Submission to the

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

WAAMH

Western Australian Association for Mental Health

Peak body representing the community-managed mental health sector in Western Australia

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1. Background

The Western Australian Association for Mental Health (WAAMH) was incorporated in 1966 and is the peak body representing the community-managed mental health sector in WA. With around 150 organisational and individual members, our vision is to lead the way in supporting and promoting the human rights of people with mental illness and their families and carers, through the provision of inclusive, well-governed community-based services focused on recovery. WAAMH advocates for effective public policy on mental health issues, delivers workforce training and development and promotes positive attitudes to mental health and recovery. Further information on WAAMH can be found at http://www.waamh.org.au

To develop this submission WAAMH consulted with our members, via a Facebook online discussion group, a face-to-face World Café event attended by approximately 50 people and a survey to which 10 responses were received. We also received input by email and through daily and weekly contact with our members and other sector organisations.

The purpose of the consultations was to explore how the community sector could respond to the Plan's opportunities and challenges as well as shape and drive community based, recovery oriented services. The World Café aimed to engage participants in a deep conversation about this, and to learn from and inform each other. Informed by deliberative democracy and appreciative inquiry, the World Café process and Facebook discussion page enabled people to seek, make sense of and share information, learning from what other people know in a collective conversation.

The Plan by itself is not person centred or recovery focused, however it is data and episodes of care focused; this is important to establish the basis on which the Plan's strategies are predicated. To achieve implementation of this ambitious agenda, the Plan needs to outline how it is person centred and how the consumer voice can be integrated into services and program design. The Plan should consider provision of incentives for effective care, meeting consumer-identified requirements and delivering wellness and outcomes. A systems approach will assist to break down the demarcation between sectors and siloes and support the Plan to achieve its intended outcomes.

2. Structure of this submission

The submission outlines the key issues arising in our consultations, suggestions to enhance procurement processes, feedback services by service stream, and recommendations on implementation processes and issues. In particular, the submission aims to contribute some of the detail about the key features of different types of services, and practical ideas to assist in meeting consumer needs, system design and transformation.

Each section outlines key themes and offers practical suggestions to inform mental health reform, service planning and/or the Plan's implementation.

3. Key Issues

3.1 Care Coordination and System Navigation

Care coordination and system navigation was one of the most frequently raised issues in our consultations, and there is strong support for the Plan's intention to improve this. It is clear that coordination and navigation are essential to meeting the Mental Health Outcomes Statements, which focus on the whole person and a good life. We have identified two main avenues for improving coordination; specific coordination services, and systems approaches that build this function into all aspects of the system.

3.1.1 Pilot community coordination program

We support the proposed pilot. In designing this service, we recommend building on the strengths of Partners in Recovery and PHaMS. It should be staffed by a multidisciplinary team including peer workers. Its key features should include:

- Client-led, strengths based, person centred, recovery and well-being oriented
- Skills in empowering consumers, assessment of needs, and understanding the access requirements of all services to facilitate access
- Easily accessible through self-referral and drop in, or provider referral
- Accountability for care coordination and service access
- Culturally secure to enable Aboriginal and CaLD access
- Develop and review a care plan in partnership with consumer, carer and family
- Consult and engage with all stakeholders including with clinicians
- Engage communities and coordinate across silos.

Models for consideration include regionally-based and place based approaches, partnership networks and/or consortia models to enable shared intake/triage, and co-located services. Models of interest included the Strong Families model, Individual Placement and Support, and the 'no wrong door' approach.

3.1.2 System design

Coordination and navigation must be a feature of whole system design. WAAMH strongly supports action 13.7.3.3, which would require commissioned services to develop coordination strategies to support transition between services. We recommend such functions be built into service design and the specifications of every mental health service, with appropriate resourcing, accountability and reporting requirements. Consideration must be given to overcoming barriers to engaging other agencies – here we offer some recommendations to support this function:

- Establish whole of government commitment and partnership framework to achieve positive outcomes for people with mental illness
- Develop a solid framework for coordination, information sharing and access that exists beyond relationships between individuals and providers
- Improve accountability for care coordination within all service types, building this into monitoring and reporting systems
- Identify clear care pathways for consumers, including those with coexisting AOD or disability

- Develop seamless IT systems including an e-health record and 'report once use many times'.

3.2 Rural and remote

Rural and remote areas were one of the most strongly advocated for issues in our consultations. In many areas there is a lack of services on the ground, especially in remote Aboriginal communities. Concerns were expressed about the urgency for more services in these areas and that the additional investment identified in the Plan will be insufficient. Key issues in country areas include high housing costs, unemployment, staff recruitment and retention challenges.

One urgent recommendation put forward during our consultations is to invest in the capacity of local communities and people with lived experience, as well as services.

WAMMH recommends that the Plan and implementation process:

- Enable local input in service co-design
- Clarify how services will be adapted and designed to address local characteristics, needs and challenges
- Strike a balance between investing in additional services now and piloting models in country locations to ensure their local effectiveness
- Factor in the additional costs of rural and remote delivery, including economy of scale issues
- Invest in local communities to address whole person needs, grow social capital, make greater use of local people, and develop local support staff
- Invest in people with lived experience to develop local peer workers, and enable them to engage meaningfully in co-production, co-design and co-delivery
- Invest in technologies that enable effective engagement of local people with city-based services and systems
- Consult with Aboriginal people on how investment should be targeted to increase local delivery including through Aboriginal mental health workers and peer worker development and support.

Avenues for community and lived experience capacity building that would work include Recovery Colleges, and training targeted at peer workers development and supervision. The latter could be included in the prospectus of Recovery Colleges or as separate programs. The local community capacity building occurring in Balgo was offered as a positive approach, as was the role of PHaMS staff in remote communities to develop and support peer workers.

3.3 Peer work

It is clear that peer workers are effective and required in all types of mental health and AOD services, across the service system and in remote Aboriginal communities. There is strong support for increasing peer worker leadership and participation in all types of service implementation and design.

We received concerned feedback that specific strategies, plans and pathways to assist consumers and carers into peer work are not outlined in the Plan, and that investment in peer workers is urgently required in country areas. To put peer work at the front and centre in the Plan's reform and implementation we recommend the following strategies:

- Increased investment in quality, affordable education, training and accreditation for peer workers
- Target investment for peer worker development and support in rural and remote areas, including the development of culturally safe models in Aboriginal communities
- Enable organisations to value, work effectively with peers, and support them in the workplace through development programs and additional funding where required
- Include lived experience as a desirable criterion during recruitment for all non-peer positions including clinical positions
- Peer involvement in procurement processes
- Consider the role of ratios and incentives to grow the proportion of peer workers in the workforce
- Develop whole of government commitment to increasing the peer workforce in associated systems
- Implement the Peer Work Strategic Framework, which outlines a number of areas where organisations need to build their capacity if they are to embed peer work into their services.

3.4 Housing

The centrality of housing in mental health recovery and the lack of affordable and appropriate housing was a key issue repeatedly raised in our consultations. Although the sector supports the Plan's statement that more specialised homelessness services are needed, financing these is a key concern, with Commonwealth funding security tenuous and under review through the Commonwealth Government's Federation Whitepaper process.

A system-wide multiagency accommodation strategy is well supported. To be effective WAAMH recommends it:

- Have a cross sector focus, working nationally and locally to ensure a broad range of responsive, flexible housing options
- Integrate housing into service specifications for all mental health services
- Build the mental health capacity of homelessness and housing support services
- Homelessness prevention strategies including tenancy, hoarding and squalor supports
- Develop new housing options e.g. supported rentals which facilitate transition from residential accommodation and 'free up' beds for others
- Have additional resourcing or alternative debt financing arrangements.

It is also necessary to pursue the rapid stock transfers to Community Housing Providers, which will in turn enable providers to leverage off this asset to build or purchase additional housing.

Housing first, wraparound and therapeutic models were of interest to the sector. One model put forward is the Safe Havens Model, which provides opportunities for street-present people to be safer and better nourished than they are on the streets. This service creates an environment that is safe, flexible and stable with no treatment participation demands but with high expectations.

Mental health housing services need to be long term, whole person focused, flexible and responsive, and able to provide more support when people become unwell. WAAMH supports the idea put forward by peer workers to build sourcing affordable accommodation options into their role, or the development of specialist mental health and housing peer workers.

3.5 Diversity and the Consumer Voice

The Plan states that it is person centred but does not articulate how this is so or how person centred services can be achieved. WAAMH understands the data is important for planning purposes; however it is essential the person is at the centre throughout its implementation.

We also received feedback that diverse voices are not sufficiently present, including those of women and Aboriginal people. Vulnerable and marginalised groups, who may not engage with services, need particular consideration in service design and engagement strategies.

3.5.1 Aboriginal people

The Plan needs to recognise Aboriginal land, cultures and Elders past and present, the health disparity between Aboriginal and non-Aboriginal people, and the need to engage Aboriginal people fully and respectfully in service design and implementation.

We received input that the Plan should reflect engagement with Aboriginal peoples on their cultural knowledge, systems, protocols, values and beliefs, and how these impact on mental health and wellbeing:

> "Mental health, illness and recovery are entwined with traditional cultural and spiritual beliefs as well as the impact of social determinants. It is essential that clients and communities are totally involved in planning and designing the models of service and then involved in implementing them."

Specific strategies need to be developed in partnership with Aboriginal peoples and in addition to extra services, which we all agree are needed, the Plan could explore:

- Elder participation in all forums pertaining to Aboriginal health
- Capacity building for Aboriginal workforce
- Cultural change in leading bodies
- More partnerships and meaningful working collaborations.

WAAMH recommends that the Commission engage with Aboriginal people to develop specific initiatives and priorities for Aboriginal people and communities. A way forward could be developed through men's, women's and youth forums or yarning circles, that bring Aboriginal people together to discuss what is working and what to do next. Another effective avenue to engage with Aboriginal people is the Looking Forward Project, an innovative model that partners mental health services with Aboriginal Elders to improve service access and responsiveness to local the Nyoongar community.

3.5.2 Women

Contributors to mental illhealth for women include family and domestic violence, poverty and structural drivers such as gender inequality. Good mental health for women includes involvement in community activities; supportive relationships; self-esteem and self-efficacy; access to education and employment; an increased sense of belonging; improved physical health; and enhanced long-term well-being.

The Plan's implementation processes require a gendered analysis and understanding of mental health issues and mental wellness to achieve the best possible outcomes for women.

WAAMH supports the priorities put forward by the Women's Community Health Network WA:

- Lead, in partnership with peak bodies, the implementation and evaluation of gendered approaches to mental health and wellbeing, focused on reducing the wide-ranging impact of long-term mental health conditions such as depression and anxiety
- Fund services to implement best practice programs with young women and girls to promote mental health and wellbeing, recognising that primary prevention and early intervention is key to lifelong mental health
- Training and education in women's issues and women-sensitive practice
- Development of a tailored approach to treatment options and service access through understanding the special needs of women
- Include women who have a diagnosed psychiatric condition, not just women who have postpartum depression in the peri-natal mental health strategy. [1]

3.5.3 Coexisting Mental Illness and Alcohol and Other Drug Issues

We received feedback that the Plan is not sufficiently responsive to the needs of people with coexisting mental illness and alcohol and other drug problems. Issues raised included the need to articulate a clear policy framework, identify clear care pathways, develop integrated services, and integrate both issues in prevention and early intervention, particularly for young people.

WAAMH recommends consideration is given to the development of an implementation framework for dual diagnosis, inclusive of policy, prevention, early

[1] 2015, Evans, A., *Women and mental health and alcohol and other drug use*, Women's Community Health Network Draft Paper

intervention and other services. This will require significant consultation with both sectors.

3.6 Commonwealth funding

The current climate of uncertainty in Commonwealth mental health funding is a primary concern to WAAMH's members. As such, the Plan's assumption that Commonwealth funding will remain unchanged is at risk.

In WA, Commonwealth mental health funding is a fundamental and essential part of mental health service delivery. The cuts and uncertainty are having very serious impacts on consumers, carers, providers and local services; these are outlined in depth in WAAMH's recent submission to the Senate Inquiry on the Department of Social Services tendering processes.[2]

In March, WAAMH conducted a brief survey of the sector about Commonwealth funding issues, with 16 responses received. The health and mental health programs, in which respondents considered Commonwealth investment most critical to mental health service provision in WA, in order of priority, were:

- Day to Day Living in the Community (DOH)
- Partners in Recovery (DOH)
- Personal Helpers and Mentors service (DSS)
- Mental Health Respite: Carer Support (DSS)
- Other, these included suicide prevention, and health programs such as perinatal, Access to Allied Psychological Services, and the Substance Misuse Delivery Grants Program.

Although we asked respondents to prioritise mental health programs in order of importance, both providers and consumers told us that all of these programs are vital. Taking a systems view, we know that the removal of one program would create pressures in other areas. This can be seen in the transition to the NDIS, which has created an even more insecure funding environment.

The need for continued Commonwealth investment in mental health community services is critical, and the WA Government should advocate strongly for it to be maintained.

3.7 Co-production and Co-Design

Consumers, carers and CMMHO's wholly endorse the Plan's principle that:

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

[2] http://waamh.org.au/assets/documents/systemic-advocacy/submissions-and-briefs/waamh-submission-senate-inquiry-dss-tender-processes-final.pdf

However, they are also concerned that the Plan does not identify and outline specific strategies to achieve this. The embedding of co-production and recovery principles are fundamental to securing the cultural change and reform required across the system; as such WAAMH recommends that the Plan outline how co-production and co-design will occur going forward and a budget for this work.

Co-design of procurement processes for mental health services through the inclusion of consumers is a strategy which could be utilised. This could occur in areas such as service specifications, encouraging co-production processes alongside collaboration, and in allowing sufficient time to enable co-design. Building Co-Production and Co-Design into procurement processes has been recommended in section 3.10 of this submission.

We also recommend that strategies, initiatives and resources to build community, consumer and carer capacity are identified. These are essential to enable a broad range of people with lived experience to confidently engage in co-production and are particularly urgent in rural and remote areas (see Section 3.2 Rural and Remote for further detail.

3.8 Workforce Development

There is a range of workforce issues that will require attention during the Plan's ten-year period.

The key issues that arose in our consultations included large gaps in staff capacity and associated burn out, staff attraction and retention challenges in rural and remote areas, and the need to expand and develop the peer workforce and implement peer programs.

Training issues include variable training across the community sector, the challenges of resourcing ongoing, contemporary and practical training, and impacts on other workforce issues including staff attraction and retention.

WAAMH recommends:

- Further development and implementation of the state-wide Workforce Strategy which the Mental Health Commission has developed . This plan should consider issues for both public and CMMH service including skills mapping, demand planning, workforce expansion and clinical governance development for CMMHO's
- The provision of cross sector training
- Resource implementation of the Peer Work Strategic Framework[3] across the State.

One model put forward to enable sustainable CMMH training was the pooling of resources by organisations to contribute to training and professional development of the workforce. A shared services model could be an alternative to the current focus

[3] Commissioned by Mental Health Commission from WAAMH in 2014

on consortia. This model maintains the identity of each individual organisation while enabling the economies of scale that come from sharing back of house infrastructure. In rural and remote areas, this approach might also include services other than community mental health, such as public services and local community services.

3.9 Community Capacity Building and Education

Capacity building and education is central to recovery. While the Plan does state a need for education for a range of audiences, we received feedback that it needs to set out a comprehensive education plan or strategy.

WAAMH recommends:

- Develop and invest in specific education strategies for the community, consumers and carers
- Invest in social capital development, education, skills development, safety networks, self-help and family and carer support, in rural and remote areas, including Aboriginal communities
- Target workforce pathways at local people in rural and remote areas including peer worker development.

Mapping the skills and expertise of local residents through a time banking model is one model of interest to enable greater use of local people and identification of gaps.

A key model arising across the capacity building, education, workforce and peer workforce aspects of reform is Recovery Colleges. These provide natural settings for consumer, carer and community capacity building through learning and education and endorsed by people with lived experience and the CMMH sector.

3.10 Commissioning processes and the role of the CMMH sector

CMMHO's effectiveness in supporting people to wellness, recovery orientation and person centeredness has been an important contributor to mental health reform. These strengths and a desire to increase the role of CMMHO's in mental health delivery across the range of service types were key themes in our consultations.

Outcomes based service design continues to be a high priority for all service types, not only in community support services. The sector is concerned that the Mental Health Outcomes Statements are not in the Plan despite their ongoing relevance and link to the Quality Standards Framework.

Procurement processes which value the Mental Health Outcomes Statements, or more broadly, outcomes related to people's quality of life, are fundamental. In the context of competitive tendering and a resultant increased focus on price and efficiency, the sector strongly endorses and promotes outcomes based contracting as being central to achieving the government's recovery policy agenda. Building co-

design into procurement processes would also help to achieve better outcomes (for more detail refer to section 3.7 of this submission).

We recommend the development of a procurement strategy that recognises the value and strengths of CMMH organisations in service delivery, grows diversity of organisations, which results in choice for consumers, and supports all types of business models including niche and small service providers in the market place. It should consider strategies to build the capability of CMMHO's in tendering and consider how to encourage partnership models including consortia, collective impact and other business models which incorporate collaboration beyond the lead agency consortia model.

Of interest to some agencies are procurement models which target a region, and place based approaches. They would like to see the expertise of communities used to define service delivery requirements, and the local community knowledge and expertise of locally based organisations valued.

Outcomes based contracting, place based approaches, co-design and rural and remote capacity building all point to the need to develop procurement mechanisms which enable collective outcomes.

To enhance recovery outcomes WAAMH recommends procurement processes which value or require:

- Longer term contracts and security of funding
- Reflect the costs of local provision
- Outcomes based service design, measurement and reporting, including the development of consistencies across providers
- Local knowledge, especially in regional and rural areas
- Mechanisms to deliver collective outcomes such as building collaboration and co-design into service specifications
- Increased use of individualised budgets.

More detail on positive tendering processes is available in WAAMHs recent submission to the Senate Inquiry into Department of Social Services tendering processes[4].

4. Service Types

A significant focus of WAAMH's consultations was the suite of services identified in the Plan, and the role of the CMMH sector in delivering these. In further sections of this submission we outline some aspects relevant to particular service streams. Here, general comments about services are provided.

The sector endorses the Plan's intent to provide services that enable personal recovery journeys and increased choice and control. The sector agreed that key foci

[4] http://waamh.org.au/assets/documents/systemic-advocacy/submissions-and-briefs/waamh-submission-senate-inquiry-dss-tender-processes-final.pdf

for improving system design include a suite of integrated services, clear care pathways including step up and step down options, earlier intervention, more community-based support, involving peer workers at all levels and the right kind of services through diversity and need responsiveness.

Concerns outlined included an insufficient focus on co-design, self-directed supports, evidence based services, a social rather than medical model, and embedding of transcultural and culturally secure processes into all services. Consumers also advocated for opportunities for education, learning, socialisation and development as well as 'services'.

Priority features of all mental health services include recovery basis, accessible for those without a diagnosis and across all income levels, flexible, person centred, trauma informed, family oriented (inclusive of carers, other family members and children), individualised, wrap around, community presence, integrated, accountable, quality focused, evidence based and appropriate to local needs.

Connecting with local communities and investing in the community was a key theme for the future direction of mental health services. Place based, systems oriented, approaches to service design and delivery, which can focus on the whole person and community inclusion, are needed.

To increase recovery focus and consumer choice and control we recommend:

- A recommitment to the Mental Health Outcomes Statements for commissioning of all mental health services
- Including self-directed supports as one of the Plan's principles
- More use of individual budgets to enable opportunity as well as service support
- Incentivising recovery, co-production and outcomes to move the system away from measurement confined to episodes of care and activity based funding.

4.1 Prevention and Earlier intervention

The focus of the Plan on increasing prevention and mental health promotion is strongly supported; in particular developing a range of complementary prevention strategies to promote social inclusion and create supportive environments (strategy 6.5.4). Models of interest for this strategy include: wellbeing services, collaborative prevention and early intervention services and a 'community of wellness' approach.

There is very strong support for the action 6.6.4 'to identify opportunities to enhance school based programs' with particular emphasis on all ages, early identification and the need to integrate mental wellness, mental health and AOD prevention with young people.

4.2 Community support

There is strong support for the Plan's intended increase in community support hours and the Plan's strategy to promote the expansion of recovery focused mental health

services. Some organisations remain concerned that the increase in support hours could still be inadequate.

Challenging the silos, normalisation and reduction of stigma through community building, education, community-service integration and place-based approaches were central themes in discussion of the Plan. When discussing community supports, much focus was on opportunities and a sense of connection and co-creation, not just service provision and medical orientation. Contemporary support groups and centres were one model offered for expansion, inclusive of integrating mental health into mainstream community centres. Recommended strategies to build community capacity to address these issues are outlined in the section 3.9 'Community Capacity Building and Education'.

A key theme in discussion of community support services was the need to ensure an increase in services that take a systems approach and are inclusive of all life domains such as housing, disability, domestic violence, effects of trauma etc. Suggested strategies to achieve this include service design and procurement, sector capacity building, and co-location along the lines of the IPS model which co-locates clinical and employment, government and non-government services.

A current failure of the system is the lack of focus on children of parents with mental illness. WAAMH recommends the development of more specific services and supports which reduce the stresses and caring burden for children, provide them with appropriate supports, provide practical household support, and support parents to regain their ability to care for themselves and their children.

In addition to these specific services, we recommend that adult mental health services include in their remit responsiveness to the needs of children in the family, and adults as parents. This fits with whole person and systems approaches to service design.

4.2.1 Recovery Colleges

In our consultations much energy and positivity was focused on the development of Recovery Colleges. In the UK Recovery Colleges have proven to be a cost effective way to keep people out of hospital as they grow to understand how to achieve their own wellness. These hands on, peer driven centres of learning have a demonstrated success outside of Australia and there is significant interest in WA's efforts to develop a Recovery College.

The Recovery College would provide a focused and natural avenue to address the critical issues of capacity building for consumers and carers, enabling them to engage confidently in co-production at all levels. It would also assist to build local social capital. Multiple Recovery Colleges could address region specific needs.

WAAMH recommends government funding and support to the development of Recovery Colleges in metropolitan and rural locations.

4.3 Community treatment

This section is about the services outlined in the Community Treatment chapter of the Plan.

The sector is supportive of the Plan's intent to vastly increase community treatment services. Key services encompass: improved acute and crisis services with pathways into other support and accountability for supporting transition to the next level of care, more intensive at-home supports, outreach services, more step up step down, multidisciplinary teams which follow people through different services and systems, increased peer support and increased embedding of clinical services within community support and CMMH organisations. Rural and remote service increase is urgently needed.

There were concerns expressed that community treatment services would operate in the health/biological model rather than a social model focused on the whole person, health and wellbeing. Models that combine clinical liaison with community sector organisations are sought. Effective models of interest include Drug and Alcohol Youth Service (DAYS) and Street Doctor.

CMMH organisations seek to expand further into community treatment but communication is a current major barrier to partnerships, and capacity building and funding support will be required for many agencies to enable recruitment, retention and supervision of clinical staff.

Recommendations:

- Embed recovery and a systems approach to enable a focus on the person as a whole into the design of all treatment services
- Require evidence based social, recovery models of support and treatment
- Require more holistic, creative and flexible options
- Require attention to consumer and carer/family engagement in procurement
- Map the capabilities and gaps of the CMMH sector to develop targeted strategies which enable further expansion into community treatment
- Develop information sharing protocols at a service system level.

4.3.1 Primary care

The sector supports an enhanced role of primary care providers in mental health including increased availability of psychological services as an earlier step in the care pathway than psychiatry, increased mental health nursing, and some support for coordination roles in primary care. WAAMH supports the Plan's proposed role for the state government in advocating for improved primary care and will continue our own advocacy on this issue.

4.3.2 Child and adolescent

There is very strong support for increasing child and adolescent community treatment services. These services need to value the lived expertise of carers and families, be strengths based, provide outreach as well as clinic based services and

integrate with education and local supports to facilitate continuity of care with school and home life.

WAAMH recommends the commissioning of expanded care pathways inclusive of integrated pathways out of service, as well as earlier intervention services to those who do not meet current CAMHS eligibility. Procurement open to the CMMH sector is recommended.

Models of interest included case management in school for children aged over 12 years and the CAMHS Rockingham Triage system which has reduce wait times.

4.3.3 Youth

WAAMH supports the increased focus on youth services and supports within the Plan. The key features of youth services include: strengths based, integration of mental health and AOD, earlier intervention, a whole person focus, coordination and integration with school, home-life and community connection/inclusion. Models to engage marginalised groups and referral pathways for youth need to be developed.

Models of interest included YouthReach and the DSC positive behaviours program, which is a good example of collaboration with schools.

4.3.4 Older adults

We received feedback there is insufficient focus on adults in the context of an aging population. Ideas put forward included a state-wide strategy for older adults and people who are prematurely aged inclusive of a support model for community aged care workers and their training, specific mental health supported accommodation services, and support models for people in aged care services.

4.4 Forensic

WAAMH strongly supports the urgent development of the full range of forensic services outlined in the Plan including improved police responses, holistic police co-responses and training, and diversion programs with roll out of the START Court.

Concerns that were outlined in relation to forensic issues included the need for forensic beds that are not prison based, concerns that the Plan misstates the evidence about mental health and a clear link to offending, and does not include attention to the very high rates of people with mental health issues as victims of crime.

Models of interest include the Disability Services Commission Justice Coordinator; a dedicated position whose role includes the development of an individual plan for prison to community transition in partnership with the person, all relevant agencies and their families/carers. The position develops specialist expertise and provides consultancy advice within the agency and to external stakeholders. The Serco/Mission Australia partnership for the Wandoo reintegration Facility also warrants investigation for its effectiveness regarding mental health outcomes and possible adaptation to adult offenders.

The key features of forensic services include a recovery orientation; rehabilitation, treatment and support focus, rather than a corrective/punishment focus; transition

from prison to community with strong in-prison engagement; staged approaches; interim support and accommodation options; and longer term (18 months) re-integration supports.

As well as services, there is a need to take a systems approach to forensic issues and consider the drivers of imprisonment. These include the urgent need to reform mandatory sentencing legislation and the *Criminal Law (Mentally Impaired Accused) Act 1996*.

Recommendations:

- The Plan is reviewed to reduce the criminalisation of mental illness
- Specific strategies are developed to provide support and pathways for people with mental health issues who are victims of crime
- Forensic beds not be built on prison grounds
- A range of early intervention, police based, diversion and transition supports are developed in consultation with people with lived experience
- The MHC increases its advocacy on justice law reform to secure increased diversion and better outcomes for people with mental illness.

4.5 Specialist State-wide Services

It is generally agreed that Specialised State-wide Services (SSS) are essential and need expansion. There were some concerns expressed that 'specialised services' could be too narrow; as with all services a whole person approach is required for good outcomes. Flexible delivery will be needed, especially in rural and remote areas.

Concerns were also expressed about the current organisational arrangements within which SSS are delivered, being tied to area health services. Effective design, funding and delivery of these services requires a state-wide view, as such WAAMH recommends the establishment of SSS that are commissioned as an independent entity by the Mental Health Commission.

As with community treatment services, our consultations showed strong support for expanding the specialised services available through the CMMH sector, including through having clinical staff as part of the team and working alongside peer workers.

Service gaps and expansions needs identified include:

- Specialist clinical supports for people with complex personality disorders, who are often overlooked and "fall through the service gaps"
- Expansion of transcultural mental health services
- Culturally secure services, particularly in remote Aboriginal communities.

We received particular input regarding the needs of people with autism and mental illness who at times experience very inappropriate treatment, particularly once they reach adulthood. WAAMH supports strategy 11.5.11, to establish a specialised service for people with co-occurring mental illness and intellectual disability, including autism. This must build on the work done in other jurisdictions and the WACOSS led

Core Capabilities Framework for working with people with intellectual disability and co-occurring mental illness.

Some key features of the new service should be that it is inclusive of people of all ages, provides support at key transition points including transition to adulthood, and provides consultancy advice to treating practitioners and other support services to enable significant improvements in practice across the system.

4.5.1 Police Co-response

A Police co-response model is strongly supported. Key features of this model include: additional training for police officers, the knowledge and resources to enable referral to community treatment and support options not just hospital based services, and engagement with hospital emergency departments and the proposed mental health 24 hour crisis service .

4.5.2 Aboriginal services and communities

Issues raised in relation to Aboriginal people included a dire need for clinical services in very remote communities, the need for a range of support options including respite or recovery houses, safe places for children and women to go, and men's spaces designed to engage men and integrate men back in to community. Going "out bush" or on to "country" is healing and should be included in treatment services. Peer workers are effective but require support and development.

When developing remote services WAAMH recommends:

- Extensive consultation with local people and organisations in culturally safe ways
- A peer work development strategy for Aboriginal communities.

5. Implementation

Key themes raised in relation to implementation included: funding being made available in the current fiscal context, the need for whole of government commitment, and the need to embed cultural change. More open, transparent consultation processes were a key theme and fuller engagement with women, Aboriginal people and marginalised groups is required to enable appropriate service design and implementation.

In implementing the Plan, WAAMH recommends:

- The Plan articulates a stakeholder engagement strategy for transparent, open consultation, including effective engagement with people with lived experience
- Transparency about budget processes and funding
- Genuine co-design of services
- Establish whole of government commitment and a partnership framework to achieve positive outcomes for people with mental illness.