Division 22: Mental Health Commission, $969 673 000 —

Mrs L.A. Munday, Chair.

Ms A. Sanderson, Minister for Mental Health.

Ms J. McGrath, Mental Health Commissioner.

Mr L. Hale, Deputy Commissioner.

Ms K. Lazenby, Deputy Commissioner, System Development.

Ms S. Davison, Chief Medical Officer, Mental Health.

Mr L. Bechelli, Assistant Director, Treatment Services.

Ms L. Lombardini, Assistant Director, Support Services.

Mr M. Canney, Strategic Management Accountant.

Ms R. Marton, Adviser.

[Witnesses introduced.]

The CHAIR: The estimates committee will be reported by Hansard and the daily proof *Hansard* will be available online as soon as possible within two business days. The chair will allow as many questions as possible. Questions and answers should be short and to the point. Consideration is restricted to items for which a vote of money is proposed in the consolidated account. Questions must relate to a page number, item or amount related to the current division and members should preface their questions with these details. Some divisions are the responsibility of more than one minister. Ministers shall only be examined in relation to their portfolio responsibilities.

A minister may agree to provide supplementary information to the committee. I will ask the minister to clearly indicate what information they agree to provide and will then allocate a reference number. Supplementary information should be provided to the principal clerk by close of business Friday, 3 June 2022. If a minister suggests that a matter be put on notice, members should use the online questions on notice system.

I give the call to the member for Vasse.

Ms L. METTAM: My question relates to page 338 and the $31 million eating disorder election commitment that is referred to, I guess, in part in item 5 under the significant issues impacting the agency. As the minister is aware, I attempted to ask this question in the health section but was directed to the Mental Health Commission. Where is that project at and what progress has been made?

[11.20 am]

Ms A. SANDERSON: I can give an overview and then perhaps the Mental Health Commissioner can give the member some more specifics about the planning and rollout of that project. The government currently provides $4.6 million towards community treatment eating disorder services for under 18s through CAMHS. The election commitment in 2021 was to expand services to adult statewide services through the $31.7 million. That was becoming an area of significant need—an increase. As part of the National Mental Health and Suicide Prevention Agreement, we also secured a further $8.5 million from the federal government to establish a third statewide eating disorder community hub within east metro. This will see a hub service within three metropolitan catchment areas, so that is south, north and east. There will be $16 million for community treatment services, which is over and above the inpatient services provided by patients requiring immediate hospital services. At the moment, there is a small number of therapy and support programs, most with private services and all having very long waitlists, many of up to eight months.

New services from 2022–23 will include three dedicated multidisciplinary area-based statewide services located in the north, south and east metro areas, providing a triage service; three intensive day programs; intensive clinical monitoring to provide support to people in the community; and specialist multidisciplinary outpatient clinics, including a stepdown service for inpatients with eating disorders. Patient transition coordinators will also be located at each HSP to coordinate the care for people living with eating disorders. There will also be an increase in community services, including community treatment and support services, as well as early identification, intervention and prevention, which all form part of the expansion. We are expecting services to commence this financial year, 2022–23. The current service for those aged 16 and over is managed by the WA public sector. They are generally admitted to the general adult mental health units if appropriate. There are no dedicated adult beds, as the member knows. The WA Eating Disorders Outreach and Consultation Service is a statewide service that provides specialist care for over 16s, but it is currently under quite significant pressure. The Department of Health has also received $4 million for the development of residential eating disorder treatment. As I said, we are seeking to provide a more

comprehensive statewide service that links in with best practice and the model of care that we deliver in WA. Did I miss anything?

Ms L. METTAM: Can the minister explain the hub? I thought the minister mentioned it was in east metro; will that be attached to a hospital or will it be a separate location?

Ms A. SANDERSON: There will be hubs in the north, south and east. Initially, it was north and south. The additional federal funding has enabled us to deliver a hub in the east as well, so we will have the whole metropolitan area covered. I will ask the commissioner to outline how the hub will work.

Ms J. McGrath: As mentioned, the original plan was to roll out the hubs in just the north and the south initially. Now, with this latest announcement, we can do the one in the east as well. We hope that all those services will start this financial year—the north and south hubs will probably begin a little bit earlier than the east one, given that we have just found out that we will be able to roll that one out earlier than next year. As mentioned by the minister, each of those hubs will have three components. Those hubs will do triaging and intensive clinical monitoring, and will have a specialist multi–disciplinary outpatient clinic and intensive day programs. A lot of work has been done with the HSPs over the last six months on this model of service.

Ms L. METTAM: How many FTE are committed or attached to this commitment?

Ms A. SANDERSON: It will be determined by need. Ongoing funding is committed in the budget, but the number of FTEs and what that model of service will look like will depend on service requirements.

Mr R.S. LOVE: Minister, I turn to page 337 and the heading "New Initiatives", specifically the line item "Relieving Immediate Rural and Remote Pressures", which has an expenditure of $4.277 million this year and similar funding in the out years. Can the minister give some indication of the scope of services that will be provided and whether there is any information regarding the geographical spread of the target areas? I have some follow-ups around that once I get the answer.

Ms A. SANDERSON: I welcome questions on this; it is an area of acute need across the country, particularly in regional areas. We have targeted our investment in this area in regional areas in particular to help try to relieve some of the pressure that they and families are feeling. I want to be clear that this—I will probably get into trouble for saying this—is the first of a number of investments that we are going to have to make over a number of years to rollout this reform. I give credit to the Mental Health Commission—it wants to see an immediate uplift in service. It is not just giving a commitment to recruiting people and then trying to find them. Where we will see an uplift—I can outline where that is—is where there is already an existing FTE who can increase their numbers, or someone who has just graduated and can take a position. We expect to be able to fill these positions almost immediately. In the child and adolescent mental health service in Esperance, there will be one FTE, a clinical nurse specialist; in the goldfields whole-of-region register—we can provide this if information if the member would like—there will be a registrar; in the great southern, Albany, there will be one FTE, a consultant psychiatrist; in the great southern whole of region, there will be one FTE, a clinical nurse specialist; in East Kimberley, there will be one FTE, a registrar; in the midwest, in Geraldton, there will be one FTE for infant mental health; in the midwest, Geraldton, there will be one FTE, a clinical nurse specialist; in the Pilbara, CAMHS in Karratha will have a one FTE, senior medical officer; in the south west whole of region, there will be one FTE, a consultant psychiatrist and a clinical nurse FTE; in the wheatbelt whole of region, there will be a CAMHS consultant psychiatrist, who will be 0.6 FTE; in the wheatbelt whole of region, there will be one FTE. We have tried to spread them across every region so that every region will receive an uplift, but it is a realistic uplift of an increase in the number of people already on the ground. It is my intention that this is the first of a number of investments.

Mr R.S. LOVE: I think the minister mentioned the midwest, but in looking at the situation of those areas affected by cyclone Seroja, 16 local governments were affected. The Shire of Northampton was one of those most greatly affected. I am told by people in the shire that, at the moment, no additional mental health services have been provided to the Shire of Northampton. I appreciate that there might be trouble sourcing people, but there does not seem to be any additional support going there and it does not appear that any additional support is going to the local high school, for instance. I am wondering what, specifically, there might be in that to assist those areas that were affected by the cyclone—not only the Shire of Northampton, but including the Shire of Northampton.

Ms A. SANDERSON: I will just clarify: is the member now asking about adult mental health services?

Mr R.S. LOVE: Sorry, I cannot—

Ms A. SANDERSON: Sorry. I just want to clarify whether you are now asking about adult mental health services?

Mr R.S. LOVE: It is mainly adult.

Ms A. SANDERSON: This is a new question.

The CHAIR: Is that a supplementary question to the last question?

Mr R.S. LOVE: No, I asked about the school as well, so the question is also about —

Ms A. SANDERSON: I am happy to provide information in answer to the member's question, but I think he is asking about the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in Western Australia.

The CHAIR: That is a different area.

Mr R.S. LOVE: Is it? Okay.

[11.30 am]

Ms C.M. TONKIN: I have a question that, again, concerns services in rural and remote areas. I refer to page 338, the "Spending Changes" table, specifically the line item "Continuation of the Mental Health Emergency Telehealth Service". Can the minister advise what the WA government is doing to ensure that this important resource for rural and remote areas continues?

Ms A. SANDERSON: Thank you. This feeds into an important provision for services for adults and youth—namely, the mental health emergency teleservices—which was previously funded by the commonwealth government. It provided three years of funding to establish a specialist telehealth service for acute mental health out of the Health Innovation Fund. When I was sworn in as minister, I was briefed early that the federal government had stopped this funding. Of all the times in our state's history, it declined to continue the funding of that service, which has provided a really important bedrock of our mental health services in the community. The state government has stepped in to provide $5.1 million to continue delivery for that community. Obviously, one of the significant commitments from the federal Labor Party was to continue psychiatric telehealth for the regions and allow that to be bulkbilled for those practitioners. It was one of the first things on my agenda. I raised it with the former Liberal minister as part of the National Mental Health and Suicide Prevention Agreement. It left a $20 million hole in our budget. It was unmoveable on this issue and absolutely refused to continue to provide that service. It will be a significant part of the agenda of the first meeting of health state and territory ministers and the federal government. Having said that, we have ensured that it continues for two years with funding from the state, but we will be seeking a continuation of that funding from the commonwealth.

Ms L. METTAM: I am not sure whether that was an extension of the question about the infants, children, and adolescent task force and the immediate response.

The CHAIR: No, this is a new question. That was specifically about telehealth.

Ms L. METTAM: This question relates to the original question asked by the member for Moore and the 11.6 FTE. Can I confirm when the minister anticipates that those additional staff will be employed? I take from the minister's original response that they are the most easily employed and that she anticipates they will be employed straight away.

Ms A. SANDERSON: Absolutely. The health service providers were notified of the budget outcomes and I anticipate that WACHS will be implementing that as soon as possible.

Ms L. METTAM: Can I also confirm that the minister will provide a list of those positions at the various locations across regional WA as well?

Ms A. SANDERSON: I will provide that by way of supplementary information.

Ms L. METTAM: Okay; thank you.

The CHAIR: The minister agrees to provide that supplementary information.

[*Supplementary Information No B2.*]

The CHAIR: Could the minister please state for Hansard exactly what she will be providing?

Ms A. SANDERSON: A breakdown of the 11.6 frontline FTEs and community CAMHS in regional Western Australia.

Ms L. METTAM: This may be provided in the question or the minister may be able to answer it. Are there any psychiatrists in the make-up of these workers?

Ms A. SANDERSON: Yes.

Ms L. METTAM: Where will they be based?

Ms A. SANDERSON: There are three in that make-up, and this is determined by need on the ground, the ability to fill the role and a range of factors. There is a range of both allied and clinical support here for youth mental health, and it is based on who we can put into those positions now, essentially. Psychiatrists are exceptionally difficult to recruit due to a worldwide shortage. As part of the ICA, we are also looking at significantly bulking up our peer support workforce, which is a really important aspect of rolling out the ICA, so that young people and their families have that kind of peer support work to rely on in their journey.

Ms L. METTAM: As the ministerial task force report highlights, there is a significant gap—a chronic under-resourcing—of child psychiatrists, which the minister has identified and recognised. What work is being undertaken to address this worldwide shortage? What incentives is the government providing to attract psychiatrists to the state?

Ms A. SANDERSON: I will let the Mental Health Commissioner outline some of the detailed programs, but it is not up to the Western Australian government to address the worldwide shortage; we need to address the shortage that we have here. To put the question in context, it is not a matter of underfunding because there are not that many, and it is through both the private and the public sector. This is not an issue of underfunding; rather, it is an issue of increased demand and not keeping up with the current workforce. There is significant work going on, particularly around rural psychiatry pathways, to uplift the number of psychiatrists, and we are working with the college to do that. I will pass to the Mental Health Commissioner to outline some of that.

Ms J. McGrath: Thanks, minister. Over the last six months, the Mental Health Commission been working with the Department of Health through its mental health workforce planning project, which is looking at the whole mental health workforce, the pipeline, the development et cetera of all staff required, as mentioned in the earlier session today. Part of that will be about psychiatrists and how we build that pipeline, and that will be a combination of growing our own and trying to attract from overseas. The commonwealth is also taking a role in that. As part of our recent bilateral negotiations, the final agreement has some shared responsibilities and some that the commonwealth will take a lead in in terms of some of that planning. In particular, it will work with the Royal Australian and New Zealand College of Psychiatrists et cetera around those pipelines. It will also particularly look at attraction in rural areas. We have got the same issues all across Australia, so it will take that lead role and we will feed into that work.

Mr R.S. LOVE: This is an excellent opportunity for the opposition to get some clarity on a lot of important issues. I refer to page 124, "Major Spending Changes Since the Mid–Year Review", "WA Country Health Services Mental Health" and the line item for the emergency telehealth service of only $5.1 million for this year. Could the minister explain what that amounts to and why it is only for the first year?

Ms A. SANDERSON: If the member had listened to the opposition's question, he would have the answer to his. I literally just outlined that.

Mr R.S. LOVE: Sorry?

Ms A. SANDERSON: If the member had just listened to the opposition's question, he would have the answer to this question. I will go through it again.

The CHAIR: The minister has just provided it. I will move on. Does the Member for Riverton have a question?

Mr R.S. LOVE: I think I was actually next in line.

Ms A. SANDERSON: I am happy to provide it again, chair.

Mr R.S. LOVE: I do not know what the minister's point is.

Ms A. SANDERSON: My point is that I just outlined that in quite a lot of detail. The commonwealth previously provided funding for the emergency telehealth service for special and acute mental health and AOD support services for rural and remote areas. This is a really critical part of our delivering mental health services to regional areas, as the member would know as a regional member. When I was first sworn in, I was briefed almost immediately that the commonwealth had declined to continue that funding despite it being a time of increased presentations, increased stress and increased strain, particularly in regional areas. The commonwealth just stopped providing that funding. It was totally immune to representations as part of the National Mental Health and Suicide Prevention Agreement. We worked incredibly hard to get that $20 million hole in our budget filled because, ultimately, the commonwealth Liberal–National government blew $20 million out of regional mental health. It was absolutely unmovable in reinstating that funding so the state government stepped in and provided $5.1 million over the course of the next two years so that we can continue that really important service. We stepped in when the commonwealth stepped out. A new federal government has just been elected and it made a very early commitment to reinstate psychiatric telehealth on the Medicare Benefits Schedule and provide the WA Country Health Service emergency and regional emergency telehealth service. I expect it to be on top of the agenda of our next state and territories health ministers' meeting, which I anticipate will be some time in June. We will be looking for the commonwealth to reinstate that funding. But in the meantime, the state has stepped in to ensure its continuity.

[11.40 am]

Dr J. KRISHNAN: I refer to page 338, "Significant Issues Impacting the Agency", specifically the heading "Community Mental Health Treatment Services", and the government's commitment to an emergency department reform package. There is an increasing number of repeat ED presentations at Western Australian hospitals by people with mental health and alcohol and other drug-related issues. What is the WA government doing to address this?

Ms A. SANDERSON: I thank the member for his question. Obviously, recognising the challenge of reducing mental health and AOD presentations in our emergency departments is part of our emergency department access package, ensuring that there are alternative models of care for those people who need support, rather than having them front up to an ED because there is nowhere else for them to go. In her report, the Office of the Auditor General identified that 10 per cent of people use around 90 per cent of hospital care and 50 per cent of emergency resources, and alcohol and drug dependency is a significant part of that.

The active recovery teams were launched a couple of years ago, I believe. This pilot provides 90 days of care for someone and is focused on coordination and responsive–tailored treatment. When someone is discharged from a rehab facility, if you like, they are provided with 90 days of support to minimise the opportunity for relapse and to support them with a range of their needs, including getting employment, rebuilding relationships and finding housing. In one case study under the pilot, one person presented to an ED seven times in 12 months with a mental health issue. They were accepted into the active recovery team program. They had no mental health ED presentations while in the program and no ED presentations in the 90 days after completing the program.

There is a lot of evidence behind this. We have provided another $10.78 million to continue this trial and we expect that it will service around 300 people in Perth and 100 people in regional areas over the next 12 months. There are seven ART sites now operating in the metro area and two in the regions. This is part of our emergency access plan, but also an important part of our mental health and drug and alcohol plan, too.

Ms L. METTAM: Just a further question in relation to that. Of the 147 new mental health inpatient beds, how many are expected to be operational this financial year?

Ms A. SANDERSON: The member referred to 147 beds in that question. There are also an additional 52 coming online this year. They are already in the appropriation. There is the 40-bed transition unit that will be opening in St James this year and taking its first clients in June, I believe. The 12-bed unit at Royal Perth Hospital will also open in June. There will be those beds and also 30 beds at Joondalup Health Campus will open in 2024; 40 beds at Fremantle Hospital in 2024; 16 beds at Geraldton Health Campus as part of its redevelopment in around 2024; six beds at Bunbury Hospital at South West Health Campus commencing in 2026–27; six beds at Midland Public Hospital in 2023–24; 30 beds at Peel Health Campus, depending on the redevelopment; 10 beds at Armadale–Kelmscott Memorial Hospital in 2025–26; and nine beds at Rockingham General Hospital in 2024. Selby House will have eight beds, and we are working through the commencement of those beds.

There is also the expansion of the youth mental treatment services and eight beds for mental health and alcohol other drugs for youth homeless, the 20-bed community care with the comp unit for people with complex illness and the establishment of the step-up, step-down services around those regional areas. A significant number of beds are coming online between now and 2026.

Ms L. METTAM: The minister may be able to provide this by way of supplementary information, but can I get the total commitment for mental health inpatient beds in the metropolitan region and the WA Country Health Service? I heard what the minister read out and the detail that was provided. Another way to ask is: are any of those beds in regional WA or Bunbury?

Ms A. SANDERSON: There is a range, and all of those are outlined in government announcements in media releases. It is all public information.

Ms L. METTAM: What would be anticipated as the average length of stay for a mental health bed such as what has been proposed?

Ms A. SANDERSON: That is like asking: how long is a piece of string? It depends on whether it is a transition bed, whether it is a drug and alcohol or whether it is acute. There is no fit-for-purpose length of stay. Step-up, step-down facilities generally have around a 28-day stay. Acute facilities have shorter stays. As I said, there are some who have been in acute facilities from eight months to 12 years. I just cannot answer that question with a single number.

Mr R.S. LOVE: In terms of the question I asked earlier, which was somehow ruled out of order because it was to do with a different program, I will rephrase it. I refer to page 337, "Appropriations, Expenses, and Cash Assets" and the delivery of services costs. Can the minister outline any funding that is going into the Northampton area and other areas affected by tropical cyclone Seroja to assist victims to recover and maintain good mental health?

Ms A. SANDERSON: Support for the community welfare and outreach program is delivered by the Department of Communities and would be a line item for that department. I can advise that the assessment of need was undertaken and a $9 million community welfare outreach program was designed across the relevant local governments, and that is in Communities' budget. The program is a two-year package funded jointly by the commonwealth and state disaster recovery to support the social wellbeing of people who have been severely affected by the impacts of Seroja. It services 16 affected local governments by funding positions, service provision and other activities that enable

welfare outreach and recovery and resilience-building to support those impacted communities. There are multiagency recovery teams, which includes Communities, the Australian Red Cross and DFES, and they operate from static or mobile recovery hubs, including Kalbarri, Northampton, Waroona and Mingenew.

[11.50 am]

Ms L. METTAM: I refer to page 342 in budget paper 2, volume 1, "Readmissions to hospital within 28 days of discharge from acute specialised mental health units". I note that the department continues to fail to meet this key performance indicator, with readmissions at 15.5 per cent and 14.4 per cent in 2021–22. Can the minister provide some guidance on why this is unable to be met?

Ms A. SANDERSON: The 12 per cent, I understand, is a national target and, obviously, an important aspiration. Mental health is complex and there are a multitude of factors that impact on people's readmissions. The fact that we are investing record amounts in our mental health system and providing multidisciplinary teams shows that we are willing to do everything we can to meet this target—there is no question about that. The rollout of step-up, step-down facilities to support people to build lives, get employment and find accommodation and housing is an important part of that and we have significant commitments around rolling out those facilities. Many of them have already been rolled out. The active recovery teams will play a very big role in reducing admissions within that 28 days. We are looking at new models of care, like hospital in the home and readmissions, so supporting people in the community rather than in a mental health facility. The reform around infant child and adolescent mental health will, I sincerely hope, prevent children from being admitted into psychiatric units. The best possible care we can provide for those children and their families is for those children in their home and in their community. We do need to shift that focus from the acute to the community, and that is what we are doing with this budget.

Mr V.A. CATANIA: Minister, one of the challenges is mental health, particularly in regional areas, and we often do not have the facilities to cater for someone who needs assistance. What we see in places like Carnarvon is a patient who needs to go to Graylands or seek other treatment. They can be taken there by the police and can stay anywhere between a day and eight days, if not longer, which, obviously, takes up resources. Sometimes they cannot get down to Graylands to get the treatment or they go down there and then within 48 hours or 72 hours, they are back in a town like Carnarvon, and, unfortunately, many have suicided simply because there is no service in a town like Carnarvon that provides for people who need assistance. Is the department looking at any ways to improve that model? When someone is sedated or in a hospital bed and they are taking up that hospital bed for eight days waiting for a flying doctor service to fly down to Perth, they then have to find their own way back, often to Carnarvon and often, unfortunately, a large number of people commit suicide simply because the treatment is not there. What does the minister say to that?

Ms A. SANDERSON: I have in quite some detail just outlined a lot of the regional programs to both the member for Moore and the member for Churchlands and what we are doing around continuing emergency mental health programs for the regions, which was cut by the federal Liberal government and which the state has stepped in to continue. I absolutely acknowledge the challenges for individuals and their families, particularly in regional areas, who are suffering acute mental health episodes. A range of facilities have been developed and committed to, and regional step-up, step-down facilities are important part of that mix. The new mental health beds in Geraldton are also an important part of that mix. There is also the police and health co-response for emergency mental health, which has been operating in Geraldton more recently. It has worked very, very well and is continuing to work well. It is about those agencies understanding each other better and how police interact with mental health patients. Central coordination is also really key. The member is right about the challenge of an individual who is sedated, put on an RFDS flight and ends up in Graylands and is discharged into not many supports, so providing that ongoing support, and support through the patient assisted travel scheme, is critical. But having a central coordination, a state health operation centre that helps to coordinate the Royal Flying Doctor Service, St John Ambulance, the hospital system, the emergency departments and all of those things together, will help with that patient journey. It will significantly help. It is not just about money and services; it is actually about coordination and systems. At the moment, we have three services that run parallel with each other. They talk to each other, but they are not necessarily coordinated. If a nurse in Geraldton needs to have an acutely mentally ill patient transferred, their job is to ring each of those patient transfer services to try and find that service, whereas, really, that should not be that nurse's job. We want them nursing; we want them doing patient care. We want to take that burden from them and find a better way of coordinating those services.

Mr V.A. CATANIA: I just want to make a further statement on that, minister. Carnarvon and the Gascoyne have one of the highest suicide rates in this state simply because the services are not there when it comes to assisting, whether they are drug and alcohol or mental health issues.

The CHAIR: Is it a question, member for North West Central?

Mr V.A. CATANIA: I am pleading with the minister. Services are needed in Carnarvon. Geraldton is 475 kilometres away and often a person is flown to Perth, like I said, to Graylands. Geraldton really does not play a part in the mental health needs of the Gascoyne in particular. I just wanted to make that statement.

The CHAIR: I will take it as a statement. Member for Mount Lawley, a quick question, please.

Mr S.A. MILLMAN: Yes, sure. It follows on from what the minister was just saying about coordinating the efforts of police and mental health. I refer the minister to pages 337 and 338 under the "Spending Changes" table, and the ongoing funding for "Perth Sobering Up and Low Medical Withdrawal Services" and new funding for the "Cardiff Model of Violence Prevention Pilot". Antisocial behaviour in Perth and Northbridge has been in the news a lot lately. Can the minister advise how these initiatives help reduce community harm?

Ms A. SANDERSON: Thank you, member for Mount Lawley. Perth sobering-up and low medical withdrawal services are in important part of the issues that we are seeing in Northbridge. The Cardiff model for violence prevention has been a well-understood and evidence-based program, which is about sharing data and resources between agencies. The government is committing $7.3 million to continue the sobering-up centre for the Salvation Army, as well as $3.5 million to develop and implement the alcohol-related violence prevention program at Royal Perth Hospital to reduce those alcohol-related ED presentations.

Ms L. METTAM: I refer to page 338 and the step-up, step-down facility in Karratha. The six-bed facility was announced in 2017. When will it be finished and where is this project at?

Ms A. SANDERSON: Completion is expected in 2024. We are just about to go to tender on that project. Some spending changes were required. Essentially, a site has been secured in Karratha and we expect that the service will be delivered by Richmond Wellbeing, which will have the contract. There has been extensive consultation around this with the City of Karratha, nearby schools and local community groups. Certainly, we expect it to be commissioned in 2024.

The appropriation was recommended.