Division 43: Mental Health Commission, $556 871 000 —

Mr N.W. Morton, Chairman.

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

Mr E. Bartnik, Commissioner for Mental Health.

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

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

Ms L. Southalan, Acting Director, Organisational Reform.

Ms E. Paterson, Director, Service Purchasing and Development.

Ms D. Pawelek, Director, Performance and Reporting.

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

Ms A. Keller, Director, Corporate Services and Governance, Drug and Alcohol Office.

Mr G. Kirby, Director, Prevention and Workforce Development, Drug and Alcohol Office.

Mr J. Hunter, Director, Client Services and Development, Drug and Alcohol Office.

Prof. B. Stokes, Acting Director General, Department of Health.

Mr R.W. Salvage, Executive Director, Resource Strategy, Department of Health.

Dr N. Gibson, Chief Psychiatrist, Department of Health.

Dr S. Kelly, Chief Executive, North Metropolitan Health Service, Department of Health.

Mr M. Morrissey, Acting Chief Executive, Child and Adolescent Health Service, Department of Health.

Mr I. Smith, Acting Chief Executive, South Metropolitan Health Service, Department of Health.

Ms N.P. O'Keefe, Executive Director, Office of Mental Health, Department of Health.

Mr S. Matthews, Acting Chief Executive Officer, WA Country Health Service.

Ms S. Rouwenhorst, Principal Policy Adviser, Office of the Minister for Mental Health.

The CHAIRMAN: 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 August 2013. 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: We will commence with a question from the member for Armadale.

Dr A.D. BUTI: I refer to the first dot point on page 539 of the *Budget Statements*, which refers to the Stokes review. I believe that the government's response to the Stokes report states —

> There are however, some recommendations relating to proposed new services which will have a significant financial cost. As such, these will need to be carefully considered as part of the 10 year WA Mental Health Services Plan that will be delivered to Government in 2013.

Has planning commenced for any of these new services and are any of these new services funded in this budget?

Ms A.R. MITCHELL: The majority of the recommendations will require medium to long-term solutions that will take quite a few years to be totally implemented. With this in mind, we are preparing for those matters to come on board. No new resources are specifically allocated in this budget, but we have costs related to

secretariat support administrative costs, and those specific costs for the implementation of the Stokes report are not in this budget. We are very lucky to have the author of that report in the chamber and I might ask Professor Bryant Stokes to comment.

Prof. B. Stokes: The report outlined quite significant deficiencies in the mental health system in this state, which had been going on for many years. Those issues were particularly associated with the coordination of mental health services and the relationships with carers and patients, and information sharing amongst those groups. The report also considered a requirement to look more specifically at the integration of mental health issues and drug and alcohol issues. The report made 117 recommendations that will obviously require the development and use of some further facilities and infrastructure. However, the majority of recommendations are about changing practices, and the main report recommendation was to develop a mental health plan that is sustainable long into the future, and it is being developed at this stage. It is hoped that something will be handed to the Minister for Mental Health by December.

Dr A.D. BUTI: My understanding is that there were two plans in the Stokes report—the WA mental health clinical services plan and the 10-year mental health plan. The clinical services plan was supposed to be a short-term initiative. If that is the case, have any aspects of that plan been put into place; and, if not, when will they be put into place considering they were supposed to be short-term initiatives, and what are the costings of that?

Ms A.R. MITCHELL: I will ask Mr Eddie Bartnik to respond to that question.

Mr E. Bartnik: A number of initiatives are outlined in the bottom table on page 537, the first of which is the line item on "Additional Inpatient Mental Health Activity". One of the key issues in the Stokes report was the demand for current inpatient services and the need to maintain those services while we do the build of community services. There is an allocation for additional inpatient and community mental health activity in the Department of Health budget, and there is also funding for the continuation of the statewide specialist Aboriginal mental health service, which is part of the Closing the Gap national partnership. That partnership funding is part of ongoing negotiations with the commonwealth, but an additional year's funding of $7.5 million or thereabouts has been allocated for that program. The Aboriginal affairs cabinet subcommittee will be reviewing that with a view to taking it forward. Those are two clear examples of a need that has been funded in this budget that relate to those earlier priorities.

Dr A.D. BUTI: I have one more follow-up question. Returning to the 10-year plan, the parliamentary secretary told us that nothing has been funded in the budget yet. This was considered to be an incredibly important report, so when will the government commit to initiating some of the recommendations from that 10-year plan?

Ms A.R. MITCHELL: Professor Stokes has indicated that many of those recommendations will be with the Minister for Mental Health by December, and those decisions will then be made. I will ask Professor Stokes whether he wishes to add anything to that.

Prof. B. Stokes: I cannot because I am not involved in the implementation of the mental health plan, as the member can understand, but it will obviously take a significant development of new resources.

[7.10 pm]

Mr R.H. COOK: My question relates to the line item for program rationalisation on page 538. With more than $5.4 million for program rationalisation in the life of the budget, what programs will be rationalised through this process? How were each year's figures determined? I also draw the parliamentary secretary's attention to recent media reports pointing to a loss of upwards of 100 positions at Bentley Hospital and also significant cuts to health positions in the mental health sector at Fremantle Hospital. Notwithstanding the accuracy of those reports, would the parliamentary secretary please provide some detail on the program rationalisation line item?

Ms A.R. MITCHELL: I will ask two people to respond to that, because there were two parts to that question: the policy part and the operational part. We will begin with Mr Eddie Bartnik and then go to Ian Smith from the South Metropolitan Health Service.

Mr E. Bartnik: The two components of the Mental Health Commission program rationalisation relate to Mental Health Commission activities and those related to the Drug and Alcohol Office. For the member's benefit, the Drug and Alcohol Office is a separate entity; it sits within the overall Mental Health Commission budget as a separately identified program. I will deal with the mental health component, which largely consists of delaying implementation of a number of new initiatives, one of which was the implementation of the Mental Health Bill, and due to the current consultation process, we were able to save some $1.5 million in 2013–14. The Community Coordination Program, also a new initiative, has been deferred for two years at $800 000 a year. Part of that has been the introduction of the National Disability Insurance Scheme and the commonwealth program Partners in Recovery, which are operating in a similar space. The department has deferred two years of expenditure. Some

value-for-money reviews are being conducted with money from the funded non-government programs that are coming up for contract review, and a modest saving will be made in that area.

Ms A.R. MITCHELL: Before going to Mr Ian Smith, I go to the Drug and Alcohol Office as well.

Mr N.S. Guard: We have two rationalisation measures, the first of which is decommissioning the library and resource centre. We will continue to provide a range of online services but we will decommission the physical resource centre and that will provide savings estimated at about $50 000 this year and $100 000 next year.

Mr R.H. COOK: Where is the resource centre?

Mr N.S. Guard: It is based at our Next Step Clinical Services. We will also be reducing the budget expenditure on our sustaining recovery program by $200 000.

Ms A.R. MITCHELL: I refer the next part of the question to Mr Ian Smith.

Mr I. Smith: The issue around the efficiencies and the media reports on staff cuts at both Bentley and Fremantle Hospitals was a convergence of two issues. One is them is through the whole configuration of the south metropolitan area and the opening of Fiona Stanley Hospital. We have done some detailed cost case-mix determinations about what patients and what acuity are going to be treated in which location. As a consequence, there will be a transfer of services across the system to allow that to occur. One element of the reported full-time equivalent reductions was some transfer from sites to the new Fiona Stanley model. That is in the year 2014–15.

The second item that converged at the same time was the pursuit to identify at the highest level of the organisation—so it is a modelling process—to see how the cost of delivering the service aligns with the state transition price, which was also discussed this morning in the Health estimates hearing; it is to see where the cost profiles align with the future price. That is an initial piece of work that then needs to be overlaid with patient safety issues and a whole range of other issues before any of those things are delivered. A modelling process determined where areas needed to improve or the model of care could become more efficient and more in line with national efficiencies.

Mr R.H. COOK: Were the Fremantle health workers asked to undertake their own risk analysis of patient safety in the hypothetical case that their position was eliminated? Is that what is called a detailed case-mix analysis, parliamentary secretary?

Ms A.R. MITCHELL: I ask Mr Ian Smith to respond.

Mr I. Smith: That is a component. The case-mix is actually determining the acuity and the style of patients going to Fiona Stanley or staying at Fremantle or the Bentley service. The bit the member is referring to is in relation to the balance, and whether it is feasible to reach those sorts of FTE targets.

Mr R.H. COOK: If it was not about the transition of jobs to Fiona Stanley Hospital, was the study that was undertaken at Fremantle about health cuts?

Ms A.R. MITCHELL: I will refer to Professor Stokes or through to Mr Smith for that question.

Mr I. Smith: May I ask for that question again?

Mr R.H. COOK: Is it correct that if the issues surrounding those cuts to the Fremantle Hospital jobs were not issues around case-mix but actually issues around cost, they were therefore examining job cuts or cuts to the health system?

Mr I. Smith: I think I said that it was a convergence of two issues. One was the transfer of case mix and activity and acuity across the whole system. The other component in that process was also to determine whether they were operating at a state-efficient price and if not, what the gap was so we could do the analysis to which the member is referring.

Dr G.G. JACOBS: I refer the parliamentary secretary to the "Sustainable Funding and Contracting with the Not-For-Profit Sector—Component II" line item at the bottom of page 537 under the heading "Spending Changes". Is this about involving more non-government organisations to do work in the mental health space or more work for the NGOs? Is this a new thrust or is it an ongoing thrust? What is component I, if that is component II?

Ms A.R. MITCHELL: Mr Bartnik will respond to the member for Eyre's question.

Mr E. Bartnik: As part of the government reforms around the Delivering Community services and Partnership Policy and the sustainability of the not-for-profit sector, there has been a two-phase process of sustaining the current activity of the not-for-profit sector. It is not about the sector doing increased activity; it is about the sustainability of its current operations and about simplifying contracting with a greater focus on standards and

outcomes in services. So there was a two-stage process. Component I was a flat 15 per cent or thereabouts that went to non-government agencies in the previous budget. The second stage process required all the contracts to be reviewed and brought into line with the simplified contracting reforms and the sustainability and quality of the services. The average increases in the second round were about 10 per cent. Of the funds that were available, all of that is around sustaining the current level of activity; it is not about them taking on increased activity.

Dr G.G. JACOBS: There was no estimated actual in 2012–13, so I cannot see what ongoing moneys were assigned for component I leading into component II.

Ms A.R. MITCHELL: We are determining who is best to respond at this stage. Mr Guard.

Mr N.S. Guard: There would not be any estimated actual in the year the member just referred to because component I was delivered the year before, so the 15 per cent across-the-board increase was in the year before, and this particular spending change comes into effect as of 1 July this year. There was no other increase relating to that last year; the 15 per cent was the year before last year.

[7.20 pm]

Mr P.B. WATSON: I refer the parliamentary secretary to the dot point under the heading "Suicide Prevention" on page 539 that reads —

> Under the 'Western Australian Suicide Prevention Strategy 2009–2013', a total of 40 Community Action Plans have been developed covering over 250 locations and more than 200 organisations have signed the One Life pledge to implement suicide prevention awareness and training in their organisations.

Funding for One Life has already been extended from 30 June to 31 December. When was extra funding provided? How much has been spent on the evaluation? When will the evaluation be completed? As continuity of care is such a vital element of service provision for people with mental health problems, how are the existing programs planned to go past 31 December with no funding commitments?

Ms A.R. MITCHELL: I can update the member. There are currently 45 community action plans in 255 locations, so it has proved to be a very popular program and it has certainly seen some wonderful benefits. The member raised a question about future funding, and I ask Mr Bartnik to respond.

Mr E. Bartnik: Approximately $4 million remains for this financial year to complete the implementation and evaluation of current community action plans.

Mr P.B. WATSON: Is that being done by Edith Cowan University?

Mr E. Bartnik: The evaluation has two components: a research and evaluation component being conducted by Edith Cowan University, which will relate directly to the work at Centrecare and the community action plans and the agency plans; and the Ministerial Council for Suicide Prevention, through the Mental Health Commission, is taking a broader view because suicide prevention encapsulates a range of strategies—for example, discharge from hospital and intergovernmental collaboration around highly vulnerable people, which are not within the realm of the Centrecare One Life strategy. There will be two components: one directly linked to the work of Centrecare through the One Life strategy; and the second component will take a broader view of all the components of suicide prevention and post-prevention support.

Mrs G.J. GODFREY: I refer to "Individualised Community Living" on page 539. What are some of the different living arrangements that have been supported through individualised community living?

Ms A.R. MITCHELL: I am very pleased to say that we have been very persistent in this matter, because we believe it is very important and we have seen some positive results. We have reached agreement with the commonwealth for a two-year trial at three sites in Western Australia. Two models of implementation will be rolled out. One that is similar to the state's My Way model will be rolled out in the lower south west from 1 July 2014 and in Cockburn–Kwinana in July 2015. Often, because the relationship between mental illness and disability is quite common, these things work well together. I ask Mr Bartnik to add further to that.

Mr E. Bartnik: There are two components, one of which is through the existing individualised community living strategy. Part of the beauty of the program is that it is personalised, so the 100 people who will be moved out of extended periods in hospital are able to choose where they live and also the style of support. For some people it might be that they have a live-in carer; for example, it might be a younger person who may have a child and they might require someone there all the time. It could be visiting support that comes from an agency at certain hours of the day or days of the week. Some people are connected to a network of other like people in the community, so it is a mutual support model. Fourthly, it can be home share, where people can share their accommodation with another person, who often provides some support in lieu of subsidised rent and those sorts

of things. We are very keen to expand the range of support alternatives, because there is no one-size-fits-everybody. The parliamentary secretary referred to the expansion of that sort of methodology into the My Way program under the National Disability Insurance Scheme, which builds on the same sort of personalised planning and support.

Dr A.D. BUTI: I refer the parliamentary secretary to "Cost of Services" on page 546, in which it is stated that the efficiency dividend for 2012–13 is $10.4 million. In a letter to Hon Giz Watson on 5 October 2012, the Mental Health Commissioner mentioned that a further announcement about implementing efficiencies would be made in the midyear review. Can we have some detail on what steps or actions have been taken to arrive at an efficiency dividend of $10.4 million?

Ms A.R. MITCHELL: Is the member asking for information from the 2012–13 budget?

Dr A.D. BUTI: Yes.

Ms A.R. MITCHELL: I thought we were referring to the 2013–14 budget.

Dr A.D. BUTI: That is right, but it is in these budget papers, so I can ask that question.

Mr E. Bartnik: There are two components to that, and I need to check I have this right. That figure would include a small proportion that relates to the Mental Health Commission's own operations, but the bulk would relate to the contract with the Department of Health. It is part of the overall agreement with the Department of Health. There was a budget allocation that included activity growth and also the efficiency dividends. As I understand it, they were applied by the Department of Health through its contract area health services. On that point, if I can, I will refer to the Department of Health.

Mr R.W. Salvage: The efficiency was passed through and reflected in the contract between the Department of Health and the Mental Health Commission and formed part of the broader efficiency request that we have to try to accommodate in 2012–13. As members will have seen from the budget papers that relate to health, there were significant ins and outs in the health budget last year. Overall, we came in pretty much close to budget, so all cost pressures were accommodated in the final approved expenditure that we had.

Mr R.H. COOK: I draw the parliamentary secretary's attention to the Department of Health division, which shows an efficiency dividend allocation associated with its contract of $9.6 million in 2012–13. Is the parliamentary secretary saying that the $10.4 million allocation in the mental health budget is actually consumed almost in whole by the $9.6 million in the Department of Health; and, if so, why has that efficiency dividend been double-counted?

Ms A.R. MITCHELL: Firstly, I am not able to comment on the Department of Health budget per se.

Mr R.H. COOK: With respect, I spent the afternoon hearing the Minister for Health say that he could not answer that question because it relates to mental health.

The CHAIRMAN: Member for Kwinana, you have put a question; give the parliamentary secretary an opportunity to answer.

Ms A.R. MITCHELL: I understand that is the case and I ask Mr Bartnik to respond to the member.

Mr E. Bartnik: The majority of that relates to the Department of Health contract. If the member looks at the Mental Health Commission's budget, some 88 per cent of the overall budget is related to the contract with the Department of Health. That then became part of our agreement with Health, and I would need to refer to Health on how that is shown technically in the budget papers. But that is how that figure is constructed.

Mr R.W. Salvage: I will have to refer to division 9 of the budget papers, which is the Department of Health budget. The major spending changes table shows a line item that identifies the pass-through from the Mental Health Commission to the Department of Health of its share of the efficiency dividend that was applied last year. The value for 2012–13 of that $10 million that question referred to was $9.7 million.

Mr R.H. COOK: That is the number to which I am referring. It looks like the Department of Health has claimed that $9.7 million as an efficiency dividend on behalf of the Mental Health Commission, and the Mental Health Commission has also counted it in its $10.4 million efficiency dividend. Does that mean it has been double-counted in the state's finances?

Mr R.W. Salvage: It is not double counted. The way the budget works between the Department of Health and the commission is that the commission receives an expense limit and an appropriation to fund services provided by the department. That is the division of the budget that we are looking at right now. On the department's side of the budget, we recognise the expenditure is associated with the commission's allocation of funding to us, because we incur the expenditure, essentially, and therefore we have to reflect the efficiency dividend on expenditure on both sides of the budget. In terms of a consolidation of financial information across government,

the double count is eliminated, but the efficiency dividend needs to be applied both to the appropriation source and to where the money will actually be spent, which is by the department.

[7.30 pm]

Mr R.H. COOK: A further question. How can it be eliminated when it has been included as part of the efficiency dividend in the Department of Health and it is also expensed in the Department of Health numbers and expensed in the Mental Health Commission?

The CHAIRMAN: I remind members to put their questions through the parliamentary secretary.

Mr R.H. COOK: Is that not the case, parliamentary secretary?

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

Mr R.W. Salvage: In the case of the Mental Health Commission, it is a budgeted reduction to the expense limit and the appropriation associated with the commission's budget. In the case of WA Health, it is reflected in a reduction to our expense limit and associated own source revenue coming from the commission. We have to eliminate on both sides of the equation.

The CHAIRMAN: Thank you, Mr Salvage. Member for Perth.

Ms E. EVANGEL: I refer to the fifth dot point on page 540, "Alcohol and Pregnancy". What is being done to educate the community about risks associated with alcohol consumption and, more specifically, what is being done to educate the community about risks associated with alcohol consumption during pregnancy?

Ms A.R. MITCHELL: I can assure the member that a great deal is being done and a great deal still needs to be done—there is no question about that. A number of areas are being addressed and a range of actions have been undertaken, certainly in the foetal alcohol spectrum disorder area, which is a focus for the Alcohol and Drug Authority and also a recent phase of the "No Alcohol is the Safest Choice" campaign. It was so successful that they are going to do that program again. For more specific information, I will hand across to Mr Guard.

Mr N.S. Guard: Regarding the broader question about what is being done around the risks associated with alcohol consumption, this is a huge concern to the community. It costs around $1.5 billion per annum in Western Australia and impacts on individuals, families, communities and emergency health and other services in a range of different ways. In part, a response to that is a sustained public education campaign, which is an evidence-based activity that can contribute to population-wide decreases in both alcohol and other drug use.

In Western Australia, the "Alcohol, Think Again" and the "Drug Aware" campaigns are the primary community education vehicles in our effort to reduce the impact that alcohol and other drugs have on the WA community. They are conducted through a service agreement and in partnership with a non-government organisation. They integrate with a range of other strategies such as early intervention policy, school drug education, legislation and community action and treatment, many of which are also delivered through service agreements that we have with non-government agencies. In 2013–14, new campaigns and a range of support strategies are planned for delivery over the next few years addressing youth alcohol use, responsible use and service of alcohol and drug-driving. Existing campaigns will be continuing over that time as well and they will include the work we are doing around alcohol and cancer, alcohol and pregnancy, and amphetamine and cannabis campaigns.

We are expecting to spend around $2.3 million on comprehensive alcohol publication initiatives and approximately $1 million on comprehensive other drug public education initiatives in the year. The sources of funds for those are varied; they include agencies like Healthway that supports us with this particular work, commonwealth funding, cannabis law reform funding and road trauma funds, as well as funds that we received a while back through the drug summit initiatives. We will also be continuing to provide funds of about $1.35 million for school drug education and about $.55 million for local drug action groups during the next year.

In relation to the consumption of alcohol during pregnancy specifically, the guidelines are now really clear. The National Health and Medical Research Council 2009 guidelines now clearly recommend that for women who are pregnant or planning a pregnancy, not drinking is the safest option; and for women who are breastfeeding, not drinking is also recommended as the safest option. Foetal alcohol spectrum disorder is a significant concern, as the parliamentary secretary has said; this is the umbrella term used to refer to a range of disabilities resulting from foetal exposure to maternal alcohol consumption during pregnancy and it can have a range of health impacts. It is considered the leading cause of intellectual and developmental disability in the western world and it is a key area of focus for us under the drug and alcohol inter-agency strategic framework. We have been a key stakeholder in the work that the Department of Health has done over recent years in developing a FASD model of care and we will continue to be a member of their project group doing that. A range of actions that focus on that are already being undertaken by the Drug and Alcohol Office and we will be continuing to do those in the years ahead.

It started back in 2011, when we formed a partnership with the Telethon Institute for Child Health Research to reproduce and distribute resources that it had produced around alcohol and pregnancy and foetal alcohol spectrum disorder for health workers. In June 2012, we launched the "No Alcohol During Pregnancy" campaign and that was replayed last financial year in May 2013 and we have a repeat of that campaign scheduled for this coming year —

Mr P.B. WATSON: Point of order. Mr Chairman, you mentioned at the start that the answers should be short and straight to the point. We feel like we are getting a whole policy read out to us at the moment.

The CHAIRMAN: Thank you, member. Yes, I did make reference to short answers and short questions. Mr Guard, if you could wind it up.

Mr N.S. Guard: I will do that. We will also be continuing the work we are doing around alcohol and pregnancy in Aboriginal communities. We have a $511 000 allocation for that. We will continue to do the training with Aboriginal health workers that we have over the past 12 months; that will be a significant focus for us in the year ahead as well.

The CHAIRMAN: Thank you for that contribution, Mr Guard.

Mr P.B. WATSON: I hope I have a quick question here.

The CHAIRMAN: So do I.

Mr P.B. WATSON: I refer to the fifth dot point, "Individualised Community Living", on page 539, which states —

> 100 people with mental illness are now being supported with a personalised package of support, individualised funding and a home in the community, with a further 16 houses and 18 packages of support to follow.

I have a few dot points here and I will give them to the parliamentary secretary all at once so I do not keep interjecting. Why are there only 100; how many people are eligible for the program; what are the criteria; what services are available; and if we also look at page 543, the average package costs $86 128, so has any compliance monitoring been done on that to make sure that the service providers are complying with the requirements that 24/7 assistance is available?

The CHAIRMAN: I am not so sure that was a short question, member.

Mr P.B. WATSON: But I got four into one, Mr Chair.

Ms A.R. MITCHELL: I ask the member to repeat the specific questions and the numbers that he is looking for because I did not get them all down.

Mr P.B. WATSON: Repeat it? Oh, good.

Ms A.R. MITCHELL: No! Not all of it please; just some of it.

Mr P.B. WATSON: The dot points. Why are there only 100? Would the parliamentary secretary like to do them individually; I was just trying to do it quickly?

Ms A.R. MITCHELL: We will take them as they are, thank you; we have them down.

Mr P.B. WATSON: Have you got them all?

Ms A.R. MITCHELL: Yes. Mr Bartnik will make a start.

Mr P.B. WATSON: Why only 100?

Mr E. Bartnik: The 100 was the initial allocation as part of the first phase of the project. A further 18 packages have been provided on top of the initial 100 through the state government budget process and a further 30 packages through a national partnership agreement with the commonwealth. In total, there will be 148 packages. The original idea was that this was for people who had been stuck in hospital and could be discharged, but did not have a home to go to.

Mr P.B. WATSON: Yes, I understand that.

Mr E. Bartnik: This was an initial response. The average package is about $85 000—some are less and some are more than that, so it is very much based on people's individual needs. They are very carefully monitored as part of that process. In regard to future planning, as part of the Mental Health Services plan, on our population basis, we will be looking at the full range of services that are needed and how this number of packages —

Mr P.B. WATSON: A further question through the parliamentary secretary: how many people are eligible or were eligible?

Ms A.R. MITCHELL: Eligible when, member?

Mr P.B. WATSON: There were 100 picked; I would like to know how many were eligible or could have been picked.

[7.40 pm]

Ms A.R. MITCHELL: At that initial time?

Mr P.B. WATSON: Yes, please.

Ms A.R. MITCHELL: Does Mr Bartnik have that information?

Mr E. Bartnik: I think the general level is that probably between 600 and 700 people might be in hospital at any point in time, and we do know that of those people, various people have become stuck in that situation. Because this was a new program, we asked that the individuals and their families, but also the clinical services, identify people who met the criteria of the program and who required a home, but —

Mr P.B. WATSON: What are the criteria?

Ms A.R. MITCHELL: Would Mr Bartnik respond to that, please?

Mr E. Bartnik: They are people who had had a significant period in hospital and who were at risk of being homeless if they were to be discharged because they did not have a home or did not have sufficient support. The majority of people got both a housing allocation and a package of support.

Mr P.B. WATSON: My last question is: has any compliance monitoring been done? We have been told that some of the service providers are not complying with the requirement to provide the 24/7 assistance that is supposed to be available. Is any compliance monitoring being done?

Ms A.R. MITCHELL: Does Mr Bartnik have any information?

Mr E. Bartnik: Through contract management, this is a new style of program that is based on individual plans. People can then choose their service provider, so, by definition, some people will have varying levels of support. Some people might require four or five hours a day; some may require 24 hours a day. It will depend on the individual plan. All the individual plans are monitored as part of the contract, and there is regular reporting through our contract management process to do with acquittal back to the individual plan.

Mr F.A. ALBAN: I refer the parliamentary secretary to the seventh dot point on page 539 under the heading "Mental Illness and the Criminal Justice System". Can the parliamentary secretary advise whether this trial is being well used and whether it will continue?

Ms A.R. MITCHELL: I thank the member. I am very pleased to tell the member that this is working very well with the pilot that occurred. I have visited the court when it has been in operation, and it is certainly very pleasing to see the ways in which people can be assisted in the criminal justice system nowadays. Mr Bartnik will probably have more information, but it has certainly been very successful.

Mr E. Bartnik: There are two components. There is a clinical support team in the adult court and a mental health team in the Children's Court. The adult court program began in March this year and the Children's Court program began in April, so they are slightly staggered starting points. As of 30 June, 138 people had appeared in the adult court, with 104 of these people having involvement with the clinical team. That is a very, very high take-up rate. In the Children's Court, in the first two months 30 children were assessed. These programs are really important because they provide a link to assessment and treatment—not just going down the criminal justice route. We have an independent evaluation of the program being set up at this time to carefully evaluate both the implementation and the outcomes of the program with a view to the continuation of the program, but also, most importantly, its extension to other country areas as well. It started in the metropolitan area and, based on the available evidence, we want to sustain the program and then look at how it can be sent out to the country regions.

Mr F.A. ALBAN: The last part of my question was: will it continue? I did not quite get that.

Ms A.R. MITCHELL: It certainly is our plan to continue this process and expand it.

Dr A.D. BUTI: I refer the parliamentary secretary to the eighth dot point on page 539, "Mental Illness and Indigenous People", which states —

> The State Government has approved expenditure of $7.5 million in 2013–14 to continue the State-wide Specialist Aboriginal Mental Health Service for severe and persistent mental illnesses.

The Liberal Party's election campaign media release of 15 January 2013 stated that the Liberal–National government is improving community support and mental health clinical services for Aboriginal people with the implementation of a $22.47 million statewide specialist Aboriginal mental health service. In respect of that, why

is there a difference in the numbers? But, in any case, how much has been spent on the statewide Aboriginal mental health service in 2013–14 and how much has been spent on the metropolitan counterpart; how many full-time equivalents are there in each service; and how many Aboriginal employees are there in each service and what are their job descriptions?

Ms A.R. MITCHELL: Before I pass over to Mr Bartnik, I reaffirm that we are very committed to the specialist Aboriginal mental health service. We recognise that Aboriginals have specific needs and that they are often in remote rural and regional locations. Sometimes those systems that are in place do not work as well as we would like them to, but we are working on that. To answer the specific questions about the number of FTEs and the number of Aboriginal workers, I will pass to Mr Bartnik.

Mr E. Bartnik: Responding to the first part of the question about the original figure of $22.4 million, I think it was —

Dr A.D. BUTI: It was $22.47 million, yes.

Mr E. Bartnik: That was part of the Closing the Gap initiative, and it was a four-year period. As with a lot of these initiatives, they take a bit of time to get going, and particularly with this initiative, because we did a lot of consultation around the state. We met with all the regional Aboriginal mental health planning forums to talk about how it could be best implemented in their regions. The amount of $7.5 million is for one year's operation over that four-year period. In a general sense, I will try to respond to the member's queries. The key thing about this program was that the actual FTEs were allocated to where Aboriginal people with mental health problems were. It was not done in the usual way of three-quarters in the metropolitan area and one-quarter in the country; it was actually loaded up to the areas where we had identified people. Areas such as the Kimberley, for example, got quite a high weight, so the funds were distributed on that basis. From memory, about 62 additional staff were appointed to the program, and the vast majority of those are Aboriginal staff. A key component of the program is to bring in and train Aboriginal staff to be long-term community members working in mental health. If the member requires, we can do the specific FTE breakdown in the metropolitan area and the country.

Dr A.D. BUTI: As supplementary information?

Mr E. Bartnik: Yes.

Dr A.D. BUTI: Yes. Thank you, Mr Bartnik.

Ms A.R. MITCHELL: Can I just clarify that the member is looking for the total number of FTEs currently in the specialist Aboriginal mental health service?

Dr A.D. BUTI: That is right—in 2013–14.

Ms A.R. MITCHELL: I might be able to provide the member with that information. I will ask Mr Dillon to respond to that request.

Mr E. Dillon: I can advise that 26.5 of the additional FTEs were metropolitan based and that 35 were in the country regions, comprising the 61.5 FTEs approximately in total funded through that program.

Dr A.D. BUTI: Can we have the other parts about the number of Aboriginal employees and the job descriptions as supplementary information?

Ms A.R. MITCHELL: We have that information.

Mr E. Dillon: It is approximately 60 per cent Aboriginal across the board.

Dr A.D. BUTI: And the various job descriptions? It would be a bit hard to provide that now.

Ms A.R. MITCHELL: Is that the various job descriptions of the work that they do?

Dr A.D. BUTI: Yes.

Ms A.R. MITCHELL: Does Mr Dillon have specific job descriptions, or do they vary depending on the locations they are in?

Mr E. Dillon: We would need to provide the job descriptions as supplementary information, I think, but there are a wide range of roles—everything from medical practitioner to social worker and Aboriginal mental health worker. A number of roles are involved in the program.

The CHAIRMAN: Is that enough information?

Dr A.D. BUTI: Yes, that will do.

Mr R.H. COOK: I think what I am referring to comes under the heading "Accommodation, Support and Other Services" on page 543. I refer to a media statement from the Liberal Party on 26 February 2013, announcing the

new step-up, step-down facilities that would be built in Bunbury and Karratha under the Liberal government's mental health plan. That media release states —

> A re-elected Liberal Government will continue its commitment to support people with a mental illness by allocating $6.2million to develop two further sub-acute facilities in Karratha and Bunbury. Work will commence on these facilities in 2013–14, with a total of $2.8million per annum to provide on-site services.

Can the parliamentary secretary please point to the part of the budget that actually provides that funding allocation for the Karratha and Bunbury facilities?

[7.50 pm]

Ms A.R. MITCHELL: I thank the member. I can inform him that no specific allocation for the step-up, step-down service for either Karratha or Bunbury was announced in last week's budget, because the planning for these two facilities is at an early stage and the Mental Health Commission will manage the initial planning for these services from within its existing resources.

Mr R.H. COOK: I again draw the parliamentary secretary's attention to the fact that she said she would allocate $2.8 million per annum to provide on-site services in 2013–14. Where in the budget is that $2.8 million detailed to provide evidence that the parliamentary secretary is going to keep that promise?

Ms A.R. MITCHELL: Can I ask the member to repeat the question?

Mr R.H. COOK: I understand that the parliamentary secretary referred to the "vibe" of the budget in terms of the allocation, but her promise to the people of Karratha and Bunbury was very specific: she said that for 2013–14 she would allocate $2.8 million per annum to provide on-site services. That is not, as the parliamentary secretary says, off in the never-never, early planning stages; that is the here-and-now. Can the parliamentary secretary point to where in the budget she will be keeping that election promise?

Ms A.R. MITCHELL: I will have to take that question on notice because I do not have that specific information in front of me; I am happy to provide an answer as supplementary information, if the member wishes.

The CHAIRMAN: Can we just clarify the supplementary information, parliamentary secretary?

Ms A.R. MITCHELL: The member is asking where the money is that was committed to provide on-site services in Karratha and Bunbury.

Mr R.H. COOK: Yes, specific budget items.

Ms A.R. MITCHELL: Specific budget items for on-site services for Karratha and Bunbury.

[*Supplementary Information No B24.*]

Dr G.G. JACOBS: There was a line item in last year's budget for a site in the goldfields for a step-down or transitional mental health unit, in the out years of the budget. Again, like the member for Kwinana, I cannot see it in this budget and I just seek some reassurance that the money is still there.

The CHAIRMAN: I think, member, that the question has been put and the parliamentary secretary is endeavouring to get supplementary information for that, so I think —

Dr G.G. JACOBS: He was talking about a different site; I am talking about the goldfields, so I would like to add that, if I could.

The CHAIRMAN: If so, it would have to be a separate supplementary information number.

Ms A.R. MITCHELL: I can ask Mr Dillon to answer the question.

Mr E. Dillon: Certainly the funding remains available; what we are doing at the moment is working with the Department of Housing to identify suitable sites. We will then need to go through a planning process that would include community consultation. At that point we would be in a position to be able to acquire the site and develop it, depending on whether it is going to be a buy-and-build or an existing facility that we would acquire. There will be a significant passage of time in terms of being able to bring the site onstream, but it certainly is the intention to proceed.

Mrs G.J. GODFREY: I refer to page 539 of budget paper No 2 and the dot point paragraph heading "Mental Health Bill". How will the Mental Health Bill improve the rights and the protection of people with a mental illness, their families and their carers?

Ms A.R. MITCHELL: I can assure the member, because I am working on it as we speak, that the Mental Health Bill will certainly increase the human rights protections of people who find themselves with a mental

illness and who are in difficult situations. It means treating people with respect and dignity, and making sure that we get them to a point at which they can actually make decisions about their own lives. One of the features that will come forward is that the bill will provide greater involvement for families and carers, because that is certainly something that came out during the consultation phase, which is still continuing. Those things have been listened to and taken on board in the preparation of this bill. I will ask Ms Southalan, who is working with me, to respond on this matter.

Ms L. Southalan: I can add a bit of additional information about some particular changes that are relevant to that question. The bill introduces a charter of mental health care principles, for example, which sets out what can be expected from mental health services. It introduces shorter time frames for involuntary status and for reviews of involuntary status by the Mental Health Tribunal, which will be the new body established to replace the Mental Health Review Board. There is a range of new powers for the Mental Health Tribunal, including reviewing possible breaches of the legislation, issuing compliance notices and approving electroconvulsive therapy for involuntary patients and for all children as well. There are a range of changes to increase access to the Mental Health Tribunal, beyond what exists under the current legislation and a range of special considerations around children, relating to shorter time frames for involuntary status and for reviews. There is a much greater role throughout the bill for carers, who will be notified about particular events happening in relation to their family member or person with a mental illness whom they are caring for, including when that person is made involuntary or goes on leave, and they will be informed and be involved as a default with the care and treatment of the patient. There is also a new mental health advocacy service, which will replace the Council of Official Visitors, which will have an enhanced role and will be expected and required to make contact with every involuntary patient and be able to provide advocacy for referred persons as well, including some voluntary patients and particular classes of patients throughout the system. There is a more comprehensive complaints process involved and a greater role for the Health and Disability Services Complaints Office. There will be increased use of audiovisual teleconferencing in rural and remote areas when it is not possible to have a face-to-face assessment. In addition, there will be a greater role for the Chief Psychiatrist, who will receive increased information about interventions such as seclusion and restraint, and provide guidelines on a wide variety of issues.

Mr R.H. COOK: The human rights elements are really important, so I am really pleased the member has raised that. My attention was drawn to an article that appeared in the *British Medical Journal* of May this year, which was an examination of a study that was done in Western Australia that showed that the gap in life expectancy for people with psychiatric disorders in Western Australia increased from 13 to 15 years for males, and from 10 to 12 years for females. That essentially means that the life expectancy gap between mainstream Western Australians and Western Australians suffering from a mental illness is actually wider than the gap between Indigenous and non-Indigenous Western Australians.

The CHAIRMAN: Are you getting to your question, member?

Mr R.H. COOK: I am, and this is specifically relevant. The editors of the journal pointed out that the huge loss of life among people with a mental illness needed to be recognised as a human rights disgrace. I ask the parliamentary secretary: to what extent does the new Mental Health Bill address these issues around the rights of people with a mental illness to receive ongoing care for their physical condition as well as their mental health?

Ms A.R. MITCHELL: There are a couple of people who will probably need to respond to that question; I will start off with Mr Bartnik and then Dr Gibson.

[8.00 pm]

Mr E. Bartnik: I think, as a general rule, the Mental Health Act deals with involuntary treatment and what people can expect; that is the focus of the legislation and what they can expect in hospital and also as part of their discharge plan. The broader issue about life expectancy of people with severe mental illness is sort of a whole-of-community issue that the Mental Health Commission has been working with the Department of Health on. Through the parliamentary secretary, if we could now go to Professor Stokes.

Prof. B. Stokes: When I did the mental health review, one of the most significant things was the general health of patients with mental illness. Their life expectancy is significantly reduced because there are often significant comorbidities that are not detected nor treated. This also includes significant oral health issues—although it may not necessarily lead to death, it does lead to disability, certainly. That is one of the major features. One of the recommendations I have made in my report is that mental hospitals should conduct clinical examinations of patients frequently to look at their hearts, lungs and kidney function and so forth. With the greatest respect to my psychiatric colleagues—or my psychiatry colleagues, I should say—they are trained in another way. There are often physicians when they start off in their training, but I think that the Chief Psychiatrist would agree with me

that often those aspects are sometimes overlooked in mental health institutions, particularly also in general practice where patients are often itinerant, and do not see their general practitioner frequently. Those are some background reasons why their life expectancy is reduced—apart, of course, from self-harm.

Ms A.R. MITCHELL: I will just ask Dr Gibson, as Chief Psychiatrist, to respond as well, please.

Dr N. Gibson: Yes, it is a disaster—it is a worldwide disaster; it is not just WA. The figures from Scandinavia are really perhaps even greater than Western Australia. On a national level, there has recently been a national summit held on this issue in Sydney. As recently as last Friday, the clinical senate within the Department of Health dedicated a session entirely to this matter sponsored by both the Mental Health Commission and me. There are active steps to address this matter, including partnerships with Medicare Locals, through the various mental health services. There have been sites in WA, including Graylands Hospital, which have been pilot sites for improved national standards around clinical physical deterioration. Active steps are being taken, but really it is a significant priority area.

Ms A.R. MITCHELL: Mr Chair, could I just clarify what the break-up of time is for the three areas we have, so that we have a rough idea?

Mr R.H. COOK: I only have two more questions, and I am not sure about the others.

Mrs G.J. GODFREY: Just one.

Ms A.R. MITCHELL: We might just take the member for Kwinana.

The CHAIRMAN: Through the Chair. If the member for Kwinana could ask some very, very brief questions so that we can get some very brief answers, we can move on. The member for Kwinana.

Mr R.H. COOK: Superb work, Mr Chair!

I refer the parliamentary secretary to page 543 under the heading, "Accommodation, Support and Other Services". It flows on from that question surrounding those broader issues around people's physical health. Could she provide me with some details about any programs specifically targeted at people with mental illness around the Quit campaigns or around stopping smoking? I am aware of one program at the Mental Illness Fellowship of Western Australia, but I ask the parliamentary secretary whether she could tell me about the ongoing support for those sorts of programs.

Ms A.R. MITCHELL: I will just defer to Mr Bartnik to respond to that question for the member for Kwinana.

Mr E. Bartnik: There are two aspects to this matter. Through the Mental Health Commission there is a funded program with the Mental Illness Fellowship of WA. That program is currently under review; it has completed its first phase. It is not in the current moneys, but we are looking to find ways to continue the program in recognition of its importance and value. Also, because it not only tackles an incredibly important issue, but also is delivered by peer workers, it has quite a lot of important relevance to the individuals themselves. Within the Department of Health there will be some other operational initiatives that I will refer to through the parliamentary secretary.

Ms A.R. MITCHELL: No, thank you. Not at the moment, just the response from Mr Bartnik. The answer is finished. Thank you.

Mr R.H. COOK: Is the parliamentary secretary saying that there is no future funding for that program at this stage?

Mr E. Bartnik: The original funding for the program was non-recurrent funding; it was time-limited project funding. Currently, we are looking at the outcomes of that work with a view to finding the resources to continue it; but at this point in time, I cannot guarantee that because of our current budget situation. However, we are actively looking to support this type of program.

Mr R.H. COOK: My final question. The only part of the budget that I can perhaps think that this would sit under is on page 542, under the heading, "Specialised Admitted Patient Services". This matter goes to a conversation earlier today with the Minister for Health in relation to the redevelopment of Osborne Park Hospital and the related redevelopment of Graylands Hospital. The budgetary papers in division 9 of the budget indicate that both developments have been pretty much put on hold. I asked the Minister for Health about this and he said there are mental health beds obviously—that is, at Graylands Hospital and that 50 mental health beds at Osborne Park Hospital were mooted. I was told to ask the parliamentary secretary. I appreciate it is not in her division, but it relates to her budget.

Ms A.R. MITCHELL: We will see whether we can provide an answer to the member for Kwinana. Professor Stokes will start.

Prof. B. Stokes: The issue of Graylands Hospital—first of all, I think we would all understand that it is a significantly archaic hospital.

Mr R.H. COOK: Distressingly so!

Prof. B. Stokes: There are significant issues about it which suggest that it is not fit for its purpose in many ways, and that has been so for many, many years. The process about what should happen with Graylands is a matter of debate at the moment with the Minister for Mental Health and obviously with government. Really, the big issue is that we need to consider the principles of whether a hospital like Graylands should still exist and whether there should not be the devolution of similar structures around our other mental health units and with step-down areas in the community. Obviously, there is a very significant unit at Graylands Hospital which is the forensic services unit. In my own personal opinion—this is my personal opinion and not that of government—it should be in a prison environment. Not necessarily physically attached to the prison but in a prison environment.

I think I am correct in saying that we are the only state in this country in which judicial persons can actually admit someone to hospital. They do it very frequently and patients go to the forensic unit at Graylands at the request of a magistrate or the judges, and the forensic unit must find space for them. Often that means patients who are there already are partially treated or assessed and go back into the prison system to be treated as an outpatient. That is the issue about Graylands Hospital's forensic unit. With Osborne Park Hospital, I understand there were plans to build a 50-bed mental health unit. That is still being considered; although at this point, no definite planning has been put forward.

Mr R.H. COOK: A follow-up question, if I may?

The CHAIRMAN: A follow-up question, member for Kwinana.

Mr R.H. COOK: I thank the parliamentary secretary. I share the director general's concerns about Graylands. I would make two observations that will, therefore, invite my question. Firstly, I note that some $600 000 has gone into the planning for the redevelopment of Graylands Hospital; that must have gone on beyond a simple debate and the parliamentary secretary must know what she is actually doing there now and why she is doing it now.

Secondly, in relation to Osborne Park Hospital, I have raised this issue in every single estimates committee hearing in my parliamentary career, and each year the government has said that it is thinking about it, but then puts it off by another year. What is the hold up?

[8.10 pm]

Ms A.R. MITCHELL: I know it might be frustrating for the member that there is not anything specific, but I can assure the member that, as Professor Stokes has indicated, the Graylands site is currently under consideration on what is the best way forward. I would also say to the member that as to specific information on the Osborne Park site, I would welcome the member to ask for that as supplementary information and we will get that information to him.

Mr R.H. COOK: Are we clear on what it was? It was supplementary information with regards to the redevelopment of Osborne Park Hospital.

Ms A.R. MITCHELL: The member wishes to know the plans for the mental health unit at Osborne Park Hospital.

[*Supplementary Information No B25.*]

The appropriation was recommended.