Division 34: Mental Health Commission, $621 493 000 —

Mr I.C. Blayney, Chairman.

Ms A.R. Mitchell, Parliamentary Secretary representing the Minister for Mental Health.

Mr T. M. Marney, Mental Health Commissioner.

Mr N.S. Guard, Executive Director, Drug and Alcohol Office.

Mr E. Dillon, Director, Policy, Strategy and Planning.

Mr K. Smith, Director, Corporate Services and Governance.

The CHAIRMAN: Good evening. This estimates committee will be reported by Hansard staff. The daily proof *Hansard* will be published at 9.00 am tomorrow.

It is the intention of the Chair to ensure that as many questions as possible are asked and answered and that both questions and answers are short and to the point. The estimates committee's consideration of the estimates will be restricted to discussion of those items for which a vote of money is proposed in the consolidated account. Questions must be clearly related to a page number, item program or amount in the current division. It will greatly assist Hansard if members can give these details in preface to their question.

The parliamentary secretary may agree to provide supplementary information to the committee, rather than asking that the question be put on notice for the next sitting week. I ask the parliamentary secretary to clearly indicate what supplementary information she agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the parliamentary secretary's cooperation in ensuring that it is delivered to the committee clerk by Friday, 30 May 2014. I caution members that if the parliamentary secretary asks that a matter be put on notice, it is up to the member to lodge the question on notice with the Clerk's office.

I now ask the parliamentary secretary to introduce her advisers to the committee.

[Witnesses introduced.]

The CHAIRMAN: The parliamentary secretary.

Ms A.R. MITCHELL: I let others in the chamber know that we have had preliminary discussions about the time for each division and, subject to change, it is perceived that we will spend an hour and a quarter on the Mental Health Commission, an hour on the Disability Services Commission and about 45 minutes on the Department for Child Protection and Family Support.

The CHAIRMAN: I see Dr Jacobs is here. The rule we are operating under is that everybody else has to ask a question before a non-committee member does. Member for Armadale.

Dr A.D. BUTI: I refer to "Spending Changes" on page 393 of volume 1 of the *Budget Statements*. I will ask two questions because one goes into another. Can the parliamentary secretary provide a full breakdown of savings made in the 2013–14 procurement savings initiative and a full breakdown of anticipated savings to be made in the planned 2014–15 procurement savings initiative?

Ms A.R. MITCHELL: I ask Mr Tim Marney to provide a response.

Mr T.M. Marney: The amounts detailed in the *Budget Statements* regarding procurement savings in the context of totality of the Mental Health Commission's procurement are fairly minor. The savings were made through general reductions in consumables and purchasing rather than in areas of service delivery or procurement of activity either through the Department of Health or non-government service providers. In essence, both those savings amounts are about the same in each financial year. Basically, those savings have come from being more frugal across the board with the procurement activities of the commission and its back-of-office supplies.

Mr D.J. KELLY: I also refer to page 393, "Spending Changes". How many staff of the Mental Health Commission were made redundant as part of the government's voluntary separation scheme? What positions did those staff members hold at the time of redundancy? What has happened to the roles those staff members used to occupy?

Ms A.R. MITCHELL: I will get that information for the member. While we are waiting for that, I ask Mr Neil Guard to provide a response regarding the Drug and Alcohol Office because it has been operating separately.

Mr N.S. Guard: Two staff members in the Drug and Alcohol Office accepted voluntary redundancy. One was the position of librarian, and the library is being decommissioned. The other position was a contract procurement officer position in our client services area, and that position has not been refilled.

Ms A.R. MITCHELL: I now ask Mr Marney to give the member the answer on the Mental Health Commission.

Mr T.M. Marney: My understanding is that there were three voluntary redundancies in the Mental Health Commission: one in the performance and reporting area; one human resources officer; and one in the Mental Health Review Board, who was technically an employee of the Mental Health Commission. Neither the HR position nor the Mental Health Review Board position is necessary in the structure at this point. The reporting and performance area is subject to restructure at the moment. Therefore, that position, albeit in the management tier, is no longer considered necessary. Given the impending merger of the Drug and Alcohol Office with the Mental Health Commission, subject to the passage of legislation through Parliament, a number of positions and the management position in particular will not need to be refilled.

Dr A.D. BUTI: It has been reported—this still comes under the general spending changes—that the mental health budget is being increased by 6.1 per cent or $46 million, including the addition of 136 beds. Can the parliamentary secretary please provide details on how that reported increase in spending has been allocated? Can she also provide us with the infrastructure projects that have been included in that additional funding allocation?

Ms A.R. MITCHELL: I will ask Mr Marney to give the more specific information for that because it is easier for him to refer to that.

[7.10 pm]

Mr T.M. Marney: The bulk of the expenditure will flow through to two main areas, including the purchase of services from the Department of Health and Area Health Services. That is reflected in the weighted average units of service being purchased from the Department of Health. There are two growth factor components, if you like, in the weighted average units. One is the price. I will rely on my chief finance officer to correct me if I get this wrong, but my understanding is that the Independent Hospital Pricing Authority set price growth for the 2014–15 year at 3.6 per cent. A big chunk of that growth goes to the price increase associated with the existing activity. Then on top of that there is further growth in activity, which is spread throughout the health system. That brings the increase in health funds to the figure of six per cent or thereabouts, as the member for Armadale mentioned.

As I said, the growth inactivity is spread across the system, but there are a few specific pockets of infrastructure that come onstream in 2014–15 and some transfers of activity across the system. Probably the most notable element is the commissioning expected in 2014–15 of additional beds associated with the opening of Fiona Stanley Hospital, and with that there are an additional 30 beds coming onstream. That is not a straight net addition of beds; there is some transfer of activity from other facilities, including Bentley Child and Adolescent Mental Health Service, transferring to the Perth Children's Hospital. Again, with the commissioning of Perth Children's Hospital there will be additional child and adolescent beds there. I think those are really the main, if you like, capital components of growth. Through 2014–15 though there will be ongoing investment in the Rockingham subacute facility, which is funded as part of the budget, and there will be further development of the Broome subacute facilities as well through the 2014–15 year. They are probably the priority areas of focus during that year of additional service expansion and the government's commitment to the goldfields subacute facility will follow soon after that. Those are probably the key areas, unless my chief finance officer has anything to add. Coming back to the percentages in growth, it was actually not 3.6 per cent and 3.9 per cent in price, so there is the inflation factor, if you like. There is estimated inpatient growth of 2.6 per cent.

Mr N.S. Guard: In the alcohol and drugs area the increase above the 2013–14 estimated actual is around $3.23 million, mainly attributed to $800 000 in the north west for our royalties for regions drug and alcohol support program, particularly relating to the Carnarvon dual purpose centre that comes onstream in the next financial year. There is an additional $64 000 next year as part of the additional commitment of $5.2 million over the next four years to expand the alcohol and drug integrated community drug service model in the metropolitan area, in particular in the northern corridor up to Joondalup, and then the remainder of that $2.36 million is an indexation next year.

Dr A.D. BUTI: Royalties for regions was mentioned. Is there funding in that with respect to transitional housing and support programs for the north west?

Mr N.S. Guard: No, the transitional housing program was not funded through royalties for regions; it was funded through a different state government appropriation three years ago, which included the cost of purchasing 15 houses and $450 000 per annum to operate and support people in those transitional houses.

Dr A.D. BUTI: Is there ongoing funding for transitional housing support programs?

Mr N.S. Guard: No, we have to produce a case for the continuation of that funding in next year's budget process.

Dr A.D. BUTI: Can I just get some more detail in regards to beds? By way of supplementary information could the parliamentary secretary provide a list of current mental health beds in the system, a list of future beds due to come online as a result of the budget and what years they will come online?

Ms A.R. MITCHELL: Through supplementary information I will provide the member for Armadale with a list of the current mental health beds in the system. When the member asks about future mental health beds, how far out does he want to go?

Dr A.D. BUTI: Up to the budget increase when those beds will come online.

Ms A.R. MITCHELL: So that will go out of 2014–15 and when they are coming online.

[*Supplementary Information No B19.*]

Dr G.G. JACOBS: I refer to the second dot point under "Mental Health Infrastructure" on page 395 of the *Budget Statements*. I am particularly interested in teasing out the detail in and around the goldfields for the step up, step down subacute services. Where are the allocated moneys for infrastructure in the budget papers and where is the recurrent funding? As part of that, I refer to the line item "Sub-acute Services" under "Spending Changes" at the bottom of page 393. Is that to do with recurrent funding to run these subacute services; and if so, is it true that this does not come on until 2016–17 and 2017–18?

Ms A.R. MITCHELL: As Mr Marney said previously, the proposed goldfields subacute services are in the early stages of planning development only and that is why they are not currently in place. I will ask Mr Marney to give some further information on that.

Mr T.M. Marney: It is anticipated with the development of both the Rockingham and Joondalup subacute facilities that the existing capital allocations for those facilities should provide sufficient scope to deliver those plus realise sufficient savings to develop the goldfields facility. That is certainly the desired outcome. The estimated cost broadly of the goldfields facility is around $2 million. The recurrent funding for the goldfields facility is actually built into the forward estimates already. It is really the capital component that needs to be identified as part of the process of the development of the Rockingham and Joondalup subacute facilities.

Dr G.G. JACOBS: I have a supplementary question. I was really interested in the time lines because I have had this discussion before in this place or maybe it was in the other place, but it was the same time in the year. We talked about subacute facilities in the goldfields—one in Esperance and one in Kalgoorlie–Boulder. I am really interested to know what the time lines are because there was some funding in the previous budget; there was a line item that indicated around $1.2 million. That would not be enough money to build them and it might not even be enough money to run them, but there was some money in the budget and now we hear that they are in the planning phase. I wonder what the time line is because we are feeling anxious about subacute services in those two areas. As the commissioner would understand, servicing people when they have an acute illness is fine, but it is actually what happens when they come out of the acute facility that is so important in transitioning them back into the community.

Ms A.R. MITCHELL: Can I just clarify whether the member is asking for supplementary information or further information.

Dr G.G. JACOBS: It is further information in and around the whole issue of these subacute facilities for my region.

Ms A.R. MITCHELL: That is fine, I just wanted that clarification and I will ask Mr Marney to continue with the answer.

Mr T.M. Marney: As I indicated in my previous response, there is actually money allocated for the operation of the goldfields facility, and as the member correctly pointed out, it is in the vicinity of $1.2 million or $1.3 million in 2015–16, $1.3 million in 2016–17 and $1.4 million in 2017–18. That should be sufficient to cover the operation of the six-bed facility in the goldfields.

As I indicated in my previous response, the issue is really the capital funding to establish it, and it is estimated to be around the $2 million mark. We have commenced work in conjunction with the Department of Housing to identify a suitable location for the facility, and given that that is the stage we are at with that facility, I would say it is unlikely that it would be operational within 2015. We are looking probably at calendar year 2016, somewhere.

[7.20 pm]

Dr G.G. JACOBS: In this process, it was considered that rather than build a purpose-built facility from scratch on a greenfield site, there would be potential to acquire already built appropriate facilities, such as five or six self-contained units in a complex, for instance. I have had that discussion with the minister in and around the

potential of acquiring something like that, which has a carer's house, if you like—a supervisor's house—and five or six units that are self-contained, already built, for sale on the market. Potentially, there would be significant savings and obviously the government could bring that on-stream fairly quickly. If we are talking about a greenfield site and starting from scratch, we will be a number of years away. I just wondered whether the parliamentary secretary could pass on to the minister that there is potential for that still to occur in order to bring a facility on that would do for the purposes of the region.

Ms A.R. MITCHELL: I thank the member. I will certainly take that on board for him, but I think he will find that Mr Marney is looking at any possibility out in the goldfields to bring this matter forward. I will just ask him to outline a bit more on that for the member.

Mr T.M. Marney: As the member has suggested, there are alternative methods of delivering these facilities—buying something that is already established versus complete greenfield construction. In the case of both Broome and Rockingham, both those alternatives are being pursued; therefore, we are already doing a mixture of those models. Certainly, as we explore through the goldfields—pardon the pun—we will look at any existing facilities that may be suitable, bearing in mind that, obviously, they have to comply with the appropriate regulatory settings, and that is probably the catch. Finding a facility in itself may be a little tricky, but not impossible; however, finding one that is likely to be able to be upgraded to a satisfactory standard for accreditation is probably the challenging bit. I think sometimes it can be a little easier to see a six-unit site, but not realise the complexity of bringing it up to a standard that is fit-for-purpose for a subacute facility.

The other alternative, of course, that we will consider in the procurement options analysis is whether we just go to the market and purchase the service because we do not run these subacute facilities ourselves; we procure services within them. It also can be an option to procure the provision of the facility and the provision of the services within it. All those options will be pursued with a view to achieving two end outcomes—namely, value for money for the state and also the commissioning of the facility in a timely fashion. Given that there is money allocated in 2015–16, we certainly have the flexibility to pursue all those options.

Ms J. FARRER: I refer to the second dot point under the heading, "Mental Health Infrastructure", on page 395 of budget paper No 2. What progress has been made in Broome to implement this mental health infrastructure?

Ms A.R. MITCHELL: I thank the member. Given that Mr Marney has been talking about subacute facilities, I will just ask him if he can give us an update on Broome.

Mr T.M. Marney: My understanding of the Broome facility is that a site has been identified, purchased and cleared ready for the construction of new facilities on that site. We are currently working with the Department of Housing to plan that construction project and get it underway as soon as possible. I will take advice on the current timing, but from memory it is due for operation in 2016—early 2016 is the target that I am certainly aiming for.

Mr E. Dillon: Probably towards the end of 2016 is the likely start-up date of that service.

The CHAIRMAN: Sorry, before you speak, if you could just introduce yourself so that Hansard can identify you.

Mr E. Dillon: I beg your pardon.

Ms A.R. MITCHELL: I authorise Mr Dillon to make a further response.

Ms J. FARRER: My other question is: how many people can the Broome service cater for at any one time?

Ms A.R. MITCHELL: I will ask Mr Marney to answer that.

Mr T.M. Marney: The proposed facility for Broome is a six-bed facility.

Dr A.D. BUTI: I refer the parliamentary secretary to the Mental Health Bill that was introduced in Parliament in October 2013. What funding is attached to implementing changes outlined in the Mental Health Bill and where is that funding located in the budget papers?

Ms A.R. MITCHELL: I thank the member, and, as he is well aware, the Mental Health Bill is passing through this place. Some $15 million has been allocated over four years; it started with the 2012–13 state budget. This was reduced by $1.5 million to provide savings required for efficiency dividends, but the process of implementation, as I think I explained during the debate, will take over 12 months and is well underway. The implementation reference group is chaired independently by Dr Judy Edwards. That process is well underway; it has commenced. Even though the bill is still not through the other place, it is ready.

Dr A.D. BUTI: Can we find an item in the budget papers about the funding of the changes that will result from the Mental Health Bill?

Ms A.R. MITCHELL: It is not in the current budget papers because it was in the 2012–13 budget.

Dr A.D. BUTI: As the parliamentary secretary knows, a lot of time and effort has been invested by the government into the Mental Health Bill; therefore, it would be allocating somewhere in the budget for the implementation of the changes in the 2014–15 budget—surely.

Ms A.R. MITCHELL: I am just getting further information for the member. Mr Marney will give that response.

[7.30 pm]

Mr T.M. Marney: As previously pointed out in response to the member's question, the actual expenditure decisions associated with the implementation of the Mental Health Bill were taken as part of the 2012–13 budget process. During that process, a policy decision was taken to allocate $15 million over four years for the purpose of implementation. That was detailed in budget paper No 2 as a new spending initiative for the Mental Health Commission at that point in time, which would have been on the equivalent of page 393 in the 2012–13 budget. It would also have been highlighted in budget paper No 3 in the chapter on new expenditure initiatives, which is usually chapter 6, from memory. Given that they were allocated for a specific purpose by the government, those moneys have been quarantined pending the passage of the bill, for the bulk of the implementation. There are some elements of expense that have been funded through those moneys, mainly relating to the operations of the Mental Health Review Board, consultation processes around the bill and the planning for the implementation of the bill once it passes, so there has been a drawdown on those funds. Also funded is the purchase of a new patient case management system, which needs to be in place when the act is proclaimed. There are also some minor funds, in the order of $200 000 to $300 000, allocated to the trial of an interim patient transport service, which is a matter that is considered in the bill. The rest of the funds are held within the forward estimates of the Mental Health Commission and they are subject to consideration of negotiations between the Mental Health Commission, the Department of Health and the Office of the Chief Psychiatrist, in terms of allocation of those funds to the various projects that are needed to support the implementation of the bill. Those sorts of projects include the implications for the Office of the Chief Psychiatrist, in terms of his roles and responsibilities, and the full implementation of patient transport. As the member will know, there is a substantial communication and education process for clinicians and other stakeholders. In the case of clinicians in particular, there will be a need for a substantial learning, training and education process for the implementation of the bill. We are looking towards an e-learning package that will provide that support to clinicians in terms of their understanding of what their new responsibilities are under the operation of the act, as it will be, and the best way to discharge those responsibilities. There will also be a need for additional expenditure in transition to various elements of the bill, which again will be subject to the implementation effort of the Mental Health Commission, the Department of Health and the Office of the Chief Psychiatrist, as well as the Council of Official Visitors and the Mental Health Review Board. The $15 million will remain in the forward estimates and is only to be drawn down subsequent to approval by all those parties as to the allocation of those moneys for the effective program of implementation of the bill.

Dr A.D. BUTI: Was the allocation in the 2012–13 budget papers based on the 2011 draft bill or the bill that is currently going through Parliament?

Ms A.R. MITCHELL: We will take that question on board and provide a supplementary response. Is the member asking on which year the money that was allocated for the Mental Health Bill was based?

Dr A.D. BUTI: Was it based on the 2011 draft bill or the bill that is currently before Parliament?

[*Supplementary Information No B20.*]

Mr J. NORBERGER: I refer the parliamentary secretary to page 395 and the heading "Mental Health Infrastructure". There have obviously already been a few questions tonight with regard to the step up, step down facility. Can the parliamentary secretary provide some greater detail around the subacute service program?

Ms A.R. MITCHELL: I thank the member. I know he has a step up, step down subacute facility in Joondalup, and I know he believes it is very important. I must admit, it worries me that we need so many of the subacute services, but the important thing about subacute services is that they provide support for people who are at risk of becoming unwell and also help people to transition out of being in an acute bed situation in a hospital, so they do provide a valuable service. They are places that are not authorised hospitals, but also support the family and the carers. The new bill recognises a great deal more, and is providing a valuable part in the care of a person with mental illness. Those, we believe, are very important. We will always need acute beds, but we also want to do that transition, either into or out of acute beds, with greater effect, so that hopefully, the need to return to an authorised hospital is reduced and the time that is spent in a facility is reduced. We believe that those subacute facilities will play a valuable part in the future, hence our focus on providing more of them, spread out across the state.

Mr D.J. KELLY: I refer again to page 393, under the heading "Spending Changes", and the line item "National Perinatal Depression Initiative Funding Transfer". What funding is allocated in this budget to perinatal health? What programs are funded in each hospital in Western Australia?

Ms A.R. MITCHELL: The perinatal and postnatal issue is one that is a focus for the area, because it has been largely pushed aside. More focus is going to be given to both perinatal and postnatal depression, along with the experience of other areas and organisations. I will ask Mr Marney to give a more detailed response.

Mr T.M. Marney: The member may be aware that the particular service area referred to is actually subject to a national partnership agreement with the commonwealth government, which is the predominant funder of that service. Unfortunately the commonwealth, in recent negotiations, has basically decided not to continue that agreement beyond the current financial year; there may possibly be an extension in 2014–15, but it certainly will not continue beyond that. The services that are funded directly by the state are concentrated at King Edward Memorial Hospital. The commonwealth national partnership agreement services were spread more broadly across the system; that is my understanding but, as I said, they will cease to continue.

Mr D.J. KELLY: When did the state become aware that the commonwealth was not going to fund those services beyond this financial year?

Mr T.M. Marney: That was the position of the commonwealth government prior to its recent budget. It is my understanding that there is a possibility of extension of funding of up to $1 million for 2014–15, but we are currently in negotiations with the commonwealth to confirm that. But it has indicated, as part of those negotiations, that there definitely will not be funding beyond 2014–15.

Mr D.J. KELLY: In respect of the $1 million that is possibly there for the next financial year, how does that compare with the commonwealth government's contribution for this financial year?

Mr T.M. Marney: It remains the same as its level of contribution for 2013–14.

[7.40 pm]

Dr G.G. JACOBS: I refer to the last line item, "Suicide Prevention Program", on page 393 of budget paper No 2. Under those spending changes there is an allocation of $2.95 million. Will this appropriation continue the state government's suicide prevention strategy, and what will it look like in the future? Indeed, is it a continuation of the One Life program or will it be modelled on something different?

Ms A.R. MITCHELL: Suicide prevention is a key part of the Mental Health Commission and its work. The member for Kimberley has often spoken to me about suicide prevention and we are all very concerned about the rate of suicide in Western Australia. There has been some good quality work done, albeit that there has been a temporary gap as we move forward to the next round. I will ask Mr Marney to give further information on that.

Mr T.M. Marney: I hate to correct the parliamentary secretary, but there is no temporary gap. In fact, the additional expenditure the member referred to reflects a continuation of the existing suicide prevention strategy under the auspices of the Ministerial Council for Suicide Prevention. The member referred specifically to the One Life strategy; the government has invested substantially in that strategy over the past four years. As part of that investment it has established a recognised brand in the One Life strategy. The One Life strategy has been subject to examination by the Auditor General, and there are some learnings in the Auditor General's findings on the first stage of the state suicide prevention strategy. Those learnings will be taken on board to formulate the next phase of the suicide prevention strategy. The $2.9 million in 2014–15 is to ensure that we do not lose momentum with the strategy, but allow enough time for substantial evaluation of what we have achieved with that strategy with the funds already allocated. There are two evaluation processes either underway or proposed and soon to be underway. The first is a substantial evaluation of the strategy to date. That evaluation should be completed in the coming weeks and will provide invaluable information for the formulation of the next phase of the strategy. I am sure the member would agree that to reflect on what has worked well and what should have worked better in the existing strategy before embarking on a new planning cycle is crucially important.

The first element is specifically aimed at the community action planning component of the suicide prevention strategy. There is a need for a broader evaluation, and that will be finished in the second half of this calendar year. Coincident with those evaluations and the release of the findings to the ministerial council, I understand that the ministerial council will undertake a round of strategic planning, based on updated research and evidence, to inform the formulation of policy that will underpin the next phase of the suicide prevention strategy. That will need to be considered by government as part of its budgetary considerations in the lead up to the *Government Mid-year Financial Projections Statement*. I think that forms a very sound process for evaluating what worked well and what we can do better before we continue down the same path and continue to spend public money on

the strategy. Having said that, I think we all understand that the latest figure of 366 suicides in 2012 is a figure that we would all like to see much lower.

Ms J. FARRER: I refer to page 395, and the dot point under the heading "Mental Illness and Aboriginal People". This spending was not allocated in the last budget. Will this spending be allocated to Kimberley centres where it is most needed?

Ms A.R. MITCHELL: Firstly, we believe that the statewide specialist Aboriginal mental health service is an important service, particularly as we have employed and trained Aboriginal people to provide that service in the community. It is also important because it is more localised and it is a service that we are keen to ensure that Aboriginal people feel comfortable about and is serving a purpose that is important to them. Hence there is the increase in money towards that service, because we have seen that it has proven to be quite effective. But of course we could always do more; there is no question about that. We are hoping that this further $29.1 million over three years will assist in that process. I will ask Mr Marney if he has specific information on how that money may be spent. Actually, we may not do that; as how the money will be spent, it is still being worked out.

The CHAIRMAN: A follow-on question for the member for Kimberley.

Ms J. FARRER: Which Kimberley programs have been funded, and how much funding has been allocated to each, because there is the east Kimberley and the west Kimberley?

Ms A.R. MITCHELL: Member, we do not have that information with us tonight. We can provide some information, but I do not know that we can go down to each program. I will ask Mr Marney to provide the information that he does have.

Mr T.M. Marney: My understanding is that there are eight full-time equivalent positions allocated to WACHS in the Kimberley region and expenditure in the order of $2 million per annum. I do not have an east Kimberley–west Kimberley split ready to hand, but we could take that on as supplementary information and both confirm those figures and give a better understanding of the distribution and where exactly the FTEs are and how they will be deployed.

Ms A.R. MITCHELL: I will provide supplementary information on the distribution between the east Kimberley and the west Kimberley for the specialist Aboriginal mental health services.

[*Supplementary Information No B21*.]

Mr J. NORBERGER: I refer to page 395 of budget paper No 2, and the dot point under the heading "Mental Illness and the Criminal Justice System". I note that the mental health court diversion and support project is to continue. Could the parliamentary secretary provide more detail about the program and how much funding it will receive?

Ms A.R. MITCHELL: This initiative has been quite effective. It follows on from the success we had with the drug and alcohol diversion program, which has been going a lot longer. This program only commenced in 2013. It operates at the Perth Magistrates Court as the Specialist Treatment and Referral Team Court for adults, and at the Perth Children's Court, where it is known as the Links program. There has been $4.6 million allocated to the programs: $3.3 million for the adult program and $1.2 million for the children's program. I will give an idea of how effective it has been. It is disconcerting that between 18 March and 31 March 2014, 362 individuals were listed to appear before the Specialist Treatment and Referral Team Court. Of those referred for clinical assessment, 140 were found to be suitable for inclusion into the program and 34 individuals successfully completed the program during that time. There were 161 referrals made to the Links program for children between the period 8 April 2013 and 31 March 2014. Of that number referred for assessment, 65 were found to be suitable and 15 successfully completed the program. This will be evaluated during 2014. Obviously, from here further decisions will be made about the future.

[7.50 pm]

Dr A.D. BUTI: I refer to the "Mental Health and Alcohol and Other Drug Services Plan" under "Significant Issues Impacting the Agency" on page 394 of the *Budget Statements*. I have four short questions, but I might as well ask the four together because they roll into one another. Can the parliamentary secretary confirm that the Minister for Mental Health received the plan from the Mental Health Advisory Council in December 2013? When will the plan be made public? What funding is attached to implementing the plan in the 2014–15 budget? If funding has been allocated, where is it located in the budget papers?

Ms A.R. MITCHELL: I will ask Mr Marney to respond to that.

Mr T.M. Marney: My understanding is that stage 1 of the mental health services plan was received by the minister in December 2013. That really was a preliminary scoping of the broader, more complete mental health services and drug and alcohol service 10-year plan. The objective is to have that plan ready for consultation

within the next couple of months and to have it ready for consideration by government in around July–August. Subject to the government's decision, it will be released shortly thereafter. That is of course assuming that all goes well with the development of the plan.

In terms of the development of the plan, a big component of the work revolves around fairly complex technical work around modelling demand over the 10-year period that is encompassed by the plan. That work is substantially complete. The body of work that we are turning to is mapping, if you like, the supply chain to go against that set of demand projections and indeed the strategies for reform and demand management. It is a fairly technical and expansive exercise in cost and demand modelling. Once the supplier is mapped, that is applied to optimise the delivery against that demand profile. Flowing from that are a number of requirements in terms of capital investment and, with that, the necessary recurrent funding to increase the activities through existing facilities. The commissioning of new facilities may be required, as identified in the plan associated with further capital investment. The costing task that goes with this is fairly substantial. As the plan is yet to be considered by government, and indeed as the costs are yet to be finalised as part of stage 2 of the plan, there is no funding allocated in the 2014–15 budget for the implementation of that plan. I expect that consideration of funding for the implementation of the plan, once the plan is considered by government, would be made most likely as part of the 2015–16 budget process once a full implementation plan has been developed. The development of the plan obviously has to take into consideration a number of elements, including the recommendations of the Stokes review. Indeed the plan itself and its development was one of the recommendations out of the Stokes review, but there are many elements of the Stokes review that need to be embodied in the plan.

Having included the elements of the Stokes review in the plan, there is also substantial consultation, as I am sure the member would understand, that is required with clinicians and, as importantly, if not more so, with consumers and carers. I did put some caveat around when the plan will be delivered. My understanding from the minister is that that consultation with consumers, carers and clinicians needs to be thorough and robust, and that the views of those stakeholders must be taken into consideration as part of the development of the plan. Should we stumble across some major issues in that consultation process, my view is that we would not compromise the value of that consultation for the sake of delivering the plan a month earlier. This is a rare opportunity—we need to get this right or as right as it can be. Following that, issues of funding will be considered by the government. Obviously, delivering a plan that has, shall we say, overly ambitious funding requirements attached to it is not particularly helpful to the government and is not particularly helpful to the implementation of the plan. We need to deliver something that is realistic in terms of the demand that we model, the supply constraints that we have and the financial considerations of government. All of those things need to be weighed up, along with the views of clinicians, carers and consumers.

Dr A.D. BUTI: Still dealing with the item "Mental Health and Alcohol and Other Drug Services Plan", the government introduced a bill into the other place related to the linkage between mental health and drug and alcohol, which can have dangerous consequences, but that is the way the government decided to go. I inquire why alcohol and drugs has not been included under the title of the Mental Health Commission and what assurance there is in the budget that the alcohol and other drugs area will be identified in the future as a direction that will be pursued in regard to mental illnesses?

Ms A.R. MITCHELL: If I could talk about the name first. I cannot talk much about the name because I was not involved in those discussions, but I can assure the member that there is no intention to reduce the importance of "drug and alcohol". The Drug and Alcohol Office, over 25 years or more, has been very effective in its work. There is no reason at all to contemplate that its influence, albeit in another agency—with the words "drug and alcohol" not being there—will be reduced. That is certainly not the intention at all. Its work is always evaluated and proven. The evaluations show the effectiveness and efficiencies. That will continue because we definitely see those results. Mr Marney will give more detail about the budget.

[8.00 pm]

Mr T.M. Marney: The member referred to two issues: one, the potential of "dangerous consequences" of the naming of the merged entity of the Drug and Alcohol Office and the Mental Health Commission into the Mental Health Commission. That is one issue. The second issue was the transparency of resourcing the existing Drug and Alcohol Office and whether or not that transparency will be maintained. I assume that is coming from a concern that the resources of the Drug and Alcohol Office may be poached or hollowed out by the broader Mental Health Commission. I will take both issues separately. Firstly, the minister, the executive director of the Drug and Alcohol Office and I are acutely aware that there are significant issues in dealing with the comorbidities of mental illness and drug and/or alcohol issues. We are equally aware that not everyone who has a drug and alcohol issue has a mental health issue, nor do they want to identify with an entity that is associated with mental health. We understand that requirement for stakeholders, consumers and carers to identify with drug and alcohol services separately to the mental health title, if you like. With that in mind, the executive director,

myself and the minister have been working on a functional structure for the merged entity—not wishing to pre-empt the consideration of Parliament, of course, but obviously we need to be ready—that has clarity of identification of drug and alcohol services within it, and that is sufficiently integrated from a policy, planning and prevention perspective to address the complexity of comorbidity of drug and alcohol issues and mental illness, but also sufficiently transparent such that those who do not wish to identify or do not have mental illness but require the services of the Drug and Alcohol Office as it currently stands can identify strictly with drug and alcohol issues. That is an answer to the first part of the member's question, and we are committed to ensuring that we do not compromise the existing success of the Drug and Alcohol Office in that regard.

In terms of the second issue, transparency of resourcing—that is something I do know a little bit about—we will ensure that through the structure of our output and outcome statements in the budget statements so that Parliament will be able to fully track the transition of funding arrangements, as it does now. As it stands now, the Drug and Alcohol Office funding actually flows through the Mental Health Commission, so we should see very little change; but in the interests of transparency, we will ensure that areas of overlap will be clear in our output statements and performance reporting.

[Mr I.M. Britza took the chair.]

Mr D.J. KELLY: Under "Mental Health Infrastructure" at page 395, I ask about the commitment to redevelop Graylands Hospital. Specifically, where is the funding in this budget for that commitment? How many beds are currently available at Graylands? How many beds are actually open? How many wards are currently mixed wards and how many are female-only wards?

Ms A.R. MITCHELL: We are checking to see who can respond. It is probably best that it all comes at one time, so I ask Mr Marney to respond to the question.

Mr T.M. Marney: In terms of the first part of the question—that is, what is the status of funding for the redevelopment of Graylands—from memory, I think $16 million was previously allocated in the state's finances provisionally for the redevelopment of Graylands. As part of the most recent midyear review, that money was removed from the budget. I understand that that was taken as part of reallocation of funds for the Department of Health more broadly to deal with some of its infrastructure pressures. I regret to inform the member that in my previous role I recommended that removal of funds, and I regret having recommended that now. There is, however, money, I understand, within the Department of Health to continue the planning for the redevelopment of Graylands, and that, of course, is subject to consideration and decision by cabinet as to the future direction of the Graylands site.

Mr D.J. KELLY: The other question is about the existing number of beds available at Graylands: how many are open, how many are mixed wards and how many have female-specific wards?

Mr T.M. Marney: My understanding is that at Graylands as at 2013–14 there were 62 acute beds and 90 non-acute beds in the adult facility, and there were 30 acute beds in the forensic facility. In 2014–15, it is expected that the acute beds will increase by seven. The other categories will remain as is. The total at Graylands will be 189 beds, comprising 99 acute beds and 90 non-acute beds.

Mr D.J. KELLY: This is a repeat of the question as opposed to a further question. How many are mixed wards and how many are female-only wards?

Mr T.M. Marney: My understanding is that they are all mixed wards.

Mr D.J. KELLY: A few weeks ago, the Premier on radio identified Graylands as a potential site for the second disability justice centre. Can the parliamentary secretary inform us whether that option is in fact being considered?

Ms A.R. MITCHELL: I am unaware of the Premier making that statement, and I do not believe it is in the mix at this point in time.

Dr G.G. JACOBS: This will be my last question. At page 393 under "Spending Changes" I draw members' attention to the "Fresh Start Recovery Program", which certainly sounds like Dr George O'Neil's naltrexone implant program, where there is an allocation of $1.08 million. Were there any conditions to the granting of these moneys to George to progress his naltrexone implants to Therapeutic Goods Administration accreditation? How much money of the over $1 million goes to progressing TGA approval and how much goes to treating patients? I believe that almost every year there is an allocation to George, however we do not seem to progress any closer to final TGA approval. It is really important that perhaps we should elucidate any conditions towards progressing that product, which may indeed end up being the gold standard for treating heroin addiction; but it is imperative that we move towards TGA approval.

Ms A.R. MITCHELL: I was expecting the member for Eyre to ask a question along those lines, and I ask Mr Guard to give you a detailed response.

Mr N.S. Guard: The entire $1.08 million allocated in this budget is to continue the existing funding provided to the Fresh Start Recovery Program, and it is entirely to support and sustain the operations of the program while they progress registration of the naltrexone implant. It is a clear condition of this grant of funding that that work is expected to be progressed. The member for Eyre would be aware that, regrettably, one of the reasons for delay in progressing registration is that the factory used to manufacture the implants was completely burned down in 2011. It has taken the program a couple of years to raise the funds to rebuild the factory. The building work was completed in February this year and they are going through the final parts of the process with the TGA to get it now licensed to be under good manufacturing compliance to be able to properly manufacture those implants again. What then needs to happen is 12 months' stability testing of the implants out of the new factory and one final 12-month pharmacokinetic trial conducted in the United Kingdom, which is around testing the release via those implants. That will take around 12 months and those two pieces of work can operate in tandem. Over the next 12 months they will be writing up the application to register those implants. Clearly, any continued funding will be dependent on progress towards that application over that 12-month period. The final part of the process is the Therapeutic Goods Administration decision-making process itself, which generally takes around nine to 10 months to come out with a decision. All the funds here are around the ongoing operation of the existing program—no increase—while the work is progressed, now that the factory has been rebuilt to move towards registration of naltrexone implants with the TGA.

[8.10 pm]

Ms A.R. MITCHELL: I wish to provide some further information to the member for Bassendean on the question he asked earlier about Graylands and the composition of the wards. Mr Marney has some documentation, and he can give the member some further information.

Mr T.M. Marney: I apologise for misleading the member unintentionally. There are 15 secure acute male beds in the Smith ward.

Ms J. FARRER: I refer to mental illness in Aboriginal people. What is the breakdown of the $29.1 million over three years, and where is this money being spent, particularly in relation to services in the Kimberley?

Ms A.R. MITCHELL: I might ask Mr Dillon to answer that question directly.

Mr E. Dillon: Twelve FTE are allocated from the Statewide Specialist Aboriginal Mental Health Service. Eight of those FTE operate through the WA Country Health Service and four operate through the Kimberley Aboriginal Medical Services Council. Approximately $2 million has been allocated for Kimberley services. We indicated that we would provide the breakdown of the FTE across the Kimberley as a supplementary question earlier in proceedings.

Mr J. NORBERGER: I refer to suicide prevention on page 395 of the *Budget Statements*. We all know that suicide is a great tragedy and it results in significant grief and loss for families, friends, and communities for that matter. Can the parliamentary secretary outline how local communities can support suicide prevention?

Ms A.R. MITCHELL: What is really important with suicide prevention is that it is not just what government does. I am very pleased to hear the member ask what the community can do. The basis of the whole program is about awareness, support, caring and everyone taking a note and action when watching our friends, neighbours and family to ensure that we pick up the telltale signs. Some of the programs that have operated under the community action plans have been very effective in many cases, particularly in the regional areas. I believe there is a further grant program for community action plans. One of the other ones that is coming on board at the moment is workplace involvement—that is, being aware and promoting awareness, support and encouragement. A lot of people within the mining sector are taking mental health on board as an important part of their responsibility, not just physical health and occupational health and safety. Both the closer community and the broader community can be involved in a number of ways. It is total community involvement, not just what government is going to do.

Mr D.J. KELLY: I refer to "Mental Health Infrastructure" on page 395 of the *Budget Statements*. There is a reference to the 56 new mental health beds that will come online at the Midland health campus. Given that that hospital will be run by an outside provider, the Catholic Church, are there any implications for the care of those patients, given that there will be a restriction on the types of services that can be provided to patients at Midland hospital? I am thinking that a patient with a mental health issue who is at Midland may, for example, want contraceptive advice as part of their treatment or the care they receive at the hospital and that may be prohibited by the provider. Has the government given any consideration to how the policies of the provider may impact upon the care of the patients?

Ms A.R. MITCHELL: We are not aware of any restrictions at this point but we certainly recognise the fact that the member has raised it and it is something that we need to be cognisant of. If we can provide any information, we will provide it on notice. I am not sure what I can provide specifically but we will see if anything has come up that we can provide for the member.

Mr D.J. KELLY: There are a range of restricted services in the contract that are clear for everyone to see. It has been a matter of public debate. I thought that if the government is going to have 56 mental health beds at the Midland health campus, it would have made sure that there was no impediment on holistic care being provided to anyone who is admitted to Midland as opposed to being admitted to Sir Charles Gairdner Hospital.

Ms A.R. MITCHELL: Mr Marney will provide a further response.

Mr T.M. Marney: The member is correct. The restricted services are quite clearly detailed in the contract. It is fair to say that we do not have a good understanding of the extent to which those restricted services impact on our expected mental health patients. However, the government has strategies in place to deal with the service restriction that does apply on site and ensure that alternative services are provided at or near that site to address the service restriction within the contract. That is probably a matter that will need to be taken up with the Department of Health, as the signatory to the contract. It is really an operational matter that is more appropriate for it to address.

Mr D.J. KELLY: Mr Marney mentioned alternative services. I understand, for example, that a facility will be built at the other end of the car park where things such as terminations or sterilisations might occur. I think that is very unsatisfactory. If a patient is admitted to Midland hospital and wants advice during the course of their treatment that is contrary to the policies of the provider, it is completely impractical to send them to the other end of the car park to get it. I would have thought that the government would have considered this issue from a mental health perspective given that this is a major expansion of the number of beds available. I would have thought it would have considered how the operator fits into that mix rather than just saying it is an issue for the health department.

Ms A.R. MITCHELL: We would certainly be very much aware of the situation and would follow it through. The member has raised a point. It is not one that I particularly thought of. Obviously, other people may have thought of it. It will certainly need to be considered.

Mr D.J. KELLY: Can the parliamentary secretary provide us with further information on the commission's strategy for dealing with that issue?

[8.20 pm]

Ms A.R. MITCHELL: I will ask Mr Marney to respond.

Mr T.M. Marney: The commission's strategy is to purchase mental health services from the Department of Health that take into consideration the physical health requirements of the patient as well, how those requirements are met and, in this case, how restricted services or practices are nonetheless met in terms of the needs of the patient. I know I sound as though I am fobbing it off, but it is an operational matter for the Department of Health to ensure that it meets the requirements of its contracts with not only the operator of Midland Public Hospital but also the Mental Health Commission. I expect the member for Bassendean will find that answer unsatisfactory, but —

Mr D.J. KELLY: Why does the parliamentary secretary not take it on notice?

Mr T.M. Marney: If I can finish —

The CHAIRMAN: Let him finish.

Mr T.M. Marney: I am happy to take that on notice and provide supplementary information on how the Department of Health will meet contractual requirements of the Mental Health Commission given its contractual constraints with the operator of Midland Public Hospital.

Ms A.R. MITCHELL: I confirm that the Mental Health Commission will seek from the Department of Health how it will meet its contractual obligations with the Mental Health Commission and the contractor for those services at Midland Public Hospital.

[*Supplementary Information No B22.*]

Dr A.D. BUTI: I refer to "Specialised Admitted Patient Services" and "Employees (Full-time Equivalents)" on page 398. The question really relates to the state government's hiring freeze. As it is the last question in this division, I will try to make it quick. Can the parliamentary secretary let us know how many vacancies existed in the Mental Health Commission on 1 May 2014? I have a supplementary question, but I will ask that first.

Ms A.R. MITCHELL: I will get Mr Marney to respond to that.

Mr T.M. Marney: We will have to take that as supplementary information so that I can give the member accurate information for that point in time. However, the Mental Health Commission has a number of employees on finite contracts associated with different programs and different lines of service delivery, so it is a fairly fluid workforce. I am certainly happy to give the member a report on the number of vacancies as at 1 May.

Ms A.R. MITCHELL: We will provide to the member for Armadale the number of vacancies of staff at the Mental Health Commission as at 1 May 2014.

Dr A.D. BUTI: As a further supplementary —

The CHAIRMAN: We can do only one at a time.

Dr A.D. BUTI: I will add this because it relates to the same issues. Can the parliamentary secretary provide us with a list of the positions that are vacant? We would like not only the numbers but also the positions that are vacant and where those are positions located. How many of these positions will not be filled until 1 July 2014?

Ms A.R. MITCHELL: The total supplementary information requested is the number of vacancies in the Mental Health Commission as at 1 May, the list of positions that are vacant, where those positions are located and which of those positions will not be filled until 1 July.

[*Supplementary Information No B23.*]

The appropriation was recommended.