Division 73: Mental Health Commission, $466 522 000 —

Mr M.W. Sutherland, Chairman.

Dr K.D. Hames, Minister for Health.

Mr E. Bartnik, Mental Health Commissioner.

Ms A. Keller, Director, Corporate Services and Governance.

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

Ms D. Pawelek, Director, Performance and Reporting.

Ms E. Paterson, Acting Director, Services Purchasing and Development.

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

Mr K. Snowball, Director General, Department of Health.

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

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

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

Ms M. Browne, Director, Policy Strategy and Information, Drug and Alcohol Office.

[Witnesses introduced.]

[3.20 pm]

The CHAIRMAN: The member for Bassendean.

Mr M.P. WHITELY: Minister, I will start with what I think are two very significant statements. These statements can be found in the dot point at the bottom of page 868 under the heading "Trends". The first statement is —

> Recent data continues to highlight that approximately half of all Western Australians will experience one or more of the common mental health disorders at some point in their lifetime.

The second statement is —

> Approximately three quarters of all severe mental illness begins before the age of 24 years.

I would like to know the source of those claims. I would also like to know how the department categorises the distinction between common mental disorders, as mentioned in the first statement, and severe mental illness, as mentioned in the second statement. What is the distinction between the two? Presumably there must be a list of mental health disorders, and some are categorised as severe mental illness and some are categorised as common mental disorders.

Dr K.D. HAMES: I will hand that question over to Mr Bartnik.

Mr E. Bartnik: Thank you, minister. The information on prevalence is sourced from the Australian Bureau of Statistics national surveys of mental health and wellbeing, and these figures are from the 2007 survey. The difference between the 75 per cent of people with a severe mental illness and that broader classification basically relates to the high prevalence, low severity disorders, typically anxiety and depression, versus some of the lower prevalence, higher severity disorders, typically schizophrenia and bipolar disorder. That is the general distinction.

Mr M.P. WHITELY: Is it possible to get some follow-up information that lists the criteria by which this distinction is made? These are quite alarming figures. The claim that half of us will experience a common mental disorder at some time in our lifetime sets an impossible task for government, frankly, if it is true that the role and responsibility of government is to respond to those common mental health disorders. The minister can see the point I am getting at. I am trying to distinguish what is severe enough to warrant government intervention— presumably that is what is referred to as severe mental illness. That can be found in other places in the budget papers as well.

Dr K.D. HAMES: Mr Bartnik will provide that as supplementary information, but can the member make clear what exactly he wants us to provide?

Mr M.P. WHITELY: I want the source of those two statements. Mr Bartnik has advised me of one of the sources, the ABS 2007 survey, and I presume that applies for both quotes, so I would like to have the reference

point for that. I would also like to get the distinction between common mental disorders as mentioned in the first statement, and severe mental illness as mentioned in the second statement, in as discrete terms as is possible.

[*Supplementary Information No A26.*]

Dr G.G. JACOBS: I would like to talk about transitional accommodation. I draw the minister's attention to page 869. The first dot point under the heading "Mental Health Infrastructure" states that the proposed development of subacute facilities in Joondalup, Rockingham and Broome will assist patients in their transition to and from home. At page 867, in a line item under the heading "Major Spending Changes", there is a reference—this is probably a little local flavour—to the provision of a subacute service in the goldfields–Esperance region. What is being done, minister, to help people with a mental illness make the transition from hospital to the community?

Dr K.D. HAMES: Mr Bartnik.

Mr E. Bartnik: Recurrent funding of $2.526 million over two years has been approved as part of the new budget to develop six subacute beds, or what can be called a step up, step down service, in the goldfields region, with the investment commencing in 2014–15. Part of the reason for that is that we need to do some good work with the community about the location of that service, because there is some division about whether it should be in the Kalgoorlie area or the Esperance area. This new service will add to the subacute services that are already being developed in Joondalup, Rockingham and Broome. These services make a real difference, because they mean that people who are no longer acutely unwell and who may be stuck in hospital and not quite ready to go home are able to step down into this facility, get some more support around them, get a good discharge plan going, and have a graduated return to home. In addition, last year we provided 100 packages for people who were in hospital and required support to go home. So, in addition to the subacute facilities, there are packages of housing and support to get people back home.

Dr G.G. JACOBS: The funding for the provision of subacute facilities in the goldfields–Esperance region is $1.238 million in 2014–15 and $1.288 million in 2015–16. Will that be for the building of two facilities, one in Kalgoorlie and one in Esperance, for instance? Are these infrastructure costs; and, if so, where will the running costs come from?

Mr E. Bartnik: The funding is for operational costs; it is two full years of operational costs for one facility. The capital funding we believe we can find from the previous allocations for Rockingham and Joondalup. We initially thought that the Rockingham facility would be 22 physical beds. But our community consultations are telling us they want a combination of some physical beds and some Hospital in the Home–type arrangements. So we believe we will be able to make some savings in capital that can be redirected to the Esperance facility.

Dr G.G. JACOBS: What configuration are we talking about in, say, Joondalup? Will these be homes on residential sites, or will these be particular facilities with so many beds in them?

Mr E. Bartnik: The Joondalup facility is being built at the moment and is almost complete. It comprises 22 individual home-like units on the hospital site, in sort of a discrete area at the back of the hospital, facing onto the other street. That is the first of these facilities in Western Australia. With regard to the Rockingham facility, we have consulted with the community, which is keen on a combination of onsite and offsite. But we want these facilities to be as personalised and as flexible and as much like a person's home as possible. The Broome facility is likely to be a six-bed physical facility.

Ms J.M. FREEMAN: I refer to the income statement on page 875 and the heading "Cost of Services". One of the items under "Expenses" is the service delivery agreement with the Department of Health. The minister would be aware of this. The 2012–13 budget estimate for this item is $4.98 million. Can the minister provide the key effectiveness indicators and the key efficiency indicators that the Department of Health abides by in the delivery of mental health services in the service agreement with the Mental Health Commission? That is, what does the Mental Health Commission set as the key effectiveness and key efficiency indicators? How often does the Director General of the Department of Health report on these key effectiveness and key efficiency indicators to the Minister for Mental Health; in other words, what is the agreement in terms of reporting? What are the percentages and number values for the key effectiveness and key efficiency indicators from the Department of Health for the last financial year?

[3.30 pm]

Dr K.D. HAMES: That is an excellent question. Mr Bartnik will respond.

Mr E. Bartnik: I will respond in two ways. Generally, the Mental Health Commission and the Department of Health have an agreement each year about the quantity, quality and cost of mental health services and the information that is required to support that agreement. Under that agreement, there is accountability to the

Mental Health Commission and the Minister for Mental Health. Some of those indicators are also reported in the budget papers. I refer to the director of performance reporting, monitoring and evaluation to talk about the indicators in the documents related to health activity.

Dr K.D. HAMES: Director general.

Mr K. Snowball: Adding to that, as the funds from the commission come to the Department of Health, we in turn effectively have service level agreements with all our area health services to deliver the services at the level of safety and quality standards that have been set by the commission and our legislation. As part of the overall assessment of monitoring and performance, the Office of the Chief Psychiatrist's job is to oversee the safety and quality aspects of our service delivery, particularly around our services and the application of the policies and practices that are designated for those facilities, bearing in mind that this relates specifically to specialised mental health services. Other mental health services are provided by our hospitals, whether they be in emergency departments or other settings. This is specifically in respect to those specialised mental health services.

Ms J.M. FREEMAN: Firstly, I was told I would be shown where the indicators are reported in the budget papers, and, secondly, that made no sense at all. Can someone tell me where the key performance indicators are? There is an agreement that says how it will be delivered. That is great, but I assume that both departments would have that because the two different organisations have to work together with a lot of money. That was not my question. My question was whether I could be provided with the key performance indicators. What are they? What are the key things that I can look at to know that they are being delivered according to the budget parameters, so that I know they are being delivered efficiently? I now know that both departments talk regularly, so that has answered that question. How were the KPIs met and what percentage of them were met in the last financial year?

Dr K.D. HAMES: Mr Bartnik has an adviser who can answer that question.

Mr E. Bartnik: I will do that in two lots. Firstly, the director of performance reporting, monitoring and evaluation can talk about the performance indicators relating to health activities that are in the budget papers and, secondly, the director of policy will talk about the additional indicators in the service agreement. I refer those two matters to Ms Pawelek and Mr Dillon.

Ms D. Pawelek: In the budget papers, there are two efficiency indicators that relate to the services provided by the Department of Health. One indicator is the percentage of contacts with community-based public mental health non-admitted services within seven days of being discharged from a public mental health inpatient unit. We specify the targets for this indicator, one of which is that more than or equal to 70 per cent of clients who have been discharged should be seen by the community mental health services. Another efficiency indicator is the readmission to hospital within 28 days of being discharged. Obviously, we would like to minimise the number of readmissions. The target is currently less or equal to 12 per cent. In 2010–11, the Department of Health exceeded the target readmission rate, which was 14 per cent. The preliminary data, using the budget papers, indicates that the department is close to the target of 12 per cent. In addition, there are two effectiveness indicators. One relates to the average cost per purchase bed day from specialised mental health inpatient units and the other relates to the cost of the community episode of care.

Mr E. Dillon: There are 14 key performance indicators currently required in routine reporting. I will quickly go through those. The first is the change in the consumers' clinical outcomes, which is a six-monthly reporting frequency; the 28-day readmission rate is also required to be reported on a six-monthly basis; the national service standards compliance is reported six-monthly; preadmission community care has a quarterly reporting frequency; post-discharge community care is also reported quarterly; consumer outcomes participation is reported six-monthly; outcomes readiness is reported six-monthly; the rate of suicide is reported annually; the rate of seclusion is also reported annually, I think; the post-discharge community care for self-harm episodes only is reported quarterly; the number of admissions to specialised mental health inpatient units is reported monthly; the number of occasions of service and community mental health services is reported monthly; the average cost per bed day in specialised mental health inpatient units is reported annually; and the average cost per episode of community care provided by public mental health services is also reported on an annual basis.

Mr R.H. COOK: I refer to the total cost of services on page 867. My question also relates to employee benefits on page 875. Can the minister provide the number of full-time equivalent mental health staff and their average salaries in all public psychiatric hospitals in Western Australia, broken down into the following categories—salaried medical officers, registered nurses, enrolled nurses, diagnostic and allied health professionals, administrative and clerical staff, and domestic and other staff?

Dr K.D. HAMES: That is a significant question and I do not think anyone would expect us to have that information at hand ready for regurgitation.

Mr R.H. COOK: That is correct.

Dr K.D. HAMES: The question for Mr Bartnik is whether he can provide that as supplementary information within a week or, if it is sufficiently complex, he will need longer, in which case he will need to take it on notice.

Mr E. Bartnik: There are two lots of information: those that relate to the Mental Health Commission, which I can speak for, and those that relate to the operation of the Department of Health.

Mr R.H. COOK: That would have to be a separate question.

Dr K.D. HAMES: The Director General of Health said he would prefer the second component to be put on notice, if the Deputy Leader of the Opposition would not mind sending that in. Mr Bartnik will respond to the first component now.

Mr E. Bartnik: No, not now; I can provide the information as supplementary information.

The CHAIRMAN: Does the minister know exactly what was requested?

Mr R.H. COOK: Perhaps I can assist. I would like the full-time equivalent mental health staff numbers and average salaries across a range of categories. If I read them out it will make it clearer. They are salaried medical officers, registered nurses, enrolled nurses, diagnostic and allied health professionals, administrative and clerical staff, and domestic and other staff.

Dr K.D. HAMES: Can I ask why the Deputy Leader of the Opposition did not send me that question last week or next week?

Mr R.H. COOK: The minister cannot know the mystery of our ways. We are far too clever to be able to explain them to him!

[*Supplementary Information No A27.*]

Mr P. ABETZ: I refer to the second dot point from the top of page 870, "Mental Illness and Indigenous People". I would like an update on this statewide specialist health service for Indigenous people with a severe and persistent mental illness. Some $22.5 million has been committed over three years to implement this program. Can the minister tell us how that will work in practice, particularly in the remote communities?

[3.40 pm]

Dr K.D. HAMES: Mr Bartnik.

Mr E. Bartnik: The $22.47 million under the Closing the Gap initiative is for the statewide specialist Aboriginal mental health service. The majority of the contracts were in place in January 2011. We took a bit longer with the Kimberley because there was a period of community consultation with the Aboriginal medical services about a blended model. In the rest of the state the services are provided through the WA Country Health Service, the public provider. In the Kimberley we have a blended model, with eight positions through the Kimberley Mental Health and Drug Service and four positions through the Aboriginal medical services. So it is a little later but it is all underway at the moment. When it is fully established, we will have a full complement of 83 full-time equivalents, of which 61.5 are funded by the new program and 21.5 are existing staff. As at April 2012 we had 69.5 of the 83 positions in place. Recruitment has been a challenge in some areas, but we are making good progress on that.

Mr M.P. WHITELY: I refer to the draft mental health bill referred to at the top of page 870 of the budget papers. I would like to know about the process of consultation that happened in the drafting of the bill, given some of the extraordinary and highly controversial contents of the bill and the responses to the bill. It is fair to say that there were some fairly strong responses from the Commissioner for Children and Young People and a number of other credible sources. I wonder what the time line is of the bill. The rationale for the bill in the first dot point on page 870 is that it will significantly improve human rights protections. Clauses 421 and 422 of the draft bill allow social workers, occupational therapists, registered nurses, midwives and psychologists who are designated authorised mental health practitioners, and other people who are designated authorised mental health practitioners by the Chief Psychiatrist, to involuntarily detain somebody for up to 72 hours. Also, there is capacity under clause 132 of the bill for police officers to enter any premises, conduct body searches and seize any articles from an individual suspected of having a mental illness. How can those sorts of provisions in the draft bill for public comment be reconciled with that statement about significantly improving human rights protections? So there is that question, and just to repeat: can the minister also say something about the consultation process?

Dr K.D. HAMES: That is in two parts. Can we deal with that first?

Mr M.P. WHITELY: There are actually three parts.

Dr K.D. HAMES: Sure, but that is a big question, so I will get Mr Bartnik to deal with it.

Mr M.P. WHITELY: Perhaps he could deal with the human rights stuff first.

Mr E. Bartnik: The process of drafting the new bill really went in a number of different stages. There was the Holman review, which was done some years ago and came up with a certain set of recommendations. With the formation of the Mental Health Commission and the new minister appointed recently, there was a process of review of the Holman recommendations. An expert group, comprising a broad cross-section of people from the community and representing different groups and roles, was brought in to look at the change in context from the earlier review to identify which aspects might need to be changed. For example, the United Nations Convention on the Rights of Persons with Disabilities has come in since then, so there were some areas that clearly needed to be changed. That expert review group made recommendations to the minister about some changed drafting instructions, because the previous drafting instructions had been previously approved; so these were the changes to those instructions. In late November and early December the current minister was very keen to get that work out for public consultation with a view to taking that consultation on board prior to taking the bill into Parliament. We therefore had a substantial consultation process right around the state. We had 1 200 submissions.

Mr M.P. WHITELY: That is after the bill; I am talking about the lead-up to the original.

Mr E. Bartnik: We put out a draft bill, yes.

Mr M.P. WHITELY: Yes.

Mr E. Bartnik: Professor D'Arcy Holman had a very substantial public consultation process as part of the first drafting, but the second stage of that was to do with a smaller group really looking at just significant environmental changes to what had been proposed. So, that was a more time-limited and smaller group.

Mr M.P. WHITELY: Minister, when are we going to see the bill and has the time line changed because of the feedback that it has had?

Dr K.D. HAMES: Mr Bartnik.

Mr E. Bartnik: The minister is carefully considering all the feedback. There was a particular set of issues around the consent of children to various procedures. We have an external consultant, Professor Maria Harries from the University of Western Australia, who is very well regarded in the community. We have had work done on summarising all those public submissions and the concerns raised by people, and the minister is currently considering those. We are hoping to have something to take forward around about August or September, but the minister has said that it will depend on the complexity of the feedback and the significance of any proposed drafting changes.

Mr M.P. WHITELY: Just by way of further question and reiteration. The stuff around 12-year-olds consenting to electroconvulsive therapy and psychosurgery was the headline stuff, but there are a lot more problems with this bill that go deeper than that. I am sure that the provision for a 12-year-old to give consent without parental permission will disappear from the bill. But it concerns me, given the claim in the budget papers that this bill is about increasing human rights protections, that the bill gives the capacity for authorised mental health practitioners—I went through the list of occupational therapists, social workers et cetera—to detain people for 72 hours. I have not heard anything from within government in response to those sorts of concerns. I am also struggling to reconcile human rights issues with the capacity of the police to search and seize and to enter any premises without a search warrant—things that criminals are protected from. How do we reconcile that with the claim that we are going to significantly improve human rights?

Dr K.D. HAMES: Mr Bartnik.

Mr E. Bartnik: I will take the first part of that. Basically there are a number of measures in the bill to deal with a new charter of human rights. There are increased protections with the Mental Health Review Board and access to independent advocacy and the involvement of advocates and parents.

Mr M.P. WHITELY: Has the right to legal representation at the Mental Health Review Board also been removed? That was not in my submission, but I am aware of it coming through in another submission. The reality of it just seems inconsistent.

Mr E. Bartnik: As far as I am aware, every proposed change to the draft mental health bill is in the direction of increasing the rights and protections of people. We are not aware of any proposed change that is heading in the opposite direction.

Mr M.P. WHITELY: I think the Mental Health Law Centre actually raised that concern.

Dr K.D. HAMES: We do need to be able to finish.

Mr E. Bartnik: In relation to people who are involuntarily detained for assessment, I think this is a balance between people's individual rights and the need for some people who are seriously unwell and a danger to themselves or to other people to be protected from themselves, and also to protect other people.

Mr M.P. WHITELY: There are basically five different reasons that somebody can be made an involuntary patient. One is that the person is a danger to themselves or to others—that is fine; another is a perceived danger to property; another is perceived danger through self-harm through financial loss or through loss of a significant relationship; and the last one is a significant danger to personal reputation. Are any of those reasons proposed to be removed from the current draft of the bill?

Dr K.D. HAMES: Mr Bartnik.

Mr E. Bartnik: I will just check my notes; just give me a moment.

Mr M.P. WHITELY: One of them is legitimate but not the other four.

Dr K.D. HAMES: Mr Chair, I am just a bit concerned that this is not a question that we should be answering at this stage. We have a draft copy of a bill that is out for public comment, it is being considered and submissions are being made, and I do not think it is appropriate for the director to be responding to something on which we as government will make a decision.

The CHAIRMAN: That is the minister's prerogative, so we will move on.

Dr K.D. HAMES: Yes, indeed. I am just indicating that Mr Bartnik will not be responding to that question.

[3.50 pm]

Mr A.P. JACOB: I draw the minister's attention to "Individualised Community Living" on page 869. What funding is allocated for social housing and support for community living, and how much of that is directed to people with mental illness?

Mr E. Bartnik: The individualised community living strategy will be expanded with an additional $4.6 million over four years to deliver 18 individualised support packages. In addition, the government has allocated $8.7 million over three years in capital funding for the Department of Housing to deliver 16 homes. The component of social housing and support that is for mental illness is the 18 packages and 16 houses. We have also negotiated a new agreement with the commonwealth government for additional housing and support. Details will be announced shortly, but there will be approximately 30 packages and six houses.

Dr G.G. JACOBS: On a metropolitan–regional split, is there a proportion of those allocated to regional areas in Western Australia?

Mr E. Bartnik: We have not done the allocation process for those. The previous process of 100 people in hospital being discharged is about an 80–20 split based on the actual number of assessed individuals.

Dr K.D. HAMES: I would have thought that the minister would want to announce that herself!

Dr G.G. JACOBS: Point taken, Minister for Health.

Ms J.M. FREEMAN: This is further to the very good question I asked before, which took us to page 871 and referred to outcomes and key efficiency indicators. Can the minister provide—rather than percentages—numbers, both human and monetary, in this regard? In relation to the item for readmission to hospital within 28 days of discharge, how many people and how much money were involved in the 2010–11 actual, the 2011–12 budget, the 2011–12 estimated actual, and the 2012–13 budget target? Can the minister provide the number of contacts for community-based medical non-admission services? I refer to the next item down that table, and I seek the information in the same format. I also seek the proportion of service funding and the proportion of service funding directed to non-metropolitan areas in the same format. I note also in answer to an earlier question, the Chief Psychiatrist mentioned that one of the indicators was suicide, but I note that that has been removed from this table on page 871. Why was that removed from last year's papers as an effective indicator for the Mental Health Commission? The minister might want to take it on notice and provide it as supplementary information.

Dr K.D. HAMES: The commissioner needs to consider the time required within which it needs to be provided, which is a week. It is a significant amount of information. The request is that the member provide that question on notice because it might take more than the one-week deadline to provide supplementary information. That is particularly the case with readmission costs.

Ms J.M. FREEMAN: It can come through the normal on-notice process.

Dr K.D. HAMES: Yes. We will have a couple of weeks then to get the information back to the member, unless she needs any of the information sooner than two weeks.

Ms J.M. FREEMAN: Additionally, can the minister explain how proportional funding to community health services, community organisations and non-metropolitan areas can be used as appropriate key effective indicators for the mental health sector?

Dr K.D. HAMES: A component of the previous question related to suicide not being included as a key effective indicator.

Ms J.M. FREEMAN: Can someone say why it was removed as a key effective indicator from the Mental Health Commission for this budget?

Mr E. Bartnik: One of the major issues with suicide data is that the national data as reported goes through three processes of being cleansed. It takes up to three years to confirm actual suicide data. There can be quite significant changes to the number through each of those stages. In our discussions with the department of the Auditor General, we felt that was a problematic figure to be in the budget papers, but we will report that in our annual report. We are very happy to do that and to explain all those things.

Regarding the question about the proportionality of expenditure in certain areas, this goes to the heart of the mental health strategy: for people to be well supported in the community, they need a balanced range of supports. Some of those might be hospital and acute inpatient services; some might be community-based specialist support in their homes or in the community; and some might be psycho–social support provided by the not-for-profit sector. One of the issues in the public mental health system in Western Australia is that the majority of the expenditure has been in the acute end and a lot in the hospital end. Compared with other benchmarks around the country, there is a greater spread of both community mental health and non-government support. This is simply around a framework of trying to have the right balance of investment, each of which is very important. On the issue of inpatient hospital services, if we do not have effective community support, people go to the emergency department, end up in hospital and are discharged and go back in again. By de facto almost, the emergency department becomes the gateway to services. We need to provide appropriate inpatient and emergency department services, but the real challenge is to build the right amount of community support and earlier intervention so that we are not providing just support when things get really serious; we want to pick up on symptoms early and prevent people needing some of those acute services. The real reform is around trying to get the right balance and mix of those services.

Dr K.D. HAMES: The director general wants to add to that.

Mr K. Snowball: From an operational point of view in hospitals, these indicators are equally important to demonstrate that our services are not being diminished in our hospitals. We are dealing with pretty much record growth in mental health admissions in our hospital settings. Therefore, if we see the growth year on year in community services, we can then look at and measure what that has done to our hospital demand and admission rates. It is important to have both of these sitting side by side and being measured over time to see the shift from hospital settings to community settings and to make sure those resources land in community services and not just be reduced from hospitals.

Dr K.D. HAMES: What do members want to do? We have only one service to go. I am happy to go as long as they like with this.

Mr M.P. WHITELY: A little bit longer.

Mr D.A. TEMPLEMAN: Until quarter past four.

I refer to the sixth dot point on page 869 headed “Review of Discharge Practices” that relates to the independent review of discharge practices in mental health inpatient facilities, which I understand is currently being undertaken. The son of constituents of mine suicided and I understand he is one of the people who will come under this review. I am interested to know when we can expect to receive the final report. On behalf of the family, I ask: how will a family like that be involved in the process of the final report being released? I have read, for example, the Chief Psychiatrist’s report on the death of my constituent. On behalf of that family and other families who have experienced the tragedies of loved ones suiciding whilst in the care of the department, I ask: how will the minister ensure that we learn from the failings of the system or issues that have been highlighted by the Chief Psychiatrist’s report in this particular case and in this review?

[4.00 pm]

Dr K.D. HAMES: I ask the director general to respond first.

Mr K. Snowball: This is obviously a review that is being done for both the Mental Health Commission and the Department of Health. It focuses very much on any of the key issues in our services whereby they either do not

comply with policies and practices or we can see improvements to the policies and practices in those service areas. Professor Stokes talked to more than 400 people during the course of this review process. We agreed to extend his review because of the level of demand, if you like, to see Professor Stokes and to raise issues of concern, from not only clinicians but also recipients of our services. It is critically important to us that this is done right, so we have not pressed him to close it more quickly. We think it is important that it is a comprehensive assessment. It goes to all our specialised facilities in the state, so it is not restricted in any way at all. The expectation of both the commission and the department is that we will get a very clear way forward to improve our services across the board and understand very clearly the perspectives of families on the provision of services to their loved ones. Therefore, we want to ensure that at the end of this process we have clear actions and that people are very clear about the steps that we will take, so that will be open to people to understand and read the report. I have not seen the report because I have not got a draft yet, but to the extent that it contains personal information, we will obviously remove that information, notwithstanding that we will ensure that the findings are very clear to our clinicians, the services, the policymakers and the clients of our service.

Mr E. Bartnik: We expect a draft of the report in the middle of June. There will be a process whereby the Director General of the Department of Health and I will consider the report and come up with a communication strategy and also the parameters of the government response, which will need to be discussed. Having also spoken to many families who have lost a family member to suicide, we will be very, very sensitive to how the report is communicated to families and to other people. A lot of people are very involved with this particular area and we will be sensitive to that fact.

Mr D.A. TEMPLEMAN: The sentinel report is an annual report handed down by the health department. The latest sentinel report that I read showed that there had been a significant increase over the past three years in the number of inpatients who suicided. Last year, 2010–11, there were seven; in 2009–10, there were three; in 2008–09, there were four; and in 2007–08 there were nine. If we look at previous years, tragically there are still numbers recorded, but they were a little lower. When the sentinel report comes out annually and highlights those statistics, I am interested in how that relates to actuals; in other words, the statistics show that these are some of the things that are happening, so I would expect that normally some actions would be linked to some of the glaring concerns. Can the minister tell me what happens after a sentinel report comes out? What happens with regard to recommendations and how the health department measures that actions have actually been taken?

[Mr A.P. O'Gorman took the chair.]

Dr K.D. HAMES: I refer that question to the Chief Psychiatrist.

Dr R.M. Davidson: The processes for each of those individual events of the suicide of a person in an inpatient setting are subject to a review—that is, a root cause analysis. That is a thorough review for each of those events. From the root cause analysis there is identification of any area in which there may be an improvement—in fact, sufficient improvement perhaps at times to have been able to prevent that episode of suicide. That recommendation in a sense, or finding, is then taken up by the individual service that may have been involved in that inpatient suicide. It is also then, through both the sentinel event report and the processes of my office, established with all other services in which there may be similar requirements for services to address suicide prevention. There is a process both of the individual event of suicide resulting in actions that are then required from an individual service; and when it is clear that those actions are actions that would be appropriate to all or many of our services, that is similarly informed across our mental health care system. In this way, there is also the ability then to track whether those actions have indeed been carried out when they are relevant either to the individual service or across our entire system. I have through my office a process of reviewing the actions that have been carried out through the root cause analyses and, indeed, there have been occasions in which my office has carried out a review of individual events in addition to the RCA. The sentinel event report itself is a summative report, of course, and therefore seeks to identify the more broadly based series of actions that are appropriate to the entire system. But that is in fact in addition to, as I believe I have spoken to, the sets of actions that are appropriate to each of those suicides.

Mr D.A. TEMPLEMAN: I am happy to receive the answer to my next question as supplementary information if that will help us with time, because I know that the member for Bassendean has a question. Also on the same page, I refer to "Individualised Community Living". I seek clarification about what I understand to be individualised community living units in Rockford Street, Mandurah. I seek information on exactly what model will operate there, if indeed it is still going to be under the department, because there is a bit of uncertainty in the community about that. The houses are at 32–34 Rockford Street in central Mandurah and I understand that they are nearly ready for occupation. I seek clarification whether they will be for people as part of the individualised community living service; and, if so, what other supports will be offered? I am happy for that answer to be provided as supplementary information.

Mr E. Bartnik: I can speak in general terms. The units that the member referred to are likely to be units that were built under a previous project and are not part of the 100 individual packages. However, I can certainly take that question on notice and confirm that.

Dr K.D. HAMES: We will provide as supplementary information to the member all information available regarding the details of the construction and operation of the proposed units in Rockford Street, Mandurah.

[*Supplementary Information No A28.*]

Mr M.P. WHITELY: The dot point that the member for Mandurah originally referred to was about the review of discharge practices. Obviously, that relates a lot to some of the practices at Fremantle Hospital. I wonder how broad the review is, because I have had experience of Fremantle Hospital recently that indicates there are broader problems than simply the discharge practices. It is all well and good to get a report, but I am wondering what actions have been taken in the interim to ensure that they are getting better service at Fremantle Hospital?

[4.10 pm]

Mr K. Snowball: There are two aspects to that. One is that the breadth of Professor Stokes' review goes beyond discharge practices. I am more than happy to provide a copy of the terms of reference; they are on our website and so on. We have also had, through the Chief Psychiatrist, a specific review of Alma Street—particularly a number of deaths associated with Alma Street—that is nearing conclusion. That will go to, very much, the focus obviously that has been broadly applied to Alma Street to ascertain whether there are specific things outside of the broader review that Professor Stokes has undertaken that need to change at Alma Street.

Mr M.P. WHITELY: I am just conscious of the time, so I will jump to my question.

Dr K.D. HAMES: Perhaps we can have two more questions; one from the member for Bassendean, and I think the member for Eyre has one as well.

Mr M.P. WHITELY: Page 872 of budget paper No 2 refers to promotion and prevention services and outlines substantial increases in expenditure; from 2010 through to 2013 there will have been a tripling of expenditure. The first dot point on page 870 of budget paper No 2 makes reference to the 10-year road map for mental health reform, which has a heavy focus on early detention and intervention. This all relates to the federal government commitment of $224 million to provide dollar-for-dollar funding with the states for the rollout of early psychosis prevention and intervention centre services. I am not saying this is necessarily a good thing; I just want to get information on the progress in Western Australia. Are we jointly funding EPPIC services—I am not recommending it should happen—or has there been a renegotiation of the federal government money, or is it in fact part of that extra funding that is referred to at the top of page 872?

Mr E. Bartnik: I will answer the first part of that question related to the increase in funding in the promotion and prevention area. Some of that is where we put the new individual community living funding, so part of what the member is seeing there is the nearly $8 million worth of support packages to people.

Mr M.P. WHITELY: To live in the community?

Mr E. Bartnik: In the community, yes.

Mr M.P. WHITELY: Good; yes.

Mr E. Bartnik: That is one component. There is an ongoing process with the commonwealth government regarding the early psychosis services. There are two bidding rounds; Western Australia is in the first round, and we are negotiating, along with a number of other states and territories, to jointly fund one of the first eight of the 16 new national programs.

Mr M.P. WHITELY: Are they EPPIC or EPIC, because there is a very important distinction? Are they early psychosis intervention centres or are they early psychosis prevention and intervention centres? I am sure Mr Bartnik understands the distinction—I am conscious of the time.

Mr E. Bartnik: Sure. To the best of my knowledge, the focus has become a much broader one, to do with early psychosis and early intervention, with less emphasis on the very, very early detection but with a strong emphasis on early intervention and strong community-based preventative support.

Mr M.P. WHITELY: Once psychosis has presented? Are they prevention centres or are they early intervention centres for when a first episode of psychosis occurs? That is the key question I am asking.

Mr E. Bartnik: I will probably need to take that on notice.

Dr K.D. HAMES: We need to wind it up, but we could provide, by way of supplementary information, details on whether they are —

Mr M.P. WHITELY: And some detail on the state of negotiation and whether they have a prevention pre-psychosis function or whether they are early intervention once psychosis is established.

The CHAIRMAN: Are you happy to provide that, minister?

Dr K.D. HAMES: We understand that, yes.

[*Supplementary Information No A29.*]

Dr G.G. JACOBS: Page 867 of budget paper No 2 has a line item "Australian Medical Procedures Research Foundation's Fresh Start Recovery Program", which is known by the minister and me and probably everybody in this place to be George O'Neil's naltrexone implant program. Given that $1 million has been assigned to that program for this year and another $1 040 000 for next year, was this funding conditional on any criteria to progress the naltrexone implant to Therapeutic Goods Administration approval? I am aware that his previous allocations of money have been the subject of a financial, clinical and research audit, and where is that at?

Dr K.D. HAMES: Mr Bartnik?

Mr E. Bartnik: I will pass that on to Mr Guard.

Mr N.S. Guard: Yes, Dr O'Neil has received two years of further funding to maintain services at the current levels over the next couple of years. The government is committed to pursuing registration of the implants, and the three reviews the member talked about have been completed and have given us a much better picture of what needs to be done to achieve that. Over this period ahead of us we will be working with Dr O'Neil to get to submission of an application for registration of the implants.

Dr G.G. JACOBS: What does the minister envisage to be the time line? How long is this process going to go on, because it has been going on for a fair while already?

Dr K.D. HAMES: Mr Guard?

Mr N.S. Guard: We believe that probably the earliest that Australian Medical Procedures Research and GO Medical can get to submitting an application for registration will be during 2014, based on the work that needs to be done to write up everything that is available at the moment.

Dr K.D. HAMES: I think we need to deal now with the next item.

The appropriation was recommended.