6.5 continue to develop specialised state-wide inpatient services for:

- Eating Disorders (10 additional beds);
- Perinatal (6 additional beds); and
- Neuropsychiatry and Neurosciences disorders.[xv]

11.7 Summary of the Plan Matrix

State Total	Measure	Current	2017	2020	2025
Specialised State-wide Services (inpatient)	Beds (total)	8	40	54	70
Eating Disorders	Beds	0	24	34	44
Perinatal beds	Beds	8	16	20	26

[xiv] Bed number to be confirmed during business case development.

[xv] Bed number to be confirmed during business case development.

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12 FORENSIC SERVICES

12.1 Overview

Compared to the general community, the prevalence of mental disorders is higher at every stage of the criminal justice process, and individuals differ demographically, 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; and

- high rates of mental illness, problematic alcohol and other drug use, personality disorder, and cognitive impairment.

Internal modelling shows that approximately 65% of the juvenile and 59% of the adult prison population have mental health problems.[53]

There is a well-established association between experiencing a major mental illness, particularly a psychotic or severe mood disorder, and increased rates of violence and criminal offending. The serious mental illness of schizophrenia has a prevalence of approximately 1%, however, 10% of homicides are committed by people with serious mental illness.[54, 55, 56] It is of critical importance to note this evidence, as this explains the need for specialised services to treat those with serious mental illness that are at risk of committing violent offences.
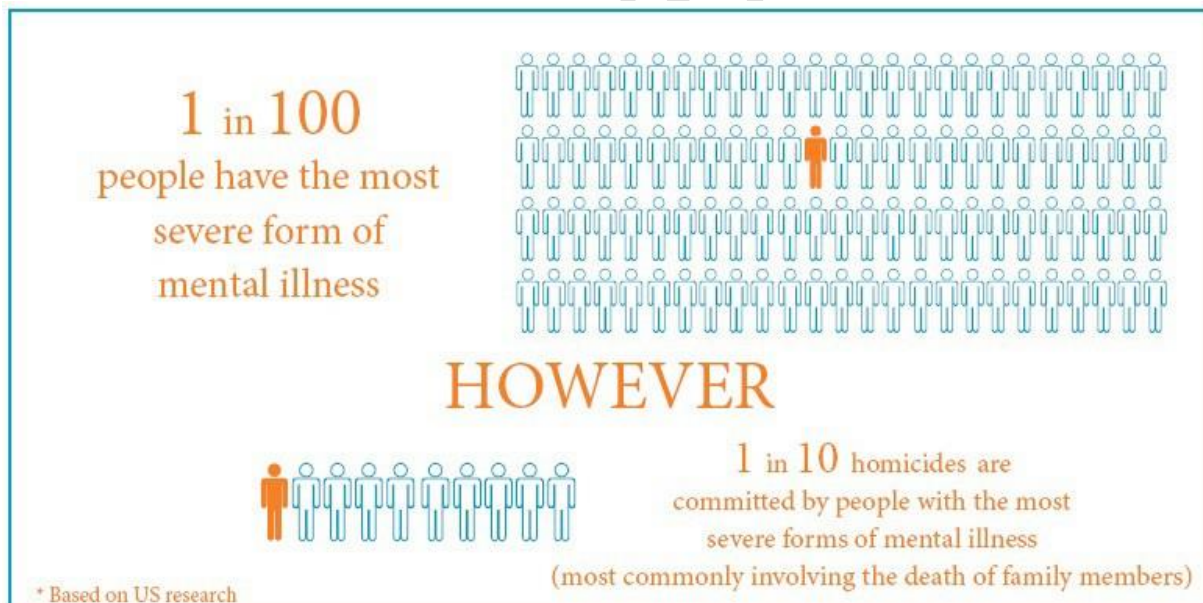
The guiding principle for the forensic services is that persons in contact with the criminal justice system should receive mental health, alcohol and other drug services equivalent to services available to individuals in the community, with due regard to community safety.

Intervening early, preventing imprisonment and hospitalisation, and decreasing the length of stay for those hospitalised can provide a cost benefit. This can reduce criminalisation and community incidents leading to arrests, allow forensic mental health authorities to divert individuals, and decrease their imprisonment time. One study has demonstrated that for every dollar spent on early intervention, a saving of $1.40 to $2.40 in Government cost is made.[57]

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Within the overall population there are some groups that require special consideration including women, Aboriginal people, young people, those with co-occurring alcohol and other drug problems, and individuals with intellectual and other cognitive disability. Another group that required Special consideration are the Mentally Impaired Accused. These are people found unfit to stand trial or are acquitted on the grounds of unsoundness of mind, but may still be detained on a custody order. They can be sent to an authorised hospital if they have a treatable mental illness. In most Australian states those with mental illness are all treated in secure forensic hospitals, however, in Western Australia many are detained in prison. The Attorney General is currently undertaking a review

of the *Criminal Law (Mentally Impaired Accused) Act 1996*, which may impact services for this group into the future.

The United Nations Standard Minimum Rules for the treatment of prisoners states unequivocally that prisoners found not guilty by reason of insanity should not be detained in prison. Very few custody orders are made in Western Australia compared with other states. Since 2008 there has been an average of three per year, and one unconditional release has occurred since then.[58, 59] In 2013, a total of 37 mentally impaired accused persons were on custody orders: 17 in prison; eight were in hospital; eight in the community; and four interstate. Twenty four of these mentally impaired accused persons had a diagnosis of mental illness; seven had intellectual impairment; and six had a dual diagnosis of a combined intellectual impairment and mental illness.[60]

12.2 Aim

Build a comprehensive, responsive, effective and efficient forensic service system that will prevent and reduce the impacts of mental illness, and alcohol and other drugs on offending individuals whilst providing increased safety for Department of Corrective Services, prison staff and the general community.

12.3 Current services

The Frankland Centre at Graylands Hospital was commissioned in 1993 with 30 acute inpatient beds, to cater for forensic services. In 1995, a further 8 subacute inpatient beds were commissioned at Graylands Hospital, with daily prison muster numbers reflecting 2,197 in the same year.[61] 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 1).

Table 1: Forensic services: beds and daily average prison muster numbers[62]

	1995	1998	2003	2008	2013
Forensic Beds	38	38	38	38	38
Prison Muster	2,197	2,388	2,915	3,824	4,956

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Currently, there are no dedicated services for women or young people in the forensic services system. Currently, women and youth 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.

In Western Australia, there are currently no declared places for people with cognitive disability who are found unfit to plead under the *Criminal Law (Mentally Impaired Accused) Act 1996.* Currently people may be detained indefinitely in prison. There is a justice centre with ten beds being built in Caversham by the Disability Services Commission. This centre is for people who have intellectual or cognitive disability and who have been charged with an offence but, due to their disability, are unable to understand the court process sufficiently to enter a plea. The state-of-the-art secure centre in Caversham will provide the declared place option, advancing social and legal justice for some of the most vulnerable people in our community.[63]

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 alcohol and other drugs.

The establishment of a pilot mental health court diversion program, one for children and young people, and another for adults is a positive direction in intervening early. The evaluation of the Mental Health Court Diversion pilot will inform future expansion.

12.4 What the Modelling Tells Us

Mental health, alcohol and other drug forensic services include:

- **Forensic mental health acute inpatient beds:** these beds are authorised to provide secure mental health care for patients 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.

- **Forensic mental health subacute inpatient beds:** forensic subacute 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.

- **Forensic mental health community services:** these services provide acute and recovery focussed forensic mental health services delivered in the communities in which people live, including specialist assessment and evidence-based treatments, for people involved in the criminal justice system with a mental illness. This includes treatments for patients who are out of prison and out of hospital on special orders within the community.

- **Forensic alcohol and other drug community services (diversion)**: alcohol and other drug community services provide the Western Australian Diversion Program (WADP). The WADP aims 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. There are two categories for diversion:

  - Police drug diversion – this has an early intervention focus by providing access to education and treatment services; and

  - Court diversion - these programs are voluntary and pre-sentence and offer the opportunity to engage in treatment programs prior to sentencing.

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- **In-prison mental health, alcohol and other drug services**: staff provide assessment, planning treatment and evaluation for people in a custodial environment with co-occurring mental illness and/or alcohol and other drug problems and offending behaviours. Staff also provides group work and administer the Methadone Maintenance Treatment Program. Staff, where possible, ensure that clients are linked with community follow-up on release from prison.

The current number of forensic beds in the State are half what they should be in order to meet demand in 2014. Figure 17 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 8 subacute, to 62 acute and 30 subacute, by 2025.

Figure 17: Forensic services: beds
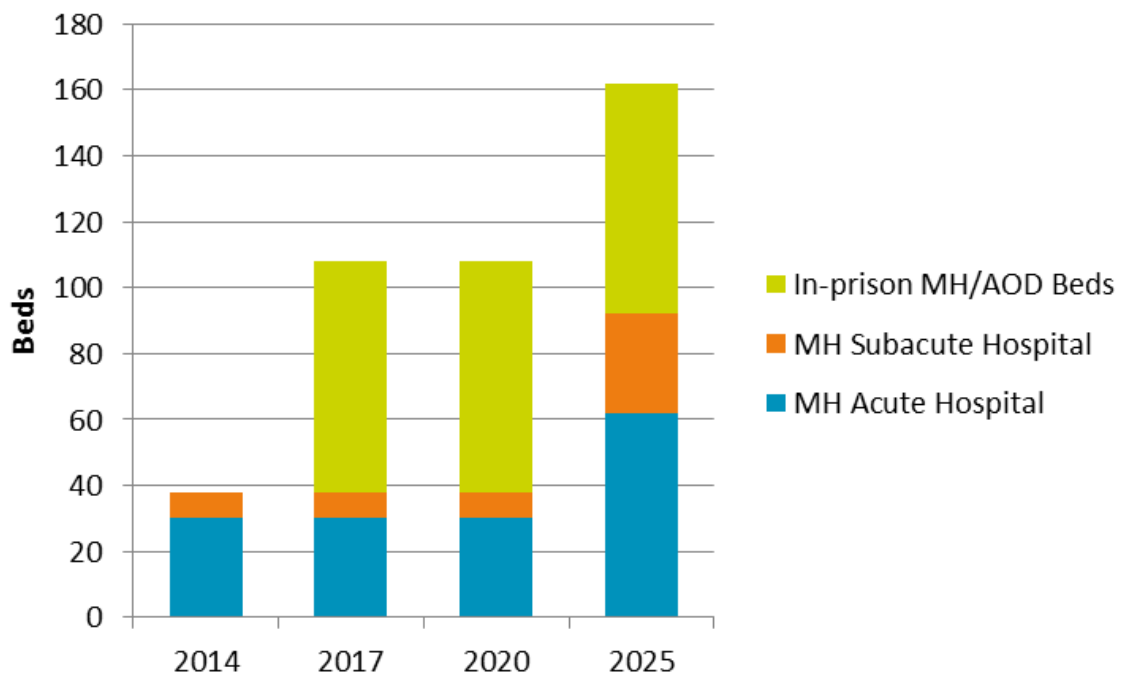
Forensic services need to be provided in a range of different settings including a dedicated forensic mental health facility on a prison site (but not necessarily in the prison which will replace the forensic inpatient beds at Graylands Hospital), beds and services in prisons, and services based in the community.

Figure 18 outlines the hours of service required to establish a comprehensive forensic service system. In relation to community services, the hours of service for alcohol and other drugs is required to grow from 49,000 hours to 163,000 hours, whereas the mental health community hours are required to grow from 33,000 to 140,000 hours, by 2025.

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Figure 18: Forensic services: hours of service
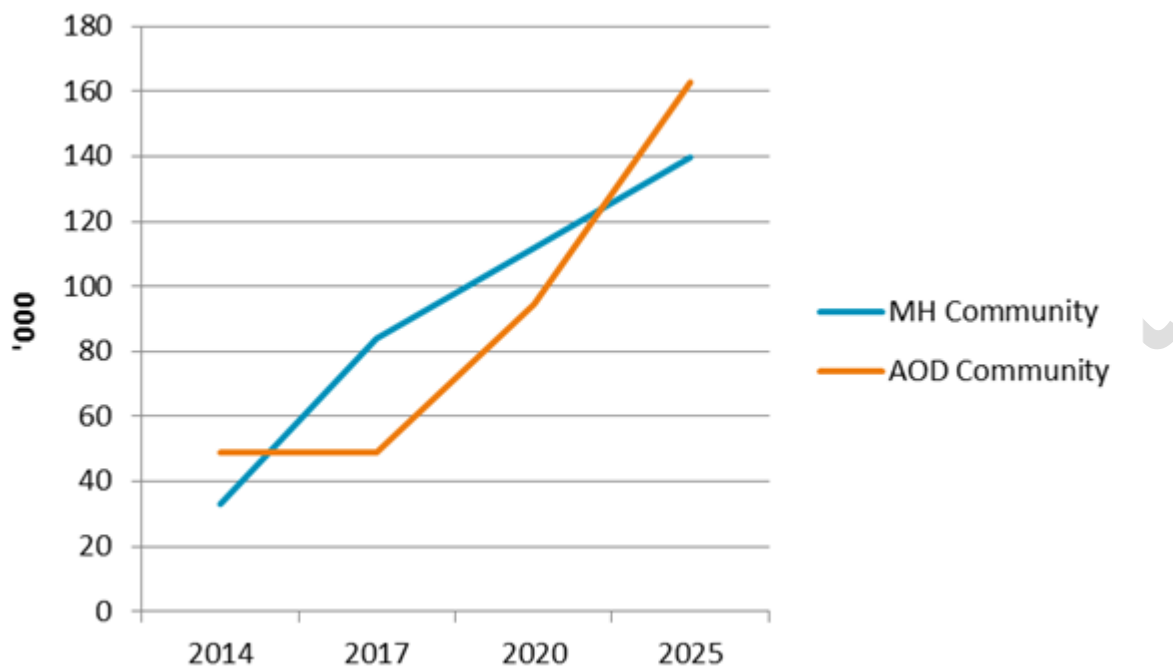
12.5 Strategies

12.5.1 Boost early identification and targeted prevention programs targeting offenders at risk of becoming involved in the criminal justice system.

Prevention and early intervention programs are essential to reduce the risk of individuals ending up 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-up, and other services where required. A mental health Police co-response program is discussed in further detail in Section 8: *Community Treatment Services*. Continued expansion of mental health, alcohol and other drug court diversion and liaison programs is also important.

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 need to be undertaken with CALD communities to improve access to diversion programs.

12.5.2 Establish youth forensic services.

Youth forensic services are a high priority, in particular early intervention programs, specialised assessment, liaison with mainstream services, in-reach to children in detention, community forensic mental health services, forensic bed based services, in-reach to juvenile detention centres, community correction programs, and transition care (between the detention centre and community). The provision of youth forensic best practice interventions provides the best chance of reducing future contact with the justice system in adulthood. We aim to progress these priorities in partnership with the Department of Corrective Services.

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12.5.3 Significantly increase the provision of contemporary services for people in the Justice system, including in-prison.

As previously mentioned, 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. With this in mind, an increase in contemporary in-prison services is urgently required, including in-prison mental health, alcohol and other drug beds. The models of service for all in-prison services would be developed in partnership with the Department of Corrective Services. A problem behaviour clinic and programs targeting sex offenders, violent extremism, arson, and stalking are also required. Further work to progress in-prison subacute services (including for women and young people) will be undertaken as an early priority.

It is imperative that these priorities are progressed in partnership with the Department of Corrective Services.

12.5.4 Expand forensic hospital services to meet the needs of the growing population.

Modelling suggests a significant increase in hospital forensic services is urgently required. In particular, this includes a 92 bed secure forensic hospital containing dedicated youth, women and Aboriginal units. Of this, 62 beds will be acute and 30 beds will be subacute. Over the next ten years we aim to develop this 92 bed inpatient service, which would replace the current 38 beds at Graylands Hospital. Services will need to be established before the phased closure of the forensic beds at Graylands Hospital. Detailed transition planning will occur to ensure costs of dual site operations are at a minimum.

12.5.5 Establish appropriate transition services for individuals transitioning from prison to the community.

Ensuring effective transition services are in place prior to an individual leaving prison is important for future outcomes. The first six months post prison release is a particularly vulnerable period of transition. Services such as community treatment services are required to be enhanced to provide individuals with the best opportunity to re-integrate successfully into the community. It is important that this is progressed in partnership with the Department of Corrective Services and the Department of Health.

12.6 Actions

The actions regarding forensic services are detailed below. For further information please refer to Section 5: *The Plan Matrix*.

Implementing Existing Commitments:

12.6.1   progress the Government's 2013 election commitment to deliver mental health adult and children court diversion; and

12.6.2   complete the evaluation of the Mental Health Court Diversion program.

By the end of 2017, to prepare for the future we aim to:

12.6.3   commence development of a 70 bed in-prison dedicated mental health, alcohol and other drug service for men and women;

12.6.4   further develop in-prison mental health, alcohol and other drug treatment and support services for men, women and youth;

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12.6.5   work with the Department of Corrective Services to develop models of service for in-prison treatment and support services;

12.6.6   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, case management, and transition services for people moving from prison to community; and

12.6.7   complete the planning of a 92 bed secure forensic unit, to replace the forensic beds at Graylands Hospital (including specific units/places for women and youth and Mentally Impaired Accused).

By the end of 2020, to rebalance the system there is a need to:

12.6.8   continue to develop in-prison mental health, alcohol and other drug treatment and support services for men, women and youth;

12.6.9   increase mental health community forensic treatment services from 84,000 to 112,000 hours of service;

12.6.10   expand the Mental Health Court Diversion and Liaison program subject to the outcomes of the current evaluation; and

12.6.11   expand alcohol and other drug diversion (community) services from 49,000 to 94,000 hours of service.

By the end of 2025, to continue the reform, modelling identifies the requirement to:

12.6.12   open a 92 bed secure forensic inpatient service with 62 acute and 30 subacute beds, including units for women, young people and Mentally Impaired Accused;

12.6.13   establish a specialised forensic community based clinic and programs for people with problem behaviours, targeting sex offenders, violent extremism, arson, and stalking;

12.6.14   further expand alcohol and other drug diversion (community) services from 94,000 to 163,000 hours of service; and

12.6.15   increase community based forensic mental health services from 112,000 to 140,000 hours of service.

EXHIBIT 315   COI.017.0001.0073

12.7 Summary of the Plan Matrix

State Total	Measure	Current	2017	2020	2025
Forensic Services	Beds (total)	38	38	38	92
	Hours ('000) (total)	82	133	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)	49	49	94	163
Forensic Services (in-prison)	Beds (total)	0	70	70	70
In-prison MH/AOD beds	Beds	0	70	70	70

EXHIBIT 315   COI.017.0001.0074

13 SYSTEM IMPROVEMENT AND SUPPORTING CHANGE

13.1 Overview

Significant system improvements and new initiatives are required to be progressed to support the achievement of our vision and aims. The need to improve how services are delivered within the mental health, alcohol and other drug system were highlighted in the Stokes Review and progress is currently being made on the implementation of relevant recommendations.

This section of the Plan outlines in greater detail what system improvements and 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 in the mental health sector and supporting **consumer's voice**.

- Encouraging **culturally competent** service development and delivery.

- Developing a **youth mental health stream of services** through the reconfiguration of existing services and commissioning of new youth specific services.

- Continuing the work already underway to improve service responsiveness for people with **co-occurring mental health, alcohol and other drug problems** and promoting trauma informed practice to better respond to those impacted by trauma.

- Improving **integration and system navigation**.

- Continuing the work already underway to improve **organisational effectiveness and efficiency** through improved safety and quality, benchmarking, system design, models of service, and by the increased use of performance measures, documentation and data collection.

- **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**.

13.2 Aim

Implement a range of system-wide improvements and new initiatives to support the transformation of the mental health, alcohol and other drug service system.

13.3 Recovery oriented practice and supporting the consumer voice

We are committed to personal recovery in the area of mental health and supporting consumer's voice across the mental health, alcohol and other drug sector. The principles of the National Mental Health Recovery Framework[xvi] are embedded in the Plan and it is

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[xvi] The national framework for recovery-oriented mental health services provides a vital new policy direction to enhance and improve mental health service delivery in Australia. It brings together a range of recovery-oriented approaches developed in Australia's states and territories and draws on national and international research to provide a national understanding and consistent approach to recovery-oriented mental health practice and

EXHIBIT 315   COI.017.0001.0075

recognised that recovery outcomes are personal and unique for each individual. The development of the future system need 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; and

- consumers to become advocates such as through participation in working groups, forums, advisory councils, boards; and in the development of new policies, programs, initiatives and legislation.

Recovery oriented practice and continued consumer involvement can be achieved across the entire service system through the promotion of leadership development, design of service models and associated practices, procedures, protocols, and commissioning practices that are consistent with the above dot points. The changes place individuals at the centre of service planning, provision, review, and would deliver consistent high quality care reflecting national standards and frameworks.

13.4 Culturally competent service development and delivery

In Western Australia, Aboriginal people are hospitalised six times more often than non-Aboriginal people for alcohol related causes,[64] and 2.5 times more often for illicit drugs.[65] According to Australian Bureau of Statistics, Aboriginal and Torres Strait Islander people aged 18 years and over were two and a half times more likely than non-Indigenous people to have experienced high/very high levels of psychological distress.[66] This demands that mental health, alcohol and other drug services understand the role of culture, and are responsive to cultural requirements of Aboriginal people.

Strategies to improve access to services include specific models of service that enable family and trusted members of the community to accompany individuals throughout their treatment. Understanding the holistic, whole-of-life view of mental health adopted by Aboriginal people and recognising their complex and culturally entwined needs is essential. Engaging with Aboriginal leaders would support service providers in understanding the ways in which traditional healers and mainstream health professionals can work in complementary ways.

Traditional Aboriginal and Torres Strait Islander Healers

The role of traditional healers is recognised in the Mental Health Bill 2013 (the Bill). The Bill defines a traditional healer as, in relation to an Aboriginal or Torres Strait Islander person, a person of Aboriginal or Torres Strait Islander descent who uses traditional (including spiritual) methods of healing, and is recognised by the community as a traditional healer. The Bill requires assessment and examination of a person of Aboriginal or Torres Strait Islander descent to be conducted in collaboration with Aboriginal or Torres Strait Islander 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.

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service delivery. It complements existing professional standards and competency frameworks at a national and state level.

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The State-wide Specialist Aboriginal Mental Health Service provides for clinical responses that facilitate access to Traditional Healers in particular cases where culture and traditional beliefs may be relevant to the recovery of the person and support of their carer and extended family.

The Department of Health's Aboriginal Mental Health Model of Care 2013[67] outlines the following when engaging Traditional Healers:

- it must be initiated by the Aboriginal person and/or their family;

- the healer must be endorsed by an appropriate local Aboriginal Elder; and

- the Aboriginal Mental Health Worker and the family take care of the arrangements for healing and it is not appropriate for non-Aboriginal staff to be involved in the process.

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. CALD individuals may have also experienced a range of stressors including trauma and discrimination.

Mental health, alcohol and other drug services need to be aware of these stressors, and provide culturally competent services. 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 Aboriginal and CALD workforce.

13.5 Youth-specific mental health services

Youth (15-24 years) experience the highest prevalence and incidence for mental illness across the lifespan.[68] Young people with co-occurring mental and 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.[69]

The development of youth-specific mental health services across all service streams is one of our highest and most 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 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.

More than 80% of those surveyed indicated that youth mental health services are not sufficient to meet demand.

"There is a crying need for more early intervention services for young children and adolescents at risk of developing serious mental health issues as a result of early deprivation, abuse, neglect and poor parental care and inadequate environments."

"This is often the time when mental health issues surface. This is where services should target more."[29]

The Government recently announced the establishment of a 14 bed youth mental health inpatient unit in the new Fiona Stanley Hospital (FSH). This unit will also accept young people with an eating disorder.

Youth services have been referred to in various parts of the Plan: Section 8: *Community Treatment Services*, Section 9: *Community Bed Based Services*, Section 10: *Hospital Based Services*, Section 11: *Specialised State-wide Services*, and Section 12: *Forensic Services*.

EXHIBIT 315   COI.017.0001.0077

Young people and their families would be involved in planning the development or establishment of services. It is imperative that all dedicated youth services coordinate referral pathways and information sharing with primary care, including *headspaces*; infant, children's and adolescent mental health services; and the Drug and Alcohol Youth Service.

13.6 Responding effectively to co-occurring problems

13.6.1 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 deliver better patient outcomes if services supported people with both conditions holistically. The amalgamation of the Mental Health Commission and the Drug and Alcohol Office will assist collaboration and integration of services and planning.

People with co-occurring mental health, alcohol and other drug problems require access to services that provide integrated, seamless support. There is a requirement for workers who are specialised in co-occurring mental health, alcohol and other drug treatments to provide expert consultancy and support to mainstream services. Hospital based consultation and liaison services have been modelled and are included in Section 10: *Hospital Based Services*.

Commissioning and/or the provision of community treatment will require services to provide integrated treatment for mental health, alcohol and other drug problems rather than expecting people to access support separately from each sector. This may involve the transfer of mental health workers into alcohol and other drug services, and vice versa.

13.6.2 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 and people who have experienced child sexual abuse. There are over four million survivors of childhood trauma in Australia. Abuse and trauma history has been reported by 90% of people who use public mental health services.[70]

Trauma informed practice recognises that the individual's past trauma experiences affect their perspectives and responses in the present. 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.[71]

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.[72]

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.

EXHIBIT 315   COI.017.0001.0078

13.7 System Integration and Navigation

It is essential that health services work together across primary, community, secondary, private and public sectors in a multifaceted approach, with efforts to improve access, treatment and support from all sectors. Good system navigation is essential and is critical to ensuring that people do not fall through service gaps. This will allow individuals to transition smoothly between hospitals, community, prison, youth, adult, and older adult services. System integration and navigation are described below, including actions to address these areas.

13.7.1 System integration

System integration ensures service delivery is comprehensive, cohesive, accessible, responsive, and optimises the use of limited resources. Services and supports need to be provided in a seamless way across service, program, organisation, and agency boundaries. As an individual's severity of illness increases and decreases, their care needs change (see Figure 19). An effective and integrated system is essential to ensure individuals do not fall through the gaps across the service continuum, and that each individual receives the appropriate level of care for their needs.

Figure 19 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% of the population will experience mental illness and 2.7% of people will experience alcohol and other drug related problems, with different levels of severity and distress.[73, 74]

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 mental illness will require access to specialised community services (e.g. community support, community treatment, and community beds) and/or inpatient services.

It is considered people with alcohol and other drug problems (mild, moderate and severe) are seen in publicly funded services, with few seeking treatment in primary care services. For more information, refer to Appendix D.

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Figure 19: Optimal service mix and severity continuum[75, 76xvii]
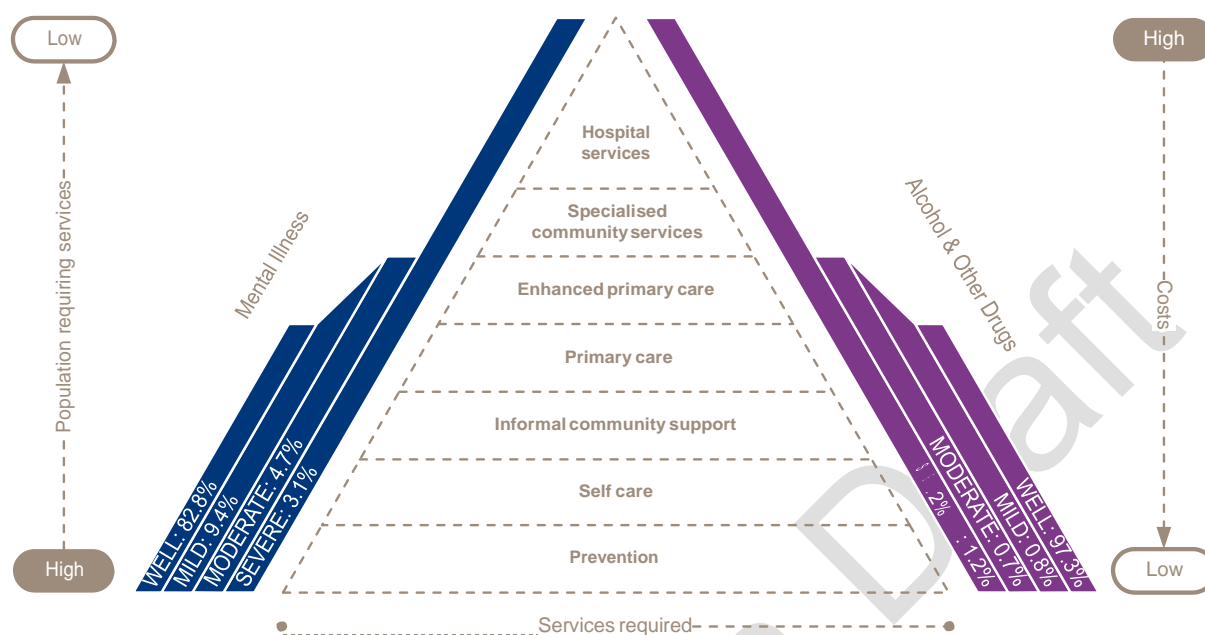
While there are some excellent examples of collaborative or integrated work occurring in the mental health, alcohol and other drug sectors, there is more often limited joint planning between services. In developing an integrated system, it is important to recognise and build upon existing services and 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 and integrated from the perspective of the person accessing the service. Critical to the success of working in shared ways are:

- clarity about shared roles and responsibilities;

- making available nominated people that assist people to navigate the system of services;

- 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; and

- 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.

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xvii Adapted from the World Health Organisation service organisation pyramid for an optimal mix of services for mental health (2007)

EXHIBIT 315   COI.017.0001.0080

13.7.2 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. Models of service outline what a particular service type should offer (based on best practice), how the service should be configured, roles and responsibilities of staff, consumers and carers. When implemented, will positively impact organisational effectiveness, efficiency and every individual's experience of services.

It is essential that the Mental Health Commission continue to work with key partners 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 state-wide services, and forensic services.

Further, working in partnership with the new Mental Health Network, the Chief Psychiatrist, the Department of Health, clinicians, consumers and carers is key. 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 Bill 2013.

Ultimately, models of service would be centred on a personal recovery approach to service delivery in the mental health sector. Where relevant, models of service would include how the improvement of the physical health of consumers can be supported through initiatives such as: establishing linkages to relevant physical health services (e.g. GPs); delivering health promotion interventions; requirements to support people with co-occurring problems (including mental health, alcohol and other drug use problems); and how carers and family members can be involved in treatment and support provision.

13.7.3 System integration actions

Implementing Existing Commitments:

13.7.3.1 implement the provisions of the Mental Health Bill 2013 and monitor the extent of improved integration of care.

By the end of 2017, to prepare for the future we aim to:

13.7.3.2 develop comprehensive models of service for all major services and commission services based on agreed models of service;

13.7.3.3 require commissioned services to develop coordination strategies to assist people to transition more effectively between services, programs and regions, particularly for people transitioning between services; and

13.7.3.4 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:

13.7.3.5 work with stakeholders including the private sector, non-government organisations, and primary care to improve communication, information flow, linkages, and coordination to facilitate earlier identification and improved referral and treatment.

By the end of 2025, to continue the reform, modelling identifies the requirement to:

13.7.3.6 continue to monitor service integration and progress improvements as necessary.

EXHIBIT 315   COI.017.0001.0081

13.7.4 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 are proven to aid individuals in navigating the system. A list of actions follows, which demonstrate how system navigation can be improved over the next ten years.

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; and

- 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. It is important to provide consideration as to how an integrated mental health, alcohol and other drug helpline can be established.

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 Western Australian Network of Alcohol and Other Drug Agencies (WANADA) and 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 smart phone 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 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 dependable when utilised. 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.

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 services they need). Often, peer workers share lived experiences with the participants, and have been shown to reduce hospital readmission and increase discharge rates.[77, 78]

EXHIBIT 315   COI.017.0001.0082

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.[79, 80]

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.

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 assists 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 existing coordination programs (e.g. Partners in Recovery). Key functions would include:

- *Individual Coordination*: facilitating access to supports and services, and supporting 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 and within community (government, private and community funded sector) to enhance outcomes for individuals; and

- *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.

13.7.5 System navigation actions

By the end of 2017, to prepare for the future we aim to:

13.7.5.1   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);

EXHIBIT 315   COI.017.0001.0083

13.7.5.2 develop resources for consumers, families, and carers including handbooks, web based, and telephone consultations with trained coaches and counsellors. This may include information regarding accessing insurance and benefits, and other information regarding navigating the system;

13.7.5.3 establish online system navigation resources to provide an easy "how-to" guide for individuals or family members seeking mental health, alcohol and other drug service assistance;

13.7.5.4 expand services for family and carers through information, support, education and skill development opportunities;

13.7.5.5 standardise, establish and monitor key performance indicators for follow-up and other communication post-discharge;

13.7.5.6 establish protocols for informing consumers, carers, families and General Practitioners (upon discharge) as to treatment plans and how to re-access services if required;

13.7.5.7 develop communication protocols for accessing patient records and treatment plans, other communication and reporting between non-government organisations, public, and private sectors, and across community, primary, secondary and tertiary services; and

13.7.5.8 establish a clear directory of services, referral pathways and system navigation support/tools to ensure access to services occurs at the earliest point of contact is streamlined and seamless for individuals, families, carers and service providers.

By the end of 2020, to rebalance the system there is a need to:

13.7.5.9 finalise an evaluation of the pilot community coordination program and expand its reach to areas of greatest need.

By the end of 2025, to continue the reform, modelling identifies the requirement to:

13.7.5.10 further progress a state-wide implementation of the community coordination program.

13.8 Organisational effectiveness and efficiency

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

- safety and quality assurance mechanisms;

- 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; and

- the use of standardised documentation (both non-electronic and electronic) across the system to improve efficiency and access to key information.

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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.
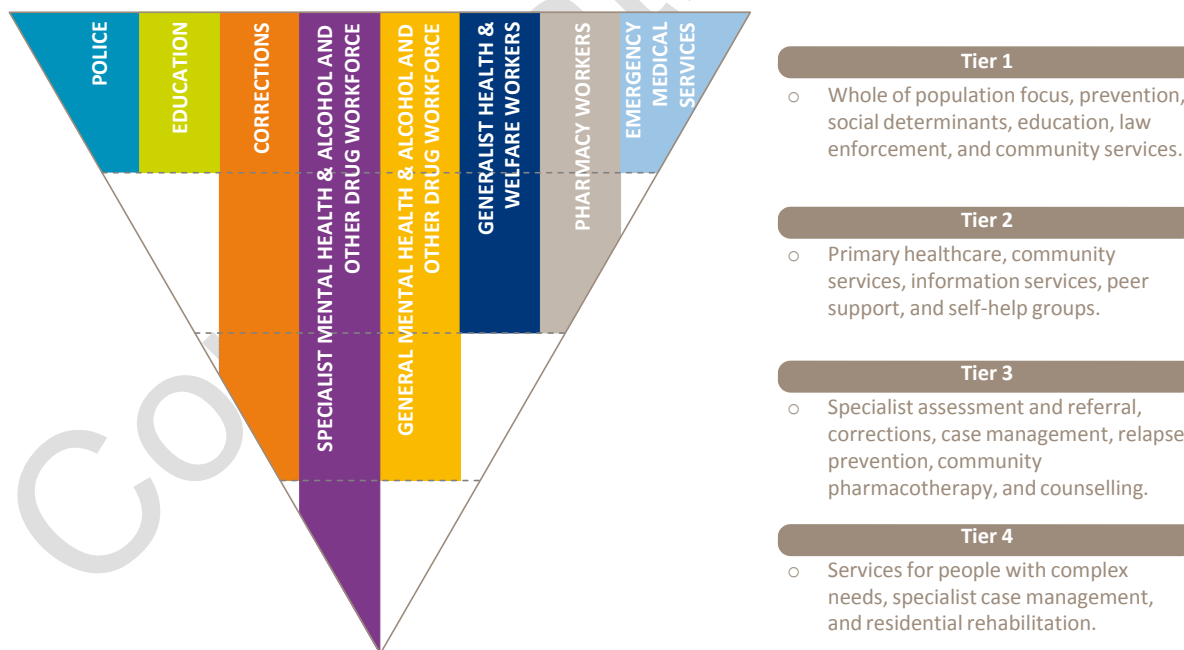
13.9 Workforce

As actions outlined in the Plan are implemented, over the next ten years there would be emerging new work roles in the mental health, alcohol and other drug workforce. Along with new roles comes the need for a greater focus on core competencies and increased service standards to reflect new, more flexible and responsive ways of providing services.

13.9.1 Build capacity across the specialist workforce.

A specifically qualified workforce is essential to provide services across the mental health, alcohol and other drug system. Increases in workforce numbers and improvements in the capabilities of the workforce are essential. It is important that this is supported by the establishment of substantive work roles and career pathways. A key element of this change would result in a workforce that has greater capacity to manage co-occurring mental health, alcohol and other drug problems.

Figure 20 identifies the levels of involvement various services would need to have in mental health, alcohol and other drug service delivery in the optimal mix of services. It also depicts the specificity of workforce capabilities across the whole health service delivery spectrum.

Figure 20: Tiered workforce capacity across the system for mental health, alcohol and other drug problems.

An efficient system requires all services in Tier 1 to have the knowledge and skills to screen for mental health, alcohol and other drug problems and refer to specialist services for assessment and treatment where needed. Tier 2 workforces should receive mandatory training on Mental Health First Aid. Tier 3 workers are competent in the provision of psychiatric treatment, and alcohol and other drug specific interventions. Tier 4 worker have

EXHIBIT 315   COI.017.0001.0085

the capacity to provide specialist mental health, alcohol and other drug services including recovery programs.

13.9.2 Increase the peer workforce.

A qualified peer workforce is essential for increasing and rebalancing the workforce requirement. The employment of peer workers is supported at both the national and state level. Accredited training for consumer and carer peer workers is under development. In mid-2012, a Certificate IV qualification for mental health peer work was formally endorsed within the Australian Qualifications Framework.[81] This will open up further training opportunities for consumers and carers who are interested in working as peers.

In future, it is envisaged that the commissioning of services would require incorporation of peer workforce positions, and assistance provided to review how peer workers can be introduced using existing resources. When employing peer workers, services would need to ensure a minimum of two peer workers are employed within the service to decrease the risk of isolation.

13.9.3 Increase community coordination.

The role of community coordinators is described in point 13.7.9. A suitably qualified workforce is required to deliver this program. It is envisaged this approach to service delivery will also expand in the future. Ensuring there is a workforce that is skilled to undertake community coordination tasks is key, and in some cases, community coordination roles could be filled by suitably qualified peer workers.

13.9.4 Increase the Aboriginal workforce

Cultural competency can be enhanced through robust and consistent training and education programs, and through the development of a skilled Aboriginal workforce. It can further be achieved by building on existing workforce strategies, such as the Strong Spirit Strong Mind[82] cultural awareness training and Certificate III and IV Aboriginal Alcohol and Other Drug Worker training program.

13.9.5 Actions

By the end of 2017, to prepare for the future we aim to:

13.9.5.1   Develop and implement workforce strategies which:

- are aligned with the Western Australian Public Sector Commission's Aboriginal Employment Strategy 2011–2015. This will ensure services offered respectfully combine the cultural rights and values of Aboriginal people;

- work with employing stakeholders (such as the Department of Health, the private sector, and non-government organisations) to increase the peer workforce and establish a career path for peer workers based on certification, experience and training;

- improve access to skilled staff across the system;

- make available adequate education and training for staff to build and sustain the principles of recovery in mental health service delivery, including the wider community;

- increase the workforce capacity to address physical health needs, and co-occurring mental health, alcohol and other drug problems; and

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- • implement a skilled migration strategy to attract staff in key areas of local undersupply.

13.9.5.2 develop partnerships with the tertiary education sector to increase mental health, alcohol and other drug information in core curricula in undergraduate courses including allied health, nursing, welfare, justice and police; and

13.9.5.3 strengthen specialist advanced training programs for staff in emergency departments and community based professionals including General Practitioners, specialist psychiatrists, nurses, and nurse practitioners.

By the end of 2020, to rebalance the system there is a need to:

13.9.5.4 further improve access to skilled staff across the system.

By the end of 2025, to continue the reform, modelling identifies the requirement to:

13.9.5.5 evaluate the effectiveness of the workforce strategies, reformulate as necessary based on updated modelling and gap analysis and inform Government of future requirements.

13.10 Information and Communication Technology (ICT)

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; and

- • improving intra and interdisciplinary communication within and between services.

There are two core components in relation to Information and Communications Technology:

13.10.1 Managing information across the system.

A centralised approach to information that translates across all care streams and all service providers. ICT (eHealth) 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; and

- • embrace innovation and standards.

13.10.2 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;

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- accessible diagnostic/assessment and consultation/treatment services including telepsychiatry, regardless of geographical location, including rural and remote regions; and

- individuals, support networks and clinicians having control and choices of when, where and how services are delivered – complementing rather than replacing traditional service delivery mechanisms.

13.10.3   Actions

By the end of 2017, to prepare for the future we aim to:

13.10.3.1   Develop a 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 services;

- implementation of innovative eHealth and telehealth for specialised mental health, alcohol and other drug services across rural and regional Western Australia; and

- the implementation of information sharing protocols across the sector.

By the end of 2020, to rebalance the system there is a need to:

13.10.3.2   Commission an effective ICT system across the mental health system.

By the end of 2025, to continue the reform, modelling identifies the requirement to:

13.10.3.3   Implement an ongoing program of ICT maintenance and enhancement, in line with the long term strategy.

13.11 Capital Infrastructure

The optimal place to provide services is close to home so that individuals can maintain connection with family, friends, carers, 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:

- QEII Mental Health Unit;

- Fiona Stanley Hospital;

- Midland Hospital; and

- Perth Children's Hospital.

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.

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The expansion in regions refers to both community and hospital services (as shown in Section 5: *The Plan Matrix*).

Further consultation, research, market evaluation and business cases will be developed over the next ten years for Government decision.

EXHIBIT 315

COI.017.0001.0089

14 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 300%. Ultimately, bed numbers are required to double over the ten years, with the majority being community based beds.

Table 2: 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)	4,006	9,298	11,598	7,592
Beds	1,400	2,370	2,949	1,549

This Plan provides us with a roadmap for the change, development and growth of Western Australia's mental health, alcohol and other drug system over the next ten years. 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.

The Plan articulates the requirements and optimal service mix in 2025. It is acknowledged we cannot implement all changes in the short term; hence actions are phased up until 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 across 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.

EXHIBIT 315   COI.017.0001.0090

APPENDIX A

SUMMARY OF ACTIONS

Implementing Existing Commitments:

Prevention and Promotion

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. Evaluate the Individualised Community Living Strategy and implement improvements.

Community Bed Based Services

4. Open new community bed based services approved by Government:

    -   Rockingham (Peel - 10 beds);

    -   Broome (Kimberley - 6 beds);

    -   Kalgoorlie/Boulder (Goldfields - 6 beds);

    -   Karratha (Pilbara – 6 beds); and

    -   Bunbury (South West – 10 beds).

Hospital Based Services

5. Open 36 new and 100 replacement mental health inpatient services at:

    -   Perth Children Hospital - 20 bed acute mental health unit for children up to 16 years (6 new beds, and 14 replacement beds (6 Bentley Hospital, 8 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), 9 replacement beds from Graylands Hospital and 6 replacement beds from Sir Charles Gairdner Hospital (to become 15 youth beds); and

    -   Fiona Stanley Hospital - 30 bed acute mental health unit, including 8 new mother and baby (perinatal) beds, 14 new youth beds, and 8 new mental health assessment beds (short stay).

Specialised State-wide Services

6. Continue the implementation of the Government's 2013 election commitment for Specialised Aboriginal Mental Health Services including specific strategies to enhance access for Aboriginal children and families.

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Forensic Services

7. Progress the Government's 2013 election commitment to deliver mental health adult and children court diversion.

8. Complete the evaluation of the Mental Health Court Diversion program.

System Integration

9. Implement the provisions of the Mental Health Bill 2013 and monitor the extent of improved integration of care.

By the end of 2017, to prepare for the future we aim to:

Prevention and Promotion

10. Increase the proportion of the Mental Health Commission budget spent on prevention and promotion from 1% to 2% and increase the hours of service dedicated to alcohol and other drug prevention from 66,000 to 108,000 hours.

11. Identify opportunities to enhance school based programs to incorporate mental health, alcohol and other drug education, and resilience building.

12. Develop a comprehensive prevention plan for mental health, alcohol and other drugs which will include a range of evidence based strategies.

Community Support Services

13. Double the state provision of community support services from 444,000 hours of support to 888,000 hours of support, with a particular focus on rural and remote areas and youth.

14. 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 on recovery.

15. 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.

16. In collaboration with key stakeholders, develop an accommodation strategy to address the housing needs of people with mental health, alcohol and other drug problems which will include working with housing providers to increase access to suitable housing options for people with mental illness.

17. Continue to provide alcohol and other drug support services for residents within existing Transitional Housing and Support Program houses in: North Metropolitan; South Metropolitan; the Goldfields; the Midwest; and the Kimberley.

18. In consultation with housing providers, establish new Transitional Housing and Support Program houses and commission in-reach treatment and support[i] (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

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[i] Referred to in Section 5: *The Plan Matrix* as "post residential rehabilitation".

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Southern (400 hours), South West (600 hours), and the Wheatbelt (400 hours) regions.

Community Treatment Services

19. Boost infant, children and adolescent community treatment services by doubling the provision of community treatment hours of service across the state from 373,000 hours to 729,000 hours.

20. Build on current youth services through commissioning dedicated public mental health youth services across the state for 16 to 24 year olds, predominantly through a reconfiguration of existing adult services.

21. Establish two new integrated alcohol and other drug treatment services (Joondalup and Mandurah).

22. Develop another community alcohol and other drug service hub in the Midwest (Meekatharra).

23. Work with Police to develop and commission a mental health Police co-response program.

24. Establish an effective 24 hour mental health crisis and emergency response service, that provides triage, assessment, and treatment services. The service will also provide relevant frontline staff with training.

25. Work with the Commonwealth Government to establish clear referral pathways and system navigation support to ensure access to services occurs at the earliest point of contact and is seamless for individuals, families, carers, service providers and General Practitioners.

26. 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.

Community Bed Based Services

27. Increase the subsidy provided for subacute 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, 6 places in Northern and Remote, and 15 Places in Southern Country).

28. Expand existing alcohol and other drug residential treatment and rehabilitation services by 50 beds (10 beds in North metropolitan, 18 beds in South Metropolitan, 12 beds in Geraldton and 10 beds in Kalgoorlie).

29. 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 Southern region of the State.

30. Commence the development and implementation of a new alcohol and other drug residential treatment and rehabilitation service in the Southwest (36 beds).

Hospital Based Services

31. Commence the process of divestment of services on the Graylands and Selby hospital campuses.

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32. Convert the Bentley Adolescent Unit into a state-wide 14 bed subacute service for youth.

33. Open 21 inpatient beds in Geraldton.

34. Expand Mental Health Observation Areas across the State to deliver an additional 11 beds (Midland Hospital, Joondalup Health Campus, Perth Children's Hospital).

35. 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.

36. Increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 218,000 to 256,000 hours of service.

37. Increase capacity for Telehealth links (i.e. telepsychiatry and specialised services) into small hospitals in rural and remote regions.

38. Expand HITH beds to meet the target of approximately 5% of inpatient mental health beds to be delivered as HITH.

Specialised State-wide Services

39. Establish and continue to develop specialised state-wide inpatient services for:

  • Eating Disorders (24 beds);

  • Perinatal (8 beds); and

  • Neuropsychiatry and Neurosciences disorders.[ii]

40. Commence establishment or enhancement of community based specialised state wide services including:

  • Transcultural services;

  • Children in Care Program;

  • Hearing and Vision Impaired service;

  • Homelessness services;

  • Eating Disorders service;

  • Perinatal services;

  • Neuropsychiatry and Neurosciences service;

  • Sexuality, Sex and Gender Diverse service;

  • ADHD service; and

  • Co-occurring Mental Illness and Intellectual and Developmental Disability service.

[ii] Bed number to be confirmed during business case development.

EXHIBIT 315   COI.017.0001.0094

Forensic Services

41. Develop a 70 bed in-prison dedicated mental health, alcohol and other drug service for men, women and youth.

42. Further develop in-prison mental health, alcohol and other drug treatment and support services for men, women and youth.

43. Work with the Department of Corrective Services to develop models of service for in prison treatment and support services.

44. 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, case management, and transition services for people moving from prison to community.

45. Complete the planning of a 92 bed secure forensic unit, to replace the forensic beds at Graylands Hospital (including specific units/places for women and youth and Mentally Impaired Accused).

System Integration

46. Develop comprehensive models of service for all major services and commission services based on agreed models of service.

47. Require commissioned services to develop coordination strategies to assist people to transition more effectively between services, programs and regions, particularly for people transitioning between services.

48. 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.

System Navigation

49. 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).

50. Develop resources for consumers, families, and carers including handbooks, web based, and telephone consultations with trained coaches and counsellors. This may include information regarding accessing insurance and benefits, and other information regarding navigating the system.

51. Establish online system navigation resources to provide an easy "how-to" guide for individuals or family members seeking mental health, alcohol and other drug service assistance.

52. Expand services for family and carers through information, support, education and skill development opportunities.

53. Standardise, establish and monitor key performance indicators for follow-up and other communication post-discharge.

54. Establish protocols for informing consumers, carers, families and General Practitioners (upon discharge) as to treatment plans and how to re-access services if required.

EXHIBIT 315   COI.017.0001.0095

55.   Develop communication protocols for accessing patient records and treatment plans, other communication and reporting between non-government organisations, public, and private sectors, and across community, primary, secondary and tertiary services.

56.   Establish a clear directory of services, referral pathways and system navigation support/tools to ensure access to services occurs at the earliest point of contact is streamlined and seamless for individuals, families, carers and service providers.

Workforce

57.   Develop and implement workforce strategies which:

- are aligned with the Western Australian Public Sector Commission's Aboriginal Employment Strategy 2011–2015. This will ensure services offered respectfully combine the cultural rights and values of Aboriginal people;

- work with employing stakeholders (such as the Department of Health, the private sector, and non-government organisations) to increase the peer workforce and establish a career path for peer workers based on certification, experience and training;

- improve access to skilled staff across the system;

- make available adequate education and training for staff to build and sustain the principles of recovery in mental health service delivery, including the wider community;

- increase the workforce capacity to address physical health needs, and co-occurring mental health, alcohol and other drug problems; and

- implement a skilled migration strategy to attract staff in key areas of local undersupply.

58.   Develop partnerships with the tertiary education sector to increase mental health, alcohol and other drug information in core curricula in undergraduate courses including allied health, nursing, welfare, justice and police.

59.   Strengthen specialist advanced training programs for staff in emergency departments and community based professionals including General Practitioners, specialist psychiatrists, nurses, and nurse practitioners.

Information and Communications Technology

60.   Develop a 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 services;

- implementation of innovative eHealth and telehealth for specialised mental health, alcohol and other drug services across rural and regional Western Australia; and

- the implementation of information sharing protocols across the sector.

EXHIBIT 315

COI.017.0001.0096

By the end of 2020, to rebalance the system there is a need to:

Prevention and Promotion

61. Increase the proportion of the Mental Health Commission budget spent on mental illness prevention and mental health promotion from 2% to 3%, and increase the hours of service dedicated to alcohol and other drug prevention from 108,000 to 192,000 hours.

62. Increase the level of evidence-based prevention activity taking place at the state, regional and local level through enhancing the capacity of the workforce.

63. Improve access to web-based/on-line strategies and interventions.

64. Expand current public education campaigns targeting harmful alcohol and other drug use.

65. Promote the adoption of evidence based mental health 'first aid' training throughout the community.

Community Support Services

66. 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.

67. Commission in-reach and out-reach support[iii] (approximately 17,500 hours of support) in the metropolitan area for people in crisis accommodation with alcohol and other drug problems.

68. Develop and commission a personalised support services[iv] for people with alcohol and other drug problems (approximately 175,000 hours of support), which would include peer workers.

69. In consultation with housing providers, continue the expansion of the number of houses with support available in the Transitional Housing and Support Program (expand the total by approximately 15,900 hours of support) across the North Metropolitan (6,600 hours), South Metropolitan (6,900 hours), Pilbara (600 hours), South West (1,200 hours), Wheatbelt (400 hours).

70. Expand mental health community support services across the state from approximately 1.5 million hours of support to approximately 3 million hours of support.

Community Treatment Services

71. Increase the total mental health community treatment hours of service across the State from 2.5 million hours to approximately 3 million hours with a priority on developing telepsychiatry, 'after hours' services and expanded clinical services for the South West.

72. Expand metropolitan alcohol and other drugs integrated treatment services to provide outpatient withdrawal, pharmacotherapy maintenance and specialist counselling and

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[iii] Referred to in Section 5: *The Plan Matrix* as "post residential rehabilitation".

[iv] Referred to in Section 5: *The Plan Matrix* as "post residential rehabilitation".

EXHIBIT 315

COI.017.0001.0097

support. Rockingham, Midland, Armadale and the Perth Central Metropolitan area are identified as priority areas.

73. Expand the number of regional alcohol and other drug service hubs and 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.

74. Expand training and engagement of General Practitioners and other primary care providers to:

- expand the Community Program for Opioid Pharmacotherapy across the State, particularly regional areas; and

- increase screening, brief interventions, early interventions, and referrals for mental health, alcohol and other drug problems in all regions.

Community Bed Based Services

75. increase the total number of mental health community beds by 103 beds (including in the North Metropolitan, South Metropolitan, Northern and Remote, and Southern Country areas);

76. Deliver a new service specifically designed for youth alcohol and other drug treatment and rehabilitation (with an additional 13 beds) in the metropolitan area.

77. Expand low medical alcohol and other drug withdrawal services in the metropolitan area by 11 beds, Northern and Remote country by 5 beds and Southern Country by 6 beds on existing residential rehabilitation sites.

78. Increase the subsidy provided for subacute long-stay (nursing home) places for older adults with mental illness by an additional 41 beds - North Metropolitan (14 beds), South Metropolitan (16 beds), Northern and Remote (4 beds), and Southern Country (7 beds).

Hospital Based Services

79. Open new mental health inpatient units in Pilbara (16 beds).

80. Expand the Next Step Inpatient Withdrawal Service, in the inner city area, to provide greater capacity for high medical withdrawal (increase from 17 to 28 beds).

81. Expand the capacity of country hospitals by 14 beds across the Goldfields, Great Southern, Kimberley, Midwest and Pilbara to provide medically supervised alcohol and other drugs withdrawal.

82. Increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 256,000 to 273,000 hours of service.

83. Expand Mental Health Observation Areas across the State to deliver an additional eight beds (Royal Perth Hospital).

84. Continue the closure of Graylands wards in a staged process as HITH and new hospital wards become operational across the State.

85. Expand HITH beds to meet the target of approximately 10% of inpatient mental health beds to be delivered as HITH.

EXHIBIT 315   COI.017.0001.0098

Specialised State-wide Services

86.   Continue to develop specialised state-wide inpatient services for:

- Eating Disorders (10 additional beds);

- Perinatal (4 additional beds); and

- Neuropsychiatry and Neurosciences disorders.[v]

Forensic Services

87.   Continue to develop in-prison mental health, alcohol and other drug treatment and support services for men, women and youth.

88.   Increase mental health community forensic treatment services from 84,000 to 112,000 hours of service.

89.   Expand the Mental Health Court Diversion and Liaison program subject to the outcomes of the current evaluation.

90.   Expand alcohol and other drug diversion (community) services from 49,000 to 94,000 hours of service.

System Integration

91.   Work with stakeholders including the private sector, non-government organisations, and primary care to improve communication, information flow, linkages, and coordination to facilitate earlier identification and improved referral and treatment.

System Navigation

92.   Finalise an evaluation of the pilot community coordination program and expand its reach to areas of greatest need.

Workforce

93.   Further improve access to skilled staff across the system.

Information and Communications Technology

94.   Commission an effective ICT system across the mental health system.

By the end of 2025, to continue the reform, modelling identifies the requirement to:

Prevention and Promotion

95.   Complete the rollout of school based education programs on mental health, alcohol and other drugs, and resilience building until available in all schools.

96.   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.

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[v] Bed number to be confirmed during business case development.

EXHIBIT 315   COI.017.0001.0099

97. Reach the target of 5% of the Mental Health Commission budget allocated to mental illness prevention and mental health promotion, and 208,000 hours of service dedicated to alcohol and other drug prevention.

Community Support Services

98. Expand community mental health support services across the State from approximately 3 million hours of support to approximately 5 million hours of support.

99. In consultation with housing providers complete delivery of houses and support available in the Transitional Housing and Support Program with a further 15,700 hours of support (approximately 52,500 total hours of support).

Community Treatment Services

100. 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 from approximately 1 million hours to 1.9 million hours of support (including establishing smaller hub sites in 18 non-metropolitan locations); and

- increasing the total mental health community treatment hours of service across the State from approximately 3 million hours to approximately 3.5 million hours.

101. 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.

Community Bed Based Services

102. Further expand alcohol and other drug residential treatment and rehabilitation in the North Metropolitan area (111 beds), Southern Metropolitan (88 beds) and Southern Country (52 beds).

103. Complete delivery of low medical withdrawal beds in the metropolitan area (14 beds).

104. Increase the number of mental health community beds across the State (all metropolitan and regional areas) from 526 beds to deliver the modelled target of 854 beds.

Hospital Based Services

105. Expand Mental Health Observation Areas by an additional eight beds (Armadale Hospital, King Edward Memorial Hospital).

106. Increase hospital consultation liaison for people with mental health, alcohol and other drug problems from 273,000 to 290,000 hours of service.

107. Continue the expansion of high medical withdrawal beds by 44 beds (South Metropolitan, Southwest and the Wheatbelt).

108. Complete the closure of the existing Graylands facilities, with final transition from the site by 2025.

109. Expand HITH beds to meet the target of approximately 20% of inpatient mental health beds to be delivered as HITH.

EXHIBIT 315   COI.017.0001.0100

Specialised State-wide Services

110. Continue to develop specialised state-wide inpatient services for:

  - Eating Disorders (10 additional beds);

  - Perinatal (6 additional beds); and

  - Neuropsychiatry and Neurosciences disorders.[vi]

Forensic Services

111. Open a 92 bed secure forensic inpatient service with 62 acute and 30 subacute beds, including units for women, young people and Mentally Impaired Accused.

112. Establish a specialised forensic community based clinic and programs for people with problem behaviours, targeting sex offenders, violent extremism, arson, and stalking.

113. Further expand alcohol and other drug diversion (community) services from 94,000 to 163,000 hours of service.

114. Increase community based forensic mental health services from 112,000 to 140,000 hours of service.

System Integration

115. Continue to monitor service integration and progress improvements as necessary.

System Navigation

116. Further progress a state-wide implementation of the community coordination program.

Workforce

117. Evaluate the effectiveness of the workforce strategies, reformulate as necessary based on updated modelling and gap analysis and inform Government of future requirements.

Information and Communications Technology

118. Implement an ongoing program of ICT maintenance and enhancement, in line with the long term strategy.

[vi] Bed number to be confirmed during business case development.

EXHIBIT 315   COI.017.0001.0101

APPENDIX B

COSTINGS

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* (the 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 Mental Health Commission and/or the Drug and Alcohol Office 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. It does not take into account the cost of implementing individual initiatives. There are two exclusions from the costings:

- prevention and promotion activities which are not funded through the Mental Health Commission and/or the Drug and Alcohol Office; and

- in-prison costs.

Prevention and promotion resources outlined in the Plan are limited to those funded solely by the Mental Health Commission and/or the Drug and Alcohol Office. 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. 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 B- Figure 1 below, which represents the annual costs of resources required in 2025, using 2012-13 dollars (unadjusted for inflation).

EXHIBIT 315   COI.017.0001.0102

Appendix B - Figure 1: Annual Operational Costs in 2025 by Service Stream (2012-13 terms)
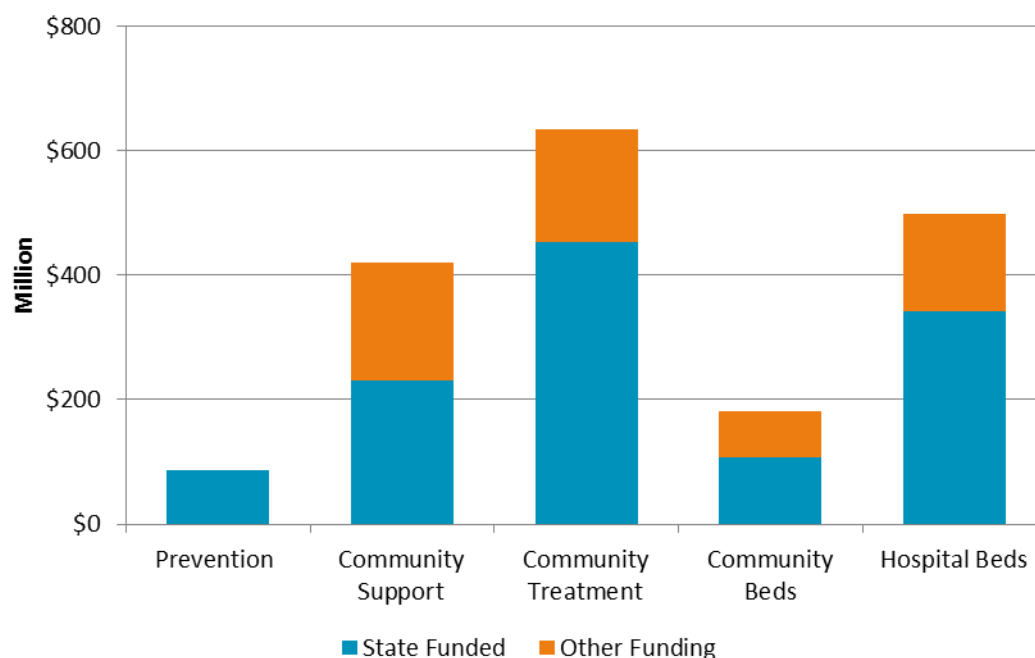

For the purposes of the costing, the Consultation Liaison and community forensic hours of service have been grouped with the community treatment hours of service, for ease of costing and comparison. Further, the specialised inpatient beds (eating disorders and perinatal), Hospital in the Home (HITH) beds, the Mental Health Observation Area (MHOA) beds, and forensic inpatient beds have been grouped with hospital beds for the above reason. Appendix B - Table 1 below details the annual costs of 2025 resources, in 2012-13 terms.

Appendix B - 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	86.7	-	**86.7**
Community Support	229.6	189.3	**418.9**
Community Treatment	452.4	181.6	**634.0**
Community Beds	107.5	73.8	**181.3**
Hospital Beds	341.8	156.1	**497.9**
System Wide Support	22.3	-	**22.3**
TOTAL	**1,240.2**	**600.8**	**1,841.1**

EXHIBIT 315   COI.017.0001.0103

As discussed in Section 10: *Hospital Based Services,* the future purchasing direction across the public and private sectors will be further explored, and the demand will be remodeled every two years. For the costing purposes only, all inpatient beds have been allocated to the State. As shown in Section 5: *The Plan Matrix,* 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 B - Figure 2 below shows the likely annual operating cost in 2017, 2020 and 2025 if phasing of initiatives occurs as stipulated in Section 5: *The Plan Matrix*.

Appendix B - Figure 2: Annual Operational Costs in 2017, 2020 and 2025 (2012-13 terms)
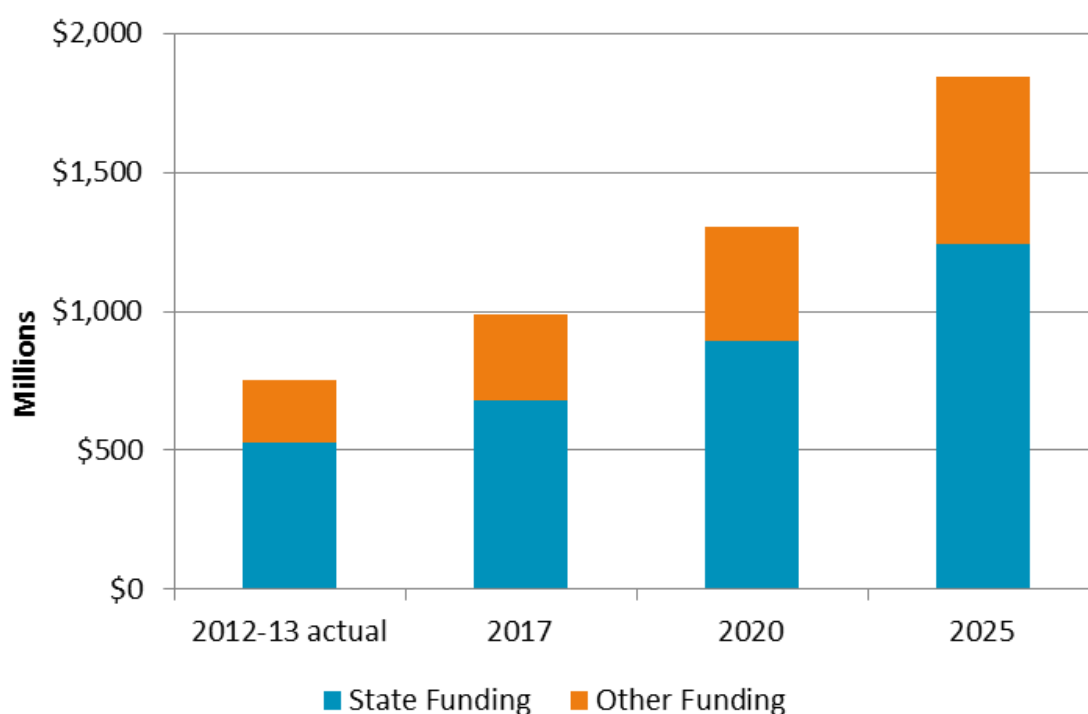
Appendix B - Table 2 below details the annual operational costs in 2017, 2020 and 2025 if the phasing of initiatives and services were in line with Section 5: *The Plan Matrix*.

Appendix B - 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	682.2	303.9	**986.1**
2020	891.8	412.4	**1,304.2**
2025	1,242.0	601.7	**1,843.7**

EXHIBIT 315   COI.017.0001.0104

The cost of implementing initiatives will occur during the development of business cases, for Government consideration and decision. 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/or the Drug and Alcohol Office, 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;

- the closure and decommissioning of Graylands Hospital and Selby Older Adult Unit; and

- in-prison beds are excluded as is not provided or purchased by the Mental Health Commission and/or the Drug and Alcohol Office.

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 B - Figure 3 below, which represents the capital costing required by 2025, using 2012-13 dollars (unadjusted for inflation).

Appendix B – Figure 3: Capital Costs by 2025, by Service Stream (2012-13 terms)
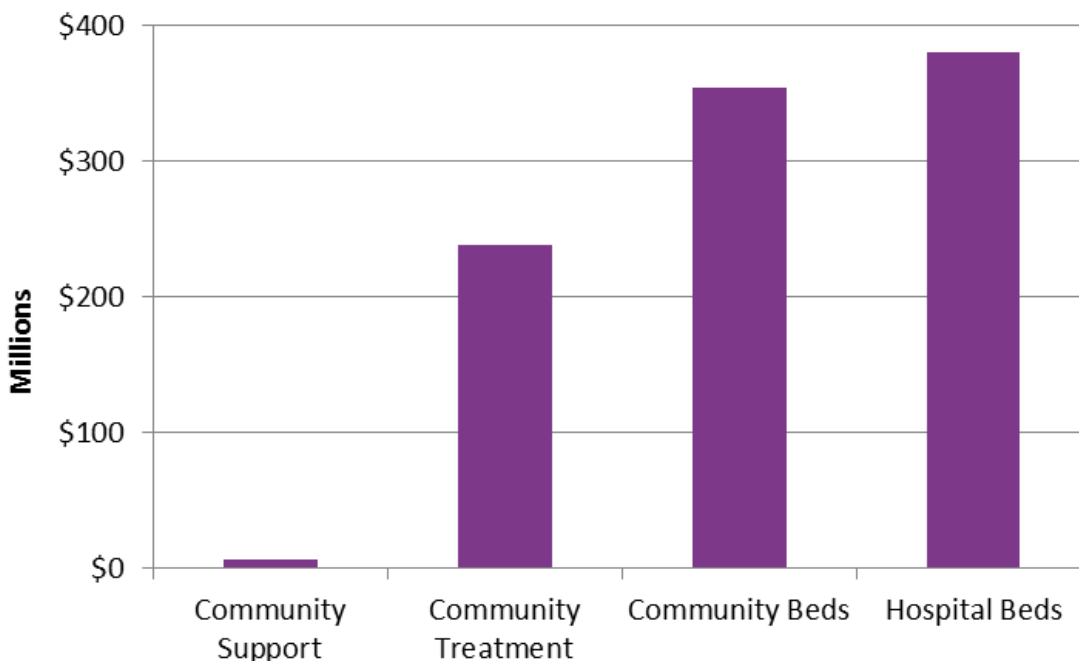
For the purposes of the costing, the community forensic services have been grouped with the community treatment services, for ease of costing and comparison. Further, the specialised inpatient beds (eating disorders and perinatal), the MHOA beds, and forensic inpatient beds have been grouped with hospital beds for the above reason. Appendix B -

EXHIBIT 315   COI.017.0001.0105

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 Section 5: *The Plan Matrix,* where it shows the time periods the various services and initiatives will come into operation.

Appendix B – Figure 4: Capital Costs in 2017, 2020 and 2025 (2012-13 terms)
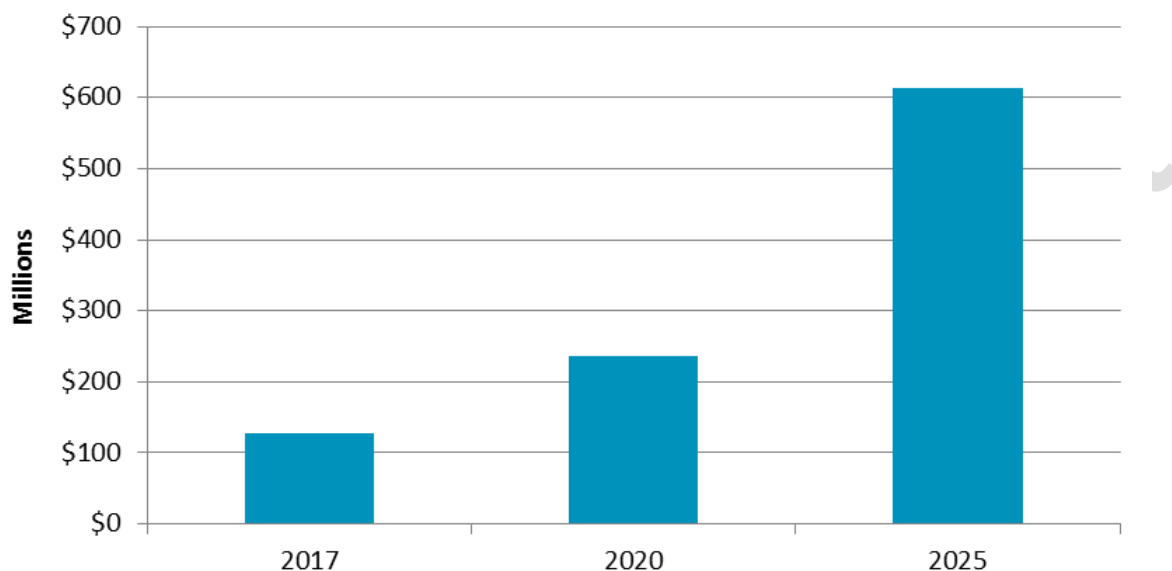
Detailed costings in relation to capital will be undertaken and included in individual business cases, as they are developed. Options analysis will also be undertaken in the business cases to ascertain optimal procurement method of delivering the capital for each individual initiative.

EXHIBIT 315   COI.017.0001.0106

APPENDIX C

KEY BODIES

A number of key bodies (with varying roles and responsibilities) exist in the Western Australian public mental health, alcohol and other drug system:

- The **Mental Health Commission** provides mental health policy advice to the Western Australian Government and purchases mental health services on behalf of the State.

- The **Office of Mental Health (OMH)** is an office within the Western Australian Department of Health that promotes improvement within the State's public mental health services. The OMH was established as part of the Western Australian Government's response to the Stokes Review.

- **Area Health Services** are responsible for providing public health services on behalf of the Western Australian Government. There are currently four Area Health Services: North Metropolitan; South Metropolitan; Western Australian Country; and Child and Adolescent (state-wide).

- The **Licensing and Accreditation Regulatory Unit (LARU)** is a unit within the Western Australian Department of Health that is responsible for licensing private hospitals and psychiatric hostels.

- The **Chief Psychiatrist** monitors standards of clinical mental health care across the State and has particular responsibilities and powers in relation to patients who receive involuntary treatment under the *Mental Health Act 1996*.

- The **Council of Official Visitors** is established under the *Mental Health Act 1996* to inspect facilities and advocate on behalf of involuntary patients and hostel residents. The proposed equivalent body under the Mental Health Bill 2013 (the Bill) is called the Mental Health Advocacy Service.

- The **Mental Health Advisory Council** is provides high level, independent advice and guidance to the Mental Health Commissioner regarding major issues affecting people with mental health problems, their families and service providers.

- The **Western Australian Alcohol and Drug Authority Board** provides advice to the Executive Director about matters relevant to the performance of functions of the Drug and Alcohol Office. This Board will become the Alcohol and Other Drugs Advisory Board following the passing of the Drug and Alcohol Authority Amendment Bill 2014.

- The **Mental Health Review Board** is a quasi-judicial oversight body responsible for reviewing involuntary treatment orders and other matters relating to the administration of the *Mental Health Act 1996*. The proposed equivalent body under the Bill is called the Mental Health Tribunal, which will have a range of additional functions.

- The **Ministerial Council for Suicide Prevention** is responsible for leading and overseeing the Strategy and provides expert advice to the Minister for Mental Health on suicide prevention initiatives.

- The **Western Australian Association for Mental Health** is the peak body of the community-managed mental health sector in Western Australia.

- **Consumers of Mental Health Western Australia** is a consumer led non-profit, community based organisation dedicated to supporting mental health reform and recovery of people with lived experience of mental health issues.

EXHIBIT 315

COI.017.0001.0107

- The **Drug and Alcohol Office** is responsible for provision and purchase of alcohol and other drug services, prevention, workforce development, research, evaluation, and strategic policy development in Western Australia.

- **Next Step Drug and Alcohol Services (Next Step)** is the clinical services directorate of the Drug and Alcohol Office and is the main public sector provider of alcohol and drug treatment in Western Australia.

- The **Western Australian Network of Alcohol and Drug Agencies** is the peak body of the community managed alcohol and other drug sector in Western Australia.

EXHIBIT 315   COI.017.0001.0108

APPENDIX D

HOW THE PLAN WAS DESIGNED

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 delivering *the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (the Plan).

NATIONAL SERVICE PLANNING FRAMEWORKS

Two population-based planning tools were adapted to address the unique needs of the Western Australian population. These planning tools were the National Mental Health Service Planning Framework (NMHSPF), and the Drug and Alcohol Service Planning Model (DASPM).

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.

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.

In October 2013, the first version of the NMHSPF and its Estimator Tool (ET) was completed. Western Australia has adapted the national tool to develop the Western Australian Mental Health Estimator Tool (MH-ET). The Western Australian MH-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 and Torres Strait Islander people, and rural and remote communities in Western Australia.

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. Like the Western Australian MH-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 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 and Torres Strait Islander people, and rural and remote communities in Western Australia.

EXHIBIT 315   COI.017.0001.0109

The Drug and Alcohol Office has 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 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 MH-ET and DASPM ET. However, the Plan ensures that estimates of future need across the system have also included calculation of activity (such as weighted activity units) where relevant. These inclusions ensure that assumptions made in the Plan can be mapped to current activity planning within the public mental health system.

ESTIMATING SERVICES NEEDED

The MH-ET and DASPM ET were used to calculate the type and quantity of services needed for the projected Western Australian population. 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). Appendix D - Figure 1 provides a summary of the inputs, modelling and outputs used in the Western Australian planning processes.

Appendix D - Figure 1: Western Australian planning - Inputs, Modelling and Outputs
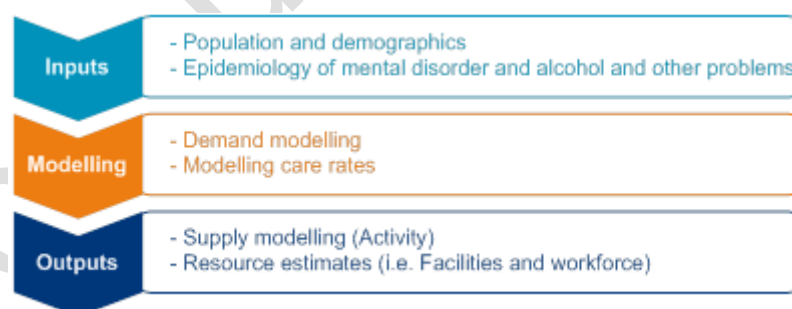
The Plan provides an estimate of the services and resources (i.e. facilities and workforce) that are required across the State and these estimates are based on the assumption that the whole system is in the "optimal" state. Therefore, a shortage in one part of the system means that other parts of the 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).

Evidence based practice and a combination of the best research evidence, clinical expertise and epidemiological prevalence is used to establish assumptions used in the modelling. 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.

EXHIBIT 315   COI.017.0001.0110

For mental health:

- 100% of people with a **severe condition** such as psychosis or affective disorders have a demand for treatment;

- 80% of people with a **moderate condition** will have a demand for treatment such as enhanced primary care; and

- 50% of people with a **mild condition** will have a demand for treatment such as shorter term primary care.

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 the primary care or the private system.

For alcohol and other drugs:

- 100% of people with a **severe condition** will have a demand for treatment (with the exception of amphetamines which is estimated at 35%);

- 50% of people with a **moderate condition** will have a demand for treatment (with the exception of opioids which are not included); and

- 20% of people with a **mild condition** will have a demand for treatment (with the exception of amphetamines and opioids which are not included).

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 in primary care services.

These assumptions are based on research that has been sourced internationally and nationally by experts in the modelling group for the National Mental Health Service Planning Framework.

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).

FORENSIC

Estimating service needs

Estimating the optimal forensic mental health service configuration for 2025 was informed by the NMHSPF. The NMHSPF does not specifically address forensic mental health 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 services were out of scope of the NMHSPF development because 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.

EXHIBIT 315   COI.017.0001.0111

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.

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.

CONSULTATION AND EXPERT ADVICE

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 provided input on:

- the Western Australian framework (classification system) and service descriptions;
- the Western Australian Framework applicability to local mental health, alcohol and other drug service issues;
- unique Western Australian population features; and
- future planning and other relevant issues.

For the mental health components of the Plan the following consultation occurred:

- over 350 individuals, representing over 100 relevant state-wide agencies and interest groups, took part in this consultation process;
- a custom designed survey provided further valuable input from over 700 respondents; and
- consultation groups across the State provided advice on its major components.

To assist in developing the alcohol and other drug treatment and support components of the Plan, the 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; and
- 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.

EXHIBIT 315

COI.017.0001.0112

APPENDIX E

WESTERN AUSTRALIAN MENTAL HEALTH, ALCOHOL AND OTHER DRUG 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 four 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). For example: the Bed Based Services Stream contains two service sub-streams: Hospital, and Community (see Appendix E - Figure 2 d).

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.

EXHIBIT 315   COI.017.0001.0113

Appendix E - Figure 2 a: Prevention

Service Stream	
Sub Stream	

Prevention

Promoting Wellbeing	**Prevention**

Service Category	
➢ Service Element	

Community Programs

➢ Promoting mentally healthy communities

➢ Community action plans and programs
➢ Volatile substance use coordination

Community Education

➢ Stigma reduction
➢ Resilience building programs
➢ Healthy ageing programs
➢ Mental health literacy
➢ Mental Health First Aid

➢ Media
➢ Peer
➢ Mass reach campaigns
➢ School based programs
➢ Parent and Family
➢ Prescriber/Dispenser

Systems and Environments

➢ Local Government
➢ Workplaces
➢ Leisure and sporting environments
➢ Licensed premises
➢ Youth settings

Health Public Policy

➢ Program for evidence-based policy adoption
➢ Systemic advocacy

Enforcement and Regulation

➢ Development of new legislation
➢ Enforcement of relevant legislation and rights
➢ Prevent diversion of drugs

Brief Interventions

➢ Screening and brief intervention
➢ Pre-arrest diversion
➢ Web based interventions

Suicide Prevention

➢ Suicide prevention strategies

Addressing Risk Factors

➢ Focussing on the known determinants of mental illness and of alcohol and other drug use

Addressing Physical Illness

➢ Reducing the physical illness gap in people with mental illness and those with alcohol and other drug problems

EXHIBIT 315   COI.017.0001.0114

Appendix E - Figure 2 b: Community support

Service Stream

Sub Stream

Service Category
➢ Service Element

Community Support

Individuals	Families and Carers

Harm Reduction

- ➢ Needle and syringe programs
- ➢ Opiate overdose prevention
- ➢ Safe places for intoxicated people
- ➢ Peer harm reduction
- ➢ Patrols
- ➢ Crisis accommodation

Group Programs

- ➢ Recovery focused programs

Personalised

- ➢ Peer support
- ➢ Recovery programs and coordination
- ➢ Health, social and welfare support
- ➢ Employment specialist programs
- ➢ Home in-reach
- ➢ Individual support and recovery (e.g. accommodation and tenancy support)
- ➢ Residential crisis support
- ➢ Post-residential support

Family and Carer Support

- ➢ Flexible outreach
- ➢ Carer/Family support
- ➢ Peer support
- ➢ Respite

EXHIBIT 315   COI.017.0001.0115

Appendix E - Figure 2 c: Community treatment

Service Stream	Community Treatment	
Sub Stream	**Primary Care**	**Ambulatory**

Service Category
➢ Service Element

General Practice
- ➢ General practitioners
- ➢ Better access to mental health practitioners through Medicare

Targeted Interventions
- ➢ Youth
- ➢ People with severe, enduring mental illness and complex needs
- ➢ Opioid pharmacotherapy
- ➢ Aboriginal social and emotional wellbeing

Non-Residential
- ➢ Specialist medical - Addiction medicine
- ➢ Medical - General practitioners
- ➢ Medical - Nursing
- ➢ Specialist counselling and support - alcohol and other drug workers and allied health

Acute/Intensive/Continuing
- ➢ Infant, Child and Adolescents
- ➢ Youth
- ➢ Adult
- ➢ Older Adult

Specialised State-wide Services
- ➢ State-wide Specialist Aboriginal Mental Health Service
- ➢ Transcultural
- ➢ Children in care
- ➢ Hearing and Vision Impaired
- ➢ Homelessness
- ➢ Eating disorders
- ➢ Perinatal
- ➢ Neuropsychiatry and Neurosciences
- ➢ Sexuality, Sex and Gender Diversity
- ➢ Attention Deficit and Hyperactivity Disorder
- ➢ Co-occuring Mental Illness and Intellectual Disability and Autism Spectrum Disorders

Forensic
- ➢ Youth
- ➢ Adult

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Appendix E - Figure 2 d: Bed based

Service Stream	Bed Based Services
Sub Stream	Community	Hospital

Service Category		
➢ Service Element		

Residential
- ➢ Low medical withdrawal
- ➢ Residential rehabilitation

Inpatient Withdrawal
- ➢ Complex medical withdrawal
- ➢ Medical inpatient withdrawal

Subacute Short-stay (Step Up/Step Down)
- ➢ Youth
- ➢ Adult

Emergency Departments
- ➢ Mental health and alcohol and other drug observation areas

Subacute Medium-stay
- ➢ Adult
- ➢ Older Adult

Consultation Liaison
- ➢ Emergency Department consultation liaison (inc. alcohol and other drug brief intervention)
- ➢ General hospitals

Subacute Long-stay (Residential)
- ➢ Adult
- ➢ Older Adult

Acute
- ➢ Infant, Child & Adolescent
- ➢ Youth
- ➢ Adult
- ➢ Older Adult

Subacute Long-stay (Nursing Home Based)
- ➢ Older Adult

Specialised State-wide Services (Acute)
- ➢ Eating disorders
- ➢ Perinatal
- ➢ Neuropsychiatry and Neurosciences

Subacute
- ➢ Short stay
- ➢ Long stay

Hospital In The Home
- ➢ Medical withdrawal
- ➢ Mental Health

Forensic
- ➢ Acute
- ➢ Subacute

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APPENDIX F

COLLABORATION AND PARTNERSHIPS

Addressing the needs of individuals facing mental health, alcohol and other drug problems is not the responsibility of any one agency, organisation or government. It requires collaboration between State and Commonwealth Governments, and non-government organisations to ensure the needs of individuals, families and carers are met holistically.

The current service system for mental health, alcohol and other drug services in Western Australia is fragmented and complex. State and Commonwealth funding is delivered through numerous agencies, and a range of government, non-government organisations are involved in planning and service delivery. This has resulted in a complex system with many different access points and entry criteria.

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.

Significant planning of investment between the State and Commonwealth Governments is an important step going forward. Working closer together, sharing information, increasing transparency of funding, ensuring clear role delineation and investment in complementary services are all essential in this regard and will deliver better outcomes for consumers, family, and carers.

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (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 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 multiagency partnerships

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.

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The owner of the DCSP Policy is the Partnership Forum (a group comprising of senior public servants and community sector representatives) formed to provide a shared approach to policy, planning and delivery of community services. The Partnership Forum aims to fundamentally change the relationship between the public sector and the non-government sector to produce a more holistic approach to the planning and delivery of community services.

This Plan will require a strong governance mechanism to oversee implementation and will require whole of system participation if the best outcomes are to be achieved. Governance of implementing the Plan may also benefit from a strong association with the Partnership Forum which could assist in establishing strong local partnerships between a broad range of community treatment and community support service providers and an effective focus on outcomes.

STATE INFLUENCES

State Government commitment

The State Government (elected in 2008) committed to a major change to the mental health system, including the establishment of the Mental Health Commission in 2010.

Following extensive consultation, new strategic policies for mental health were developed. The State Government's Strategic Policy on Mental Health, *Mental Health 2020: Making it personal and everybody's business* articulated three key mental health directions:

- **person centred supports and services:** highlighted that the unique strengths and needs of the person experiencing mental health problems are the key focus of individualised planning, supports and services;

- **connected approaches:** emphasised that strong connections between public and private mental health services, primary health services, mainstream services, businesses, communities, individuals, families and carers help achieve the best outcomes for Western Australians living with mental health problems; and

- **balanced investment:** identified that a comprehensive and contemporary mental health system provides a full range of support and services, ranging from mental health promotion and illness prevention activities, through to early intervention, treatment and recovery.

The *Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015* (the Interagency Strategic Framework), outlines strategies to prevent and reduce the adverse impacts of alcohol and other drugs and focuses on two core elements:

- prevention of illicit drug use, harmful alcohol consumption and their associated impacts; and

- providing those who need support with the assistance and services they require.

The Interagency Strategic Framework includes the following five key strategic areas:

1. focusing on prevention;

2. intervening before problems become entrenched;

3. effective law enforcement approaches;

4. effective treatment and support services; and

5. strategic coordination and capacity building.

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Mental Health Bill

Modernisation of the *Mental Health Act 1996* is a key element of the State's mental health reform agenda. Following extensive community consultation, the Mental Health Bill 2013 (the Bill) was introduced into Parliament in October 2013. The Bill has been passed by the Legislative Assembly and the Legislative Council. The Bill 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 Bill also provides increased certainty and clarity for clinicians and builds on existing best clinical practice.

The Bill and the Plan are largely separate initiatives, however, where relevant such as in the models of service in Section 13: *System Improvement and Supporting Change*, reference to the applicability of the Bill is made.

It is anticipated that there will be a 12 month implementation period before the Bill becomes operational. Implementation planning is progressing with ongoing input from key stakeholders, including a Mental Health Bill Implementation Reference Group, Lived Experience Advisory Group, Aboriginal Advisory Group, Non-Government Organisation Roundtable, and various specific working groups.

The Stokes Review

Another key component driving change was the commissioning by the State Government of key studies to identify and critically explore and analyse mental health issues. One of these key studies is the 2012 report by Professor Bryant Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia* (the Stokes Review). The State Government has made a firm commitment to implement the recommendations of the Stokes Review. This Plan was developed in response to the principal recommendation of the Stokes review. Many of the strategies and actions within the Plan address other key recommendations of the Stokes Review.

Amalgamation of the Mental Health Commission and the Drug and Alcohol Office

One of the recommendations from the Stokes Review is the need for improved collaboration between the mental health, alcohol and other drug sectors to cooperatively provide care for people with co-occurring mental health, alcohol and other drug problems.

In April 2013, the Minister for Mental Health announced the amalgamation of the Drug and Alcohol Office and the Mental Health Commission. The aim is to better integrate the State's network of prevention, treatment, community support, professional education and training and research activities across both areas.

NATIONAL INFLUENCES

Commonwealth Government 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 postvention.[i] More

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[i] Postvention is an intervention after a suicide, to support individuals and communities impacted by the death. It aims to assist people who are bereaved (family, friends, professionals and peers) to recover from major stressors, grief and loss. Debriefing and support for survivors of suicide is a critical part of suicide prevention for vulnerable people.

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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, Medicare Benefits Schedule items, and the Better Access program.

In relation to alcohol and other drugs, a *Review of the Drug and Alcohol Treatment Services Sector* project was commissioned by the Commonwealth in 2013 and is due to be finalised in 2014. This project aims to clarify Australian drug and alcohol:

- treatment funding;

- current and future service needs;

- the gap between met and unmet demand; and

- provide recommendations to inform the Commonwealth Government's planning and funding processes.[ii]

The findings of the review are expected to identify ways for governments to work more collaboratively and better plan for delivery of alcohol and other drug services and improve treatment outcomes.[iii]

A similar but separate *National Review of Mental Health Programs* has been initiated by the National Mental Health Commission at the request of the Commonwealth Government. The states and territories who have been requested to provide information for the review, have sought clarification of the governance and scope for consultation and involvement in the review. These matters remain under discussion. Both reviews have potential to impact on future planning and implementation of mental health, alcohol and other drug services.

The Commonwealth has also engaged with Western Australia in a number of National Partnership Agreements, including the National Perinatal Depression Initiative, and the Supporting National Mental Health Reform.

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; and

- the National Health Reform Agreement (NHRA).

In 2011, Western Australia signed the NHRA between the Commonwealth and all States and Territories, to drive major reforms to the organisation, funding and delivery of health and aged care. These reforms are designed to:

[ii] UNSW Medicine - Drug Policy Modelling Program. Review of alcohol and other drug treatment service sector 2014. Available from: http://www.dpmp.unsw.edu.au/resource/review-alcohol-and-other-drug-treatment-service-sector

[iii] The Department of Health and Ageing. Substance Misuse Service Delivery Grants Fund. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/drugtreat-fund

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- improve access to health care;

- improve efficiency;

- increase public information to enable comparison of health service performance; and

- ensure more transparent funding of public hospitals based on services delivered and the efficient cost of delivering those services.

Under the NHRA, the Western Australian Department of Health has implemented an activity based funding (ABF) model to provide funding to services using nationally agreed prices developed by the Independent Hospital Pricing Authority (IHPA).

In 2014-15 mental health inpatient services use a modified Australian Refined Diagnosis Related Groups (AR-DRGs) as outlined in the 2014-15 National Efficient Price Determination, in addition non-admitted services are at present block funded. IHPA are currently developing an Australian Mental Health Classification System, which is proposed to be implemented by 1 July 2016.[iv]

A commitment of significance is the National Disability Insurance Scheme (NDIS). In 2010, the Commonwealth Government requested the Productivity Commission undertake an inquiry into a long term disability care and support scheme. In 2011, the Council of Australian Governments considered the findings of the inquiry and agreed to the need for a reform to disability services through a NDIS. Its key intent is to support a better life for hundreds of thousands of Australians with a significant and permanent disability and their families and carers. This includes psychosocial disability, and potentially permanent alcohol and other drug related disability.

A two year trial of the NDIS commenced in the Perth Hills area for residents living in the local government areas of Swan, Kalamunda and Mundaring. Further two sites operating under the Western Australian My Way initiative will commence from July 2014 for people in the Lower South West area, and from July 2015 for people in the Cockburn-Kwinana area.[v] This falls within the timeframe for the Plan, and implementation planning will need to take into account the impact of the roll-out, particularly in relation to people accessing non-acute extended treatment services and those who may no longer be eligible for Commonwealth funded services.

During the trial period, there is continuity of support arrangements in place for people who have been accessing state funded services which become part of the NDIS but are found not to be eligible for the NDIS. 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.

The Commonwealth's developing role in the funding of mental health services will necessitate a greater focus on coordinating investment and service delivery. The State and Commonwealth Governments will need to work together to minimise duplication and ensure that service users experience an integrated system. The development of this Plan creates an opportunity to provide a consistent guide to State and Commonwealth Government investment in services.

[iv] For more information on the revised Australian Mental Health Classification System, please refer to:
http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/mental-health

[v] National Disability Insurance Authority. National Disability Insurance Scheme website 2013. Available from:
http://www.ndis.gov.au

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APPENDIX G

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* (the 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; 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.

Critical to the success of the Plan will be delivering benefits related to the key aims that underpin the Plan (refer to Section 1: *Introduction*).

Objectives

The Evaluation Framework has the following objectives:

- Assess the investment that has been and will be made in the mental health, alcohol and other drug sector – including those directed at forensic services (measuring inputs, efficiency and cost-effectiveness).
- Assess the impact of key client related deliverables (measuring outcomes and effectiveness).
- Monitor the implementation of the Plan (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 G – Figure 1 outlines the key activities that will be delivered as part of the 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.

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Appendix G – Figure 1: Summary of Evaluation Activities for the Plan
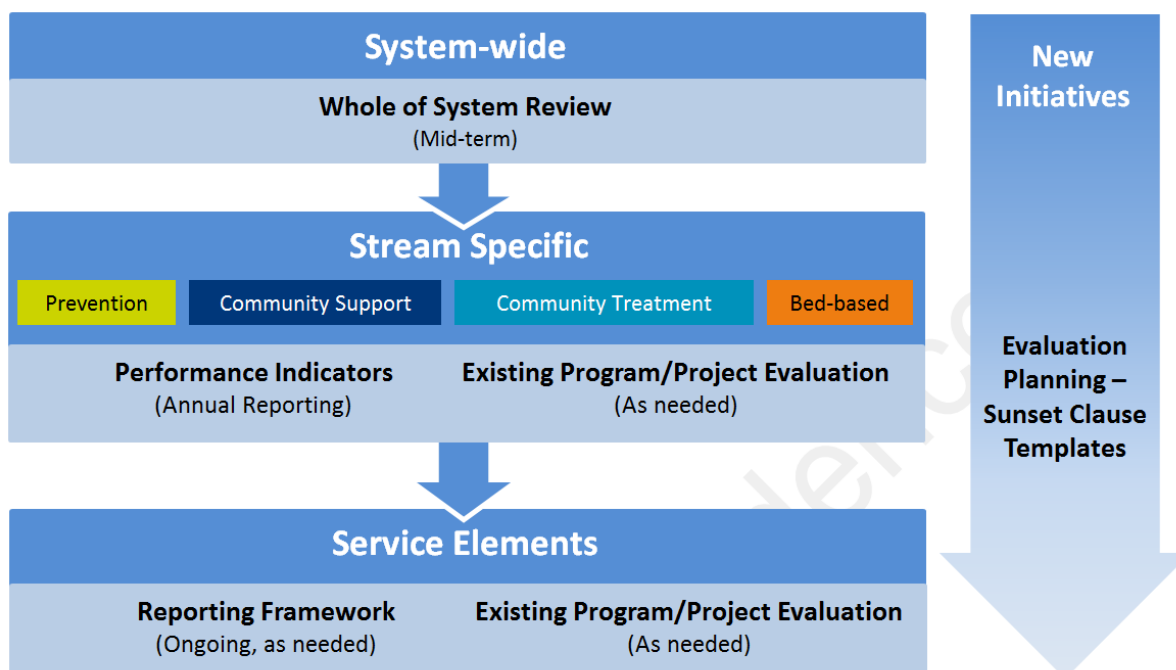
Whole of System Review

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 focussed on inputs and outputs. A priority will be to ensure all of the evaluation objectives outlined in this framework are addressed for the whole system. Further to this, an independent comprehensive mid-term review will be conducted addressing every evaluation objective, after five years of the Plan's implementation.

Performance Indicators

The Evaluation Framework outlines key indicators for the key service streams covering inputs, outputs and outcomes and their alignment with intended benefits (refer to Appendix G – Table 1). These indicators will be used as the basis for regular reporting of progress and include indicators relating to forensic services - particularly in the community treatment and bed based service streams. 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[29];
- they align with existing plans and reporting requirements;
- where possible, the data are currently available; and
- where possible, the indicators are able to be benchmarked.

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[29]Department of Treasury (2014) Program Evaluation: Sunset Clauses Agency Guide. Government of Western Australia.

EXHIBIT 315

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Appendix G - Table 1: Key Indicators by Service Stream

	PREVENTION	COMMUNITY SUPPORT
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. ***Mental Health and Wellbeing framework developed and implemented***	Proportion of total Mental Health Commission budget spent on mental health, alcohol and other drug community support services. Peer workers per 1,000 direct care full time equivalent (FTE). ***Models of care developed and implemented***
Output Indicators (What is delivered?)	Cost per capita for activities to enhance mental health and wellbeing and prevent suicide. Correct take out messages from 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 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 by non-government organisations. Average cost per package of care for the individualised community living strategy. 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. National Standards.
Outcome Indicators (What is achieved?)	Prevalence of mental illness*. Rates of stigmatising attitudes within the community. Rates of understanding of mental health and alcohol and drug problems in the community. Levels of distress (K10). Rate of intentional self-harm. Rate of suicide. 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.	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. Recovery rates for people with mental illness. Rates of experience of care. Participation rates by people with mental illness in the community. Proportion of mental health consumers living in stable housing [PROXY]. Rate of alcohol related hospitalisations (age standardised rate per 10,000 population). Rate of Illicit drug related hospitalisations (age standardised rate per 10,000 population). Level of consumer satisfaction with quality of service.

BENEFITS

Fewer people will experience stigma and discrimination.
Fewer people will experience high levels of distress.
Fewer people will experience avoidable harm.
People with poor mental health, alcohol and other drug problems will have better physical health and live longer.
More people will have good mental health and wellbeing.
More people with mental health, alcohol and other drug problems will participate in employment, education and in the community.
More people with mental health, alcohol and other drug problems will recover.
More people will have a positive experience of care.

Notes: National Standards are currently reported at a jurisdictional level. *Periodic data collection

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	COMMUNITY TREATMENT	BED BASED
Input Indicators (What resources are used?)	Proportion of total Mental Health Commission budget spent on mental health, alcohol and other drug community clinical services. Community mental health (public sector) and non-residential drug and alcohol treatment FTE per 100,000 population. Peer workers per 1,000 clinical community FTE. Consumer consultants per 1,000 clinical community FTE. Carer consultants per 1,000 clinical community FTE. *Models of care developed and implemented*	Proportion of total Mental Health Commission budget spent on bed-based services by service element type. Inpatient beds per 10,000 population (optimal mix of acute and non-acute). Community beds per 10,000 population. *Models of care developed and implemented*
Output Indicators (What is delivered?)	Average treatment days per three month episode of care. Average cost per treatment day of ambulatory care. Average cost per episode of ambulatory care. Proportion of carer and consumer workers in the mental health workforce. Number of open and opened treatment episodes (non-residential). Cost per treatment episode that are completed as planned or clients are still in treatment.	Average length of stay – acute/other/residential rehabilitation/withdrawal. Average cost per bedday by bed type (acute/other). Number of open and opened treatment episodes (hospital and community). Cost per treatment episode (completed as planned or still in treatment).
Outcome Indicators (What is achieved?)	Rate of pre admission community care. Rate of post discharge community care. Rate of treatment. Change in consumer clinical and treatment outcomes. Recovery rates for people with mental illness. Rates of experience of care. Percentage of open and opened treatment episodes that are not completed as planned for community treatment services. Levels of client satisfaction with quality of service.	28 day re-admission rates. Change in consumer clinical and treatment outcomes. Rate of treatment/inpatient/community beds. Rate of weighted activity units. Rate of seclusion and restraint. Recovery rates for people with mental illness. Rates of experience of care. Proportion of people who could have been discharged if appropriate accommodation and supports were available. The percentage of open and opened treatment episodes that are not completed as planned for bed based services. Level of consumer satisfaction with quality of service.

BENEFITS

More people with poor mental health and alcohol and drug problems will live in stable housing.
Fewer people will experience adverse effects of alcohol and other drug use.
More people will have pre-admission and post discharge community care.
More people will experience improved clinical outcomes.
Fewer people will experience drug and alcohol related harm.
More people will experience improvement in wellbeing, engagement and life circumstances.
Fewer people will be re-admitted to hospital inappropriately.
There will be little or no need for seclusion and restraint.
More people will be discharged from hospital to appropriate levels of accommodation and support in the community.

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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, treatment and support to evaluate the extent to which they realise their intended benefits. These 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. It is proposed that an ongoing schedule of program/project evaluations be identified on an annual basis with one to two conducted per service stream per year.

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. This proposal will adhere to the guidelines outlined in the Program Evaluation: Sunset Clauses Agency Guide released by the Department of Treasury.

Reporting Framework

Both the Mental Health Commission and the Drug and Alcohol Office have an extensive range of reporting requirements, which align with existing state and national processes. Activities relating to this will continue with the Mental Health Commission delivering on the Outcome Based Management Framework and Drug and Alcohol Office continuing to deliver on the Planning Review and Reporting Framework 2012. These reporting frameworks will be jointly updated in 2014-15.

These Frameworks reflect activities relating to the Financial Management Act 2006 (s61), National Mental Health Performance Framework, Fourth National Mental Health Plan, Mental Health 2020: Making it Personal and Everybody's Business, National Drug Strategy 2010-2015, Drug and Alcohol Interagency Strategic Framework for Western Australian 2010-2015 (DAS), Directorate Business Plans and other key monitoring and governance reports.

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APPENDIX H

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* (the 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;
- monitor the annual progress and the implementation of all proposals; and
- review the Plan as required.

A number 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.

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 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;
- facilitate collaboration with state representatives, non-government agencies, the private sector and consumer and carer representatives;
- contribute to the identification and development of jurisdictional data and indicators within the Plan; and
- contribute to jurisdictional input to annual reporting on the Plan.

Existing state-wide networks and other key groups at the local, regional and state level will be identified and mapped throughout the implementation process.

EXHIBIT 315

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