**Division 34: Mental Health Commission, $633 892 000 —**

Ms L.L. Baker, Chairman.

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

Mr T. Marney, Mental Health Commissioner.

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

Mr M. Moltoni, Acting Director, Performance, Monitoring and Evaluation.

Mr K. Smith, Director, Corporate Services.

**The CHAIRMAN**: This estimates committee will be reported by Hansard. The daily proof *Hansard* will be available the following day.

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 principal clerk by Friday, 19 June 2015. 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**: I call the member for Armadale.

**Dr A.D. BUTI**: I refer the parliamentary secretary to page 395 of the *Budget Statements* and to the second dot point under "Mental Health Infrastructure" with regard to the Rockingham subacute centre. My question relates specifically to how this centre may impact on Armadale–Kelmscott Memorial Hospital. From 1 July 2014 to the end of January 2015 the Armadale hospital had to lock the doors of the open wards on 57 occasions because of an overflow of involuntary mental health patients from secure wards. My question is in five parts, but I will start with the first two parts. How do these closures affect the operation of the hospital, and why is this situation so chronic?

**Ms A.R. MITCHELL**: I will refer to Mr Marney, particularly on the Armadale information because I am not familiar with that. Construction of the Rockingham facility has commenced; it was due to commence in April–May. We certainly want to bring that on board as soon as we can. Consultations are occurring with residents and people in the Rockingham area to make sure that they are fully briefed and aware of the work that will be done through the Rockingham area. I will ask Mr Marney to respond to the member's specific questions about Armadale hospital.

**Mr T. Marney**: I just want to clarify that the question relates to incidents of having to lock the Armadale wards in the case of a higher than usual number of involuntary patients: is that correct?

**Dr A.D. BUTI**: There was an overflow of involuntary mental health patients from secure wards.

**Mr T. Marney**: I thank the member. The Rockingham subacute facility will, not surprisingly, take pressure off the subacute elements of Armadale hospital by either helping to avoid admissions to the acute setting in Armadale or enabling earlier than otherwise discharge from Armadale to the subacute setting to enable people to transition back to the community in a more home-like setting, in which they will be more independent than they would be within the Armadale hospital setting. So in that sense the subacute facility will not take pressure off the need to accommodate involuntary patients at Armadale. However, it will take pressure off the need to accommodate in the open ward those patients who have a less acute condition. The more relevant issue is the opening of the new 30 beds at Sir Charles Gairdner Hospital, which is scheduled for July. As the member is probably aware, the current ward at Sir Charles Gairdner Hospital, ward D20, is not authorised for involuntary patients. The new 30-bed facility at Sir Charles Gairdner Hospital is authorised for involuntary patients, so that, as a system-wide response, will take pressure off Armadale by enhancing the capacity to deal with involuntary patients.

**Dr A.D. BUTI**: I have a follow-up question. Wards at Armadale hospital were closed on 57 occasions over a six or seven-month period. What effect has that had on the operation of Armadale hospital?

**Ms A.R. MITCHELL**: I will seek Mr Marney's opinion on that.

**Mr T. Marney**: In terms of the impact that has had on the operations of the mental health areas of Armadale hospital, no matters of an adverse nature have been brought to the attention of the Mental Health Commission. From an operational perspective, it is not uncommon for hospitals to increase their accommodation of involuntary patients by flexibly utilising their wards. It does mean, though, that the facility was dealing with an average level of acuity that was considered to be higher than normal. No doubt that was a matter of some pressure for the hospital but, as I said, no matters were raised with the Mental Health Commission in terms of adverse service or an inability to meet demand as required.

**Mr D.J. KELLY**: I refer to the table on page 394. There is an additional almost $2.5 million included in 2015–16 under the item "Youth Community Treatment". Firstly, what services are planned, how will they be delivered and where will they be located? Secondly, how much of the $2.5 million will be spent outside the metropolitan area? Thirdly, how will the proposed youth treatment fit with existing services such as headspace, and why is there no money over the forward estimates for that line item?

**Ms A.R. MITCHELL**: The youth community treatment program is one that the Mental Health Commission and the minister have been very committed to improving, because it has been an area that, sadly, probably has not been as much to the fore as it should have been. As members would know, there is a special mental health youth unit at Fiona Stanley Hospital. At the same time, we also want to support the youth of our community before they need hospital beds. That is what part of this youth community treatment involves. There are a number of factors that will come into it. It is a two-year trial that will support the youth inpatient beds at Fiona Stanley Hospital. The idea is to help people so that they do not have to go into hospital. It will be a two-year trial and the second year will be funded through a configuration of existing resources. Mr Marney is in a better position to outline the answers to some of the member's other questions.

**Mr T. Marney**: I thank the member for the question. There are numerous parts to the question. The first question asked where the service will be located.

**Mr D.J. KELLY**: What services are planned, how will they be delivered and where will they be located? What is it?

[7.10 pm]

**Mr T. Marney**: Essentially, it is the equivalent of a community treatment service that one would find associated with any major hospital. It is, if you like, the equivalent of an outpatient service. The intention is to support the newly established youth unit at Fiona Stanley Hospital, which has eight beds open at the moment with a further eight beds to open in coming months. The intention is that individuals discharged from that inpatient facility are given appropriate support and treatment as they return home and back into the community. The service is to support people transitioning back into the community or prevent their readmission by ensuring that they have timely access to services. The member mentioned headspace, and that would be one of the referral pathways that the youth community treatment team would take into consideration as they are transitioning individuals back into the community.

As the parliamentary secretary mentioned, having a dedicated youth stream is new territory for us in Western Australia. The support to the youth unit and youth community treatment is being established as a pilot, which will be funded with additional resources in the first year, 2015–16. Beyond that, it is envisaged that there would be reconfiguration of the community treatment services that currently exist, bearing in mind that we are talking about the age cohort of 16 to 25-year-olds. Currently, 18 to 25-year-olds fall within the remit of regular community treatment services. Those people are actually being captured already and treatment is being resourced for that age cohort. We need to reconfigure to ensure that the model of service is more responsive to the developmental needs and unique characteristics of the 16 to 25-year-old cohort, as opposed to a purely adult cohort. That is the whole intention around the youth inpatient facility and the youth treatment stream, recognising that 75 per cent of severe mental illness manifests in the 16 to 25-year-old cohort. The purpose of the service is to specifically target the particular requirements of that age cohort.

**Mr D.J. KELLY**: Is the $2.5 million to fund the service at Fiona Stanley Hospital or will there be other parts of the trial in other parts of the state?

**Ms A.R. MITCHELL**: I will get Mr Marney to answer that question.

**Mr T. Marney**: Initially, it will be to support the youth inpatient unit at Fiona Stanley Hospital, but it is envisaged that it will grow to become a statewide service.

**Mr R.H. COOK**: My question relates to mental health activity in the public hospital system on page 394. My first query is about the number of activity units that have been purchased in relation to the commission's work, that has led to an increase of just 2.1 per cent on the 2014–15 estimated actual. Other areas of public hospital activity are looking at three per cent growth at least, for instance inpatient and emergency department services. Why does the parliamentary secretary believe that there will be a growth in services of only 2.1 per cent given we have seen heightened awareness of and incidences of mental health presentations to EDs and there is an expectation that ED presentations overall will grow by three per cent?

**Ms A.R. MITCHELL**: I have been most impressed in the last 12 months with how the Mental Health Commission has worked with the Department of Health to improve how it costs and gets things done. I will get more specific information from Mr Marney on that, but it has been very impressive to see that occur.

**Mr T. Marney**: The modelling that leads to an increase in activity of 2.1 per cent is actually the same modelling that the broader Department of Health activity of three per cent is derived from—the same methodologies were used. But that also reflects other things happening in the system and the impact they have had on activity. For example, the introduction of the mental health observation area at Sir Charles Gairdner Hospital dramatically changed the activity profile in that hospital. The wait times in emergency departments have dropped dramatically and the admissions into ward D20 from emergency have also dropped dramatically. Although the activity is growing, based on population, demographics and epidemiology, the changes we are making in the system are having an impact as well and that is reflected in the weighted activity units. There is also a difference in case-mix; different complexity and acuity between mental health and general health impacts those activity numbers, bearing in mind we are talking about a weighted average activity unit.

**Mr R.H. COOK**: There was an article in *The Sunday Times* on 31 May titled "WA nurses may get special police powers" about the movement or management of mental health patients, particularly in an ED environment. Can the parliamentary secretary please outline to the committee how that system will work in relation to those nurses? Will they be working for the Mental Health Commission and what would the funding arrangements for them be?

**Ms A.R. MITCHELL**: There have been discussions with the Commissioner of Police, the acting director general of Health and Tim Marney as Mental Health Commissioner, and I think it is best that he responds to the member's question.

**Mr T. Marney**: The model of service is currently being developed between the Mental Health Commission, the Department of Health and WA Police and as such I cannot go into a lot of detail but, suffice to say, as part of that model we envisage that it will not be necessary for nurses or clinicians to be given any form of auxiliary police powers. That is not necessary. The model is intended to ensure that when it is identified that there may be a person in distress, whether it is through mental illness or for example drug-induced psychosis, that an appropriately skilled clinical perspective is brought to that situation to de-escalate and when appropriate triage and treat. The exact configuration of clinical involvement is currently being negotiated between the Department of Health, police and the Mental Health Commission. As such, it is subject to further consideration in terms of funding source, but it is the aim of all three entities that we achieve this outcome through the reconfiguration of existing funding. If we can prevent people having to be transported and waiting in emergency departments, it is much better for the individual, but it is also much better for the system and from a cost perspective it is far more cost effective.

**Mr R.H. COOK**: Will these people be working for WA Police under existing police powers or will they been working for the Mental Health Commission or the Department of Health?

**Mr T. Marney**: As in all cases of clinical involvement in treatment, it is absolutely paramount that there is sound and robust clinical governance. As a result, any clinical involvement will be through the Department of Health and the area health services. A clinician, whether that is a nurse or a psychiatrist, will be employed by an area health service to ensure that there is that robust clinical oversight through clinical governance.

**Mr R.H. COOK**: What powers will be transferred from WA Police to this particular person and how would that operate if that person remains an employee of the Department of Health?

[7.20 pm]

**Mr T. Marney**: As I mentioned, the model of service is under active development at the moment. We would hope that it is actually not necessary for any additional or extraordinary powers to be given to the clinical teams involved. As the member would know, under the current Mental Health Act and under the Mental Health Act 2014, upon its commencement, clinical teams and individuals already have significant powers. We do not envisage that they would need to have the same sorts of powers that police have because they will not be performing police functions. They are really there to help police in triaging and understanding the individual circumstance and assisting in de-escalating and treating, and transporting where appropriate.

**Mr R.H. COOK**: In relation to "nurses" getting police powers, what exact powers would they get?

**Mr T. Marney**: I do not envisage that they will be getting any specific or extra or additional police powers as such.

**Dr A.D. BUTI**: This is always a problem with this government, parliamentary secretary; things are announced without detail. The statement by the Commissioner of Police as reported in *The Sunday Times* stated that these nurses will receive some limited police powers such as search powers and restraint powers. They may have them already under the Mental Health Act but it would appear that the police commissioner is envisaging something additional because he said they will receive limited police powers. If that is the case, will legislation need to be introduced into Parliament to allow these nurses, who will be employed by the Department of Health or the Mental Health Commission, to exercise police powers? That is what the Commissioner of Police stated in his press statement.

**Ms A.R. MITCHELL**: Just before I go back to Mr Marney, I think Mr Marney has been quite clear in saying that it has not been finalised. Negotiation and discussion is still going on between Health, the police commissioner and the Mental Health Commission. An important factor to take note of here is that it is very much under consideration to see what might be, and then of course, once that is determined, we will know what needs to be done after that.

**Mr T. Marney**: I regret to say it would be remiss of me not to correct two points of fact. When the member prefaced his question he stated that it is typical of this government to announce stuff that is underdeveloped. The statement was made by the police commissioner —

**Mr D.J. KELLY**: You are now the Premier, are you?

**Mr T. Marney**: No, no.

**Mr D.J. KELLY**: Are you speaking on behalf of the whole government?

**Mr T. Marney**: No, no; I am just clarifying a point of fact.

**Dr A.D. BUTI**: That is up to the parliamentary secretary; it is not up to the commissioner.

**Mr T. Marney**: If I may finish: the police commissioner is not a member of government. Secondly, the member indicated that that was the police commissioner's press release. It was not a press release; it was a —

**Dr A.D. BUTI**: It was a comment.

**Mr T. Marney**: It was a comment made in an interview. That interview was broad ranging. At the point of that interview, the police commissioner and I had had one meeting and discussion around this matter. In his comments, the police commissioner was, I suspect, exploring the models that may exist. We have since had numerous subsequent meetings and clarified what is needed and what is not. We are both in agreement that there is no additional granting of police powers required to clinical teams.

**Dr A.D. BUTI**: I must say it is quite extraordinary that a public servant feels the need to politically defend the government.

**Mr T. Marney**: It is a statement of fact.

**Dr A.D. BUTI**: On that ABC segment that night, the Minister for Mental Health was also interviewed in regards to the police commissioner's statement. She was unable to clarify what additional powers were needed. It was quite interesting that the police commissioner said something in regards to her jurisdiction, which is mental health. At this stage, what level of detail do we have in respect of this? Mr Marney stated that he has had correspondence or conversations with the police commissioner; therefore, if he is saying that they do not need any police powers, what is different? What is new about this? What additional powers, if any, will these nurses receive or be empowered with?

**Mr T. Marney**: As I have tried to say before, I do not envisage that there will be any additional powers required. At the early stage of development of this concept, that was something that the police commissioner thought would be necessary. I think we have since reached agreement that that is not necessary. It is unfortunate that the police commissioner commented on specifics of the model before we had actually developed it sufficiently. I apologise for that.

**Mr I.M. BRITZA**: I refer to "Mental Health Court Diversion" under "Spending Changes" on page 393. Could the parliamentary secretary explain why this pilot is being extended rather than funded recurrently?

**Ms A.R. MITCHELL**: Before we get too far into the finances, can I say that this mental health court diversion pilot has been fascinating to be involved in and to watch. It only commenced in 2013. It was always going to be a two-year pilot program to see how it can be evaluated. At the end of 2014 a number of positive changes or findings were made, but it was also shown that it was not quite long enough to really assess the situation. It has been highly valued within the community by participants including families, carers and stakeholders within the justice system. It has been very well received. At this point in time the total effectiveness has not been able to be evaluated; therefore Mr Marney has made a decision about how best to fund that at the moment. I will ask Mr Marney to discuss the financial matters.

**Mr T. Marney**: As members can see from the papers, it is not an inexpensive or insignificant amount of money, so it does need thorough evaluation to see whether or not it is achieving its intended outcomes. We evaluated it ahead of the most recent budget process with a view to providing that information to government for decision. We found there were some significant gaps in the data and lags in the impact of the program. Given that it was only running since 2013 and ideally we are trying to address recidivism, to have 24 months of data is really not adequate to assess whether it is having a real and significant impact. In addition, as the initial scheme was a pilot, some adjustments were made to the model of service and the way in which, for example, non-government organisations were engaged to provide service as part of that court diversion. Given that it was kind of flexible in its inception, it needed at least another 12 months to get enough stability in the scheme plus to get the data through to understand whether or not it is providing value for money to the state.

**Mr I.M. BRITZA**: Is the commissioner implying that if the program is more than successful, he is open to making it recurrent?

**Mr T. Marney**: That is a decision-making matter for government. If the program demonstrates value for money, certainly the Mental Health Commission, through its minister, Minister Morton, would make a submission to the budget process for continuation of the program.

**Dr A.D. BUTI**: I refer to "National Perinatal Depression Initiative" on page 394 of the budget papers. I note that there has been quite a substantial reduction in federal government funding from 2014–15 to 2015–16. As a result of that reduction, what initiatives will be affected by the reduction in funding?

**Ms A.R. MITCHELL**: Could I ask the member to repeat the last part of his question?

**Dr A.D. BUTI**: What initiatives will be affected by the reduction in funding?

[7.30 pm]

**Ms A.R. MITCHELL**: I will ask Mr Marney to speak on the financial matters.

**Mr T. Marney**: My preference would be to take that question on notice and provide a thorough summary of the unfolding of this program, because the negotiations with the commonwealth and the consequential carryovers of funding have been a bit tortuous. The money in 2015–16 is carryover money, and we are still awaiting some payments in the current year and also confirmation from the commonwealth as to the future of the program going forward. The member's specific question was, though: when the funding in 2014–15 drops to, I think, $500 000 or so in 2015–16, exactly what programs that will fall away? The initiative has a large number of small programs; hence, if I could take that question on notice, I think it would be better way to answer it.

**Dr A.D. BUTI**: As a supplementary?

**The CHAIRMAN**: Yes.

**Dr A.D. BUTI**: I have a follow-up question, so the parliamentary secretary might want to add that to the supplementary information. How much has the state government spent on perinatal depression initiatives over the past three years and how much has been allocated by the state government to perinatal depression initiatives over the forward estimates?

**The CHAIRMAN**: The parliamentary secretary needs to agree to take on those supplementary questions.

**Ms A.R. MITCHELL**: No; I think we can answer a couple of those parts, so I would like to do that first, if the minister does not mind. Then we will fill in the gaps that the member has. I hand over to Mr Marney.

**Mr T. Marney**: In answer to the two latter questions—how much has the state spent and how much will the state spend going forward—the answer is that there has been no state funding of perinatal depression initiatives, primarily because the commonwealth grant moneys are essentially for primary care support, which is the responsibility of the commonwealth government. The state's responsibility is more in the moderate to severe incidence of the illness, which is addressed, for example, through the state's opening of the four new beds in the mother-and-baby unit at the Fiona Stanley Hospital, which will increase to eight beds. That is the state's responsibility in this space in the secondary and the more severe occurrence of the illness. Occupancy of the four

new beds in the mother-and-baby unit has been high from day one. That service is meeting the needs well and will continue to do so as it expands to an eight-bed unit.

**Ms A.R. MITCHELL**: The supplementary information that the member will receive is what reduction in programs will occur.

**Dr A.D. BUTI**: As a result of the federal government funding reduction from 2014–15 to 2015–16, what initiatives will be affected by that reduction in funding?

[*Supplementary Information No B66.*]

**Mr D.J. KELLY**: I refer to the spending changes and the accommodation relocation on page 393. How will the $3.4 million be spent? What will it be spent on? Why is the money needed over the forward estimates for accommodation relocation? Does this funding relate in any way to the sale of the Drug and Alcohol Office building on Field Street?

**Ms A.R. MITCHELL**: I will pass to Mr Marney for that detail on finances.

**Mr T. Marney**: The larger amount of the spend, the $3.4 million in 2015–16, relates to the fit-out of a new co-located facility for both the Drug and Alcohol Office as it exists today and the Mental Health Commission as is exists today, but as they will be one combined entity as of 1 July. That cost includes work stations and air conditioning fit-out, and probably the biggest chunk will be the information and communications technology fit-out and the physical relocation of people to that new facility. The ongoing costs, the $1.6 million and $1.7 million, relate to the rental payments across the forward estimates for that new facility, so it is the additional funding for that. There is an offset, which is the projected sale of the Field Street asset. I would rather not disclose a figure for that, given the commercial nature of any sale process. Obviously, we want to maximise the value of that sale, but it will offset the most part of the impact across the forward estimates.

**Mr D.J. KELLY**: A sale price has been assumed and that is factored into those forward estimates. I understand the commissioner does not want to tell me what that figure is, but that assumption is right: the cost across the forward estimates has a component of an assumed sale of Field Street.

**Mr T. Marney**: The figures in the table on page 393 are the gross cost. There is a revenue component built into the table on page 401, under "Asset Investment Program". There is a figure built into the "Loan and Other Repayments" row for 2015–16. Obviously, that includes other things, but the biggest chunk of that is the projected proceeds from the sale of Field Street, Mt Lawley.

**Mr D.J. KELLY**: What is the timetable for the sale of the Field Street asset?

**Mr T. Marney**: That will occur late in 2015–16, given that we will not be starting the process of relocating out of Field Street until the first quarter of 2016.

**Mr J. NORBERGER**: I refer to the second dot point on page 394 of budget paper No 2. I understand that "Western Australian Mental Health, Alcohol and Other Drugs Services Plan 2015–2025" was released for public consultation early in December 2014. What has the consultation process involved?

**Ms A.R. MITCHELL**: The process started with the commencement of the development of the plan back in 2012. The Mental Health Commission, the Drug and Alcohol Office, the Department of Health and the Department of Corrective Services have all worked closely with this plan because it is important; it is integrated whole-of-government work that needs to be done. In the initial stages some expert reference groups were formed. That involved clinicians, consumers and carers—a wide variety of people. Then we had specific reference groups that looked at the service trends of the plan. It has been a comprehensive and quite long process. It was new and it needed to be very comprehensive because it was an important occasion to get things as right as we possibly could. I will ask Mr Marney to give us an update on where we are at in getting the information back and the finalisation of the plan. It is something we are very much looking forward to releasing and working towards.

[7.40 pm]

**Mr T. Marney**: The consultation process concluded with a specific Aboriginal forum in Roebourne in mid-April. We are in the process of consolidating all the feedback on the plan, and incorporating the response to that feedback as part of the final document that will flow through to cabinet for consideration. It is probably worth highlighting that some points of emphasis came out of that consultation process. There was fairly widespread endorsement of the plan, but there were points of emphasis on a couple of matters for which we probably did not have sufficient actions in place, and other matters where issues of timing and location were up for debate, if you like. The specific issues that were raised in the consultation process were really about the need for stable and

safe housing for people with both mental illness and mental health issues—and drug and alcohol issues as well. Secondly, with both drug and alcohol abuse and mental health, there is a need for a cohesive 24-hour, seven-day-a-week crisis response service. Those things were in the plan, but probably did not have the emphasis in the plan that the community told us was warranted. Those are the areas we have gone back to beef up. I am not sure whether Neil Guard wishes to add anything to that.

**Mr N. Guard**: Mr Marney is right. I attended most of those consultation sessions, and there was pretty widespread agreement with the majority of what is in there. A lot of the comments that I took away were more around others having a slightly different priority from what we would have had, and wanting to bring things forward, and feeling that other parts were less important, and maybe should be pushed back. I think timing was a big issue, in a number of the regional consultations in particular, and that will be reflected in the revised draft.

**Mr R.H. COOK**: My question refers to page 395 and the heading "Mental Health Infrastructure", although this infrastructure does not get a guernsey and has not got a guernsey for some time. In the 2009–10 budget, money was allocated for the redevelopment of Osborne Park Hospital, and money was placed in the forward estimates for the redevelopment of Graylands Hospital. The redevelopment of Osborne Park Hospital was to include mental health beds, and the redevelopment of Graylands Hospital was obviously part of ridding the state of one of the most archaic mental health care institutions in Australia. It is very distressing to see that ultimately the redevelopment of Osborne Park Hospital never went ahead, and the redevelopment of Graylands is now completely off the agenda, apart from $92 000 for planning, which has been placed in the out years in this year's budget. Can the parliamentary secretary comment on what she thinks about the adequacy of the facilities at Graylands and the impact that will have on the redevelopment of that hospital in more than 10 years' time?

**Ms A.R. MITCHELL**: I think we all agree that Graylands is not a place where anyone should spend much time at all, if at all possible, and hence the totally new approach to care for involuntary mental health patients. We have addressed this as quickly as we could, because it is not the way we want to treat people with mental health issues. On the specific financial aspects the member mentioned, I will refer to Mr Marney.

**Mr T. Marney**: The specific issue around when funding was withdrawn for Osborne Park and Graylands, I would have to take as supplementary. It predates my history with the Mental Health Commission, although it is probably attributable to me in my previous role, I suspect. The imperative to replace Graylands with more contemporary facilities throughout the community is one of the highest priority issues in the 10-year plan. Having said that, we are talking about probably some of the most complex care needs across the system, and we are talking about 200-plus beds, so it is a substantial task that I envisage, and the planners envisage, can only be achieved in a staged manner. Some facilities on the Graylands site are not as old as others and are functioning, I would not say extremely well, but adequately for the moment. We need to do very careful planning for the individuals, the consumers of Graylands, to fully understand their needs and the cohorts of individuals we are dealing with. What are the more appropriate settings in the community for them? This includes the potential to have some footprint of new service on the Graylands site, because for some people, Graylands is their community. It is where they are comfortable, and their families have oriented their lives around that site as well. It is a fairly complicated task that requires staging, and obviously the investment associated with it is quite substantial, and cannot just be bitten off overnight.

**The CHAIRMAN**: Can I check on the supplementary information that Mr Marney mentioned on behalf of the parliamentary secretary? Does the member for Kwinana want that still?

**Mr R.H. COOK**: It would be interesting to see the trajectory of funds that have been withdrawn from the redevelopment of Osborne Park Hospital and Graylands Hospital for mental health beds from 2009–10. Does that make sense?

**The CHAIRMAN**: Is the parliamentary secretary happy with that?

**Ms A.R. MITCHELL**: Yes, I am happy with that.

[*Supplementary Information No B67*.]

**Mr R.H. COOK**: What planning has already gone into the development of a new forensic ward for mental health patients?

**Ms A.R. MITCHELL**: I will pass this question over to Mr Marney.

**Mr T. Marney**: Significant planning is underway in the North Metropolitan Health Service at the moment. We are in the process of bringing that together with Planning, Corrective Services and the Mental Health Commission. Part of the early work in that space that is nearing completion is, again, understanding the cohort of individuals who need to be accommodated, and the models of service that are required to meet very complex needs in the forensic space. Substantial planning is underway, but further planning is to be done between now

and the finalisation of the 10-year plan to add a bit more flesh to the plan in that space. That was an area of significant interest in the consultation process. The view was that our forensic services have not kept pace with population growth by a long stretch for the past two decades, basically. It is high priority, but it is probably one of the most complex planning exercises, particularly related to that site and across the system.

**Mr R.H. COOK**: When Mr Marney says it is a high priority, does that mean that it to falls into the Graylands category of nothing to be done for another 10 years?

**Ms A.R. MITCHELL**: I am sorry; can I ask the member to say that again?

**Mr R.H. COOK**: Mr Marney has said that it is a priority to develop a new forensic unit, and it is a priority to develop new acute mental health facilities in order to retire some of the Graylands facilities. Can the parliamentary secretary confirm that we will not see a forensic unit in Western Australia for 10 more years as well? Is that also on the 10-year planning horizon like Graylands?

**Ms A.R. MITCHELL**: I would suggest it would happen not at the end of the 10 years, but within that time frame, but I will double-check with Mr Marney.

**Mr T. Marney**: Part of the issue is the existing facility. The Frankland Centre is the newest facility on the Graylands site, so we cannot just turn our back on a substantial asset like that. The priority is not the twelfth month of the tenth year, but we need to understand exactly what is required, and to do our due diligence around that and the best way to deliver it. Certainly, in the areas of shortfall of supply relative to need, forensics is probably the most stark shortfall, albeit for a smaller number of people, but it is a drastic shortfall.

[7.50 pm]

**Mr R.H. COOK**: Can I confirm by what time the parliamentary secretary will have firm plans made public about the rollout of these facilities that we have been discussing?

**Ms A.R. MITCHELL**: I think that Mr Marney has responded to that. It is all part of the planning process at the moment and certainly understanding a cohort and working collectively with the North Metropolitan Health Service, the Department of Corrective Services and the Department of Health. However, if Mr Marney wishes to add anything more, then I am happy for him to do so.

**Mr T. Marney**: Thank you. Again, as part of the consultation progress, there was quite a desire across the communities that we engage with and through the public submissions for further detail both on the broader decommissioning of Graylands Hospital, and the timing of that, and also the timing around the forensic developments. That is certainly something that we will be looking to enhance in the 10-year plan, which will then be considered by the government. The timing of the investment associated with that is subject to government budget processes and fiscal capacity.

**Mr R.H. COOK**: I have two further questions, but I am just trying to nail down this one. I understand that the time horizon for the construction or the commissioning of these new facilities is yet to be determined under the plan. I am asking when the plan will be confirmed and when will everyone have an understanding of that horizon?

**Ms A.R. MITCHELL**: Member, the consultation process has concluded. Mr Guard and Mr Marney have both indicated that they are working on input that came from the consultation process that occurred, and I cannot recall if Mr Marney gave some indication of when. As soon as we can, it will go to cabinet and then come out from there. We want to improve those things that have come back to us from the consultation process.

**Mr R.H. COOK**: I understand it will be as soon as the parliamentary secretary can.

**Ms A.R. MITCHELL**: Look, sorry —

**Mr R.H. COOK**: I tried that with some of my university lecturers, too.

**Ms A.R. MITCHELL**: It did not work either?

**Mr R.H. COOK**: It just does not rub, parliamentary secretary. Does the parliamentary secretary expect to confirm it this financial year, next financial year, or is it by Christmas this year? When is the parliamentary secretary expecting to finalise the plan?

**Ms A.R. MITCHELL**: I am going to pass to Mr Marney and see if he will be specific with the member.

**Mr T. Marney**: I am more than happy to be specific. On our program—the Mental Health Commission's deadline—it will be during the September quarter of this year. I am going through the revised draft at the moment with a view to delivering that to the minister in July–August for cabinet consideration. Obviously, that release date is subject to that cabinet consideration and to government's decision-making around that, but that is what I am working to.

**Mr R.H. COOK**: I have one final question, and I thank the committee for its indulgence. The commissioner talked about the decommissioning of elements of Graylands Hospital. I am wondering if the commissioner could provide us with a quick description of whether that will result in the sale of land at Graylands Hospital. If that is the case, is that land owned by the Mental Health Commission or by the Department of Health? What is the value of the land that the commissioner is looking at selling at this point in time? Will that come back into the health system or will it be used to retire debt?

**Mr T. Marney**: Thank you. I understand the land is owned by the Department of Health. The Mental Health Commission does not have legislative authority to own land and it is a health department facility. The potential sale of land or, if you like, the phased decommissioning and phased or incremental staged sale of land or parcels thereof from the site, is a matter to be determined by the decommissioning planning, which is work that is underway at the moment. I apologise, but it is yet to be determined. Obviously, government will decide whether or not the proceeds of that are to be retained in Health or used to retire debt. Certainly, a potential strategy is that the redevelopment would be funded by the phased sale of land because there will need to be incremental investment over the 10-year period, as we discussed earlier, and there will need to be a funding source for that. But obviously, again, that is subject to government consideration.

**Mr R.H. COOK**: That is perfect. Thank you.

**Dr A.D. BUTI**: I refer the parliamentary secretary to spending changes on page 393 under "Mental Health Public Services and Costs Settings". Is the additional funding over the forward estimates linked to requirements for commonwealth government funding?

**Ms A.R. MITCHELL**: I am just catching up with the member.

**Dr A.D. BUTI**: It is the second-to-last line on the table.

**Ms A.R. MITCHELL**: Yes, I thank the member. Sorry, what was the last part of the member's question?

**Dr A.D. BUTI**: Is the additional funding over the forward estimates linked to requirements for commonwealth government funding?

[Mr P. Abetz took the chair.]

**Ms A.R. MITCHELL**: Mr Chairman, I ask Mr Marney to respond to that question.

**The CHAIRMAN**: Mr Marney.

**Mr T. Marney**: Mr Chairman—I turn around and someone new is there!

The funding line that the member has referred to is the figure that totals additional expenditure on mental health activity of $30 million over the forward estimates. That is the product of two components: one is the modelled increase in activity component, which the member referred to earlier—the 2.1 per cent figure. There is also a three per cent growth figure embodied in that, which is a price component. That is based on the national Independent Hospital Pricing Authority's determinations as to efficient price growth within the health system based on projected average costs across the country. It is using a pricing benchmark that is nationally determined, combined with our activity modelling on a state basis.

**Dr A.D. BUTI**: This may have already been answered, but I was not quite sure. Is the price of mental health services changed to adhere to the Australian mental healthcare classification system; and, if so, how?

**Mr T. Marney**: At the moment, there is not a separately identified price for mental health activity. That is currently under development in terms of the framework that the member has just mentioned, but that development is not yet complete; it is ongoing through 2015–16. We envisage that we will get to a point where we separately price mental health activity based on that mental health classification framework. It is work that is in development and we are heavily involved with that work with the Independent Hospital Pricing Authority, but it is at a very early stage at the moment, and not robust enough to be able to base funding and purchasing decisions on.

[8.00 pm]

**Dr A.D. BUTI**: I just want to clarify the answer given to my first question. The Mental Health Commissioner mentioned the reason for that increase in hospital services and cost settings. Is there any link to commonwealth funding with respect to those forward estimates?

**Mr T. Marney**: Under the national partnership agreement around health, my understanding is that 45 per cent of that funding is provided by the commonwealth government.

**Mr D.J. KELLY**: I refer to the suicide prevention strategy on page 394 of the *Budget Statements*. I understand that financial troubles, financial stress and financial hardship can be a significant driver towards a person's

decision to commit suicide. Tell me if I am wrong, but that is my assumption. Was the Mental Health Commission consulted before the government made a decision to withdraw funding from its financial counselling services in the metropolitan area? I understand there is also some question about country services as well. I think that decision was announced in the past week.

**Ms A.R. MITCHELL**: I will ask Mr Marney to respond to that specific question to him.

**Mr T. Marney**: I am not aware of the specifics of the programs that have been altered. I confirm that the Mental Health Commission was not consulted as part of that process. However, obviously that is a decision for cabinet and the minister who represents the commission in that process.

**Mr D.J. KELLY**: I suppose the assumption of my question is that financial stress can be a significant driver to a person deciding to take their own life. I appreciate that the Mental Health Commissioner said he is not aware of the particular decision. If the government was to withdraw access to financial counselling for people who are unable to pay for it themselves—so free financial advice to people who are in financial stress—is that likely to lead to an increase in the number of suicides in our community?

**The CHAIRMAN**: To what extent is that a legitimate question? It does not really relate to a line item as such.

**Mr D.J. KELLY**: It relates to "Suicide Prevention" on page 394 that is referred to as a significant issue impacting the agency.

**The CHAIRMAN**: It is a borderline one. If the parliamentary secretary chooses to answer it, I will allow her to answer, but it is borderline in terms of whether it is an appropriate question. It is the parliamentary secretary's choice. She should not feel obligated to respond.

**Ms A.R. MITCHELL**: The point that the member is making specifically relates to another portfolio which will come on later. The issue of suicide prevention is one that this government takes very seriously, hence the production of "Suicide Prevention 2020: Together We Can Save Lives", which was recently released and demonstrates that commitment to suicide prevention and the funding that will be put towards that. The member might raise a specific strategy that he believes might be warranted in that plan, but his question might be better asked in a later portfolio. Mr Marney indicated that he wished to make a contribution in response as well.

**Mr T. Marney**: I encourage members to read the suicide prevention strategy. It goes into the detail of some of the causal factors around suicide and suicide ideation. Interestingly, in summarising the current literature around suicide, it highlights the fact that in 90 per cent of cases of suicide there is a pre-existing, either diagnosed or undiagnosed, mental illness. That is without doubt a significant finding and a significant driving factor.

Someone's consideration to take their own life is complex and that is why suicide prevention is complex. Although I acknowledge the member's hypothesis, I certainly would not be able to validate it any way other than to say that many factors lead to someone being in such a state of distress to take their own life or attempt to do so. They include financial stress, employment, relationships, social isolation, fatigue and exposure to risk-taking behaviour. Suffice to say it is extremely complex.

**Mr D.J. KELLY**: I certainly accept the comment that what drives someone to take their own life is immensely complex and a number of factors are often at play. It is well known that financial stress is one of the issues that impacts upon that. If a government is going to have a suicide prevention strategy, it has to deal with all the issues. The issue that I have raised is if a government is going to withdraw access to financial counselling, it surely leaves itself open to an increase in the number of people who commit suicide because of issues such as financial stress, albeit it is a complex issue. That is the proposition I am putting. I do not really think the parliamentary secretary is disagreeing with me.

**Ms A.R. MITCHELL**: I am not sure. That question just threw me for a minute. I need to get my thoughts back about where I was going.

**The CHAIRMAN**: You do not need to answer a question if you do not want to.

**Ms A.R. MITCHELL**: I did have a response. I will use it later.

**Mr R.H. COOK**: My question relates to "Drug and Alcohol Services", which is detailed on page 395 of the *Budget Statements*. I was disturbed recently to see that the Food and Drug Administration in the US has approved powdered alcohol for marketing and use. Could the parliamentary secretary comment on any concerns that she might have about the introduction of powdered alcohol into Western Australia, particularly the effects that it would have on remote communities, and whether the government is taking steps to ban it or not make it legal?

**The CHAIRMAN**: Which dot point does that relate to?

**Mr R.H. COOK**: It is under "Drug and Alcohol Services". There is extensive discussion around the National Drug Strategy.

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

**Mr N. Guard**: The product that the member is referring to is generally known as Palcohol.

**Mr R.H. COOK**: I thought if I said that, I would be trying to sound too trendy.

**Mr N. Guard**: That is a common name. The member is right; it has gone through the FDA in the United States. It has been banned in a number of jurisdictions in the United States as well because of a range of concerns that come with the introduction of a product such as that. Victoria was the first jurisdiction in Australia to raise concerns about the potential for the product to arrive in Australia and has opened dialogue with other states as well about mechanisms to prevent that. I know that Western Australia is engaged in those discussions. It is not through the drug and alcohol strategy; it is through other bodies, including the Department of Health and the Department of Racing, Gaming and Liquor. There are significant concerns about a product like that that potentially could be used by young people at festivals, for example. It is very easy to sneak in. A range of potential risks go behind it. It is well over one standard drink per packet. There is a range of risks behind a product like that. We do have concerns, but jurisdictionally there are conversations about what can be done to stop it arriving and being used in Australia.

[8.10 pm]

**Mr R.H. COOK**: Has the Drug and Alcohol Office been involved in discussions with other government departments about Palcohol and have those discussions canvassed the issue of banning Palcohol before it comes to Western Australia?

**Ms A.R. MITCHELL**: I think Mr Guard has responded to that, but I will come back to him. I was smiling before and I did mean to say that I think the member did well to stretch that to bring in his topic.

**Mr R.H. COOK**: If it is introduced, the government will have some work on its hands. We will start talking about alcohol treatment services shortly.

**Mr N. Guard**: Again, yes the Drug and Alcohol Office has been in conversations with the Department of Health and the Department of Racing, Gaming and Liquor. We have also registered the item as one for discussion at the Intergovernmental Committee on Drugs, of which I am a member. That will be a discussion item at the next meeting in July.

**Dr A.D. BUTI**: I refer to "Mental Health Infrastructure" on page 395. I note that the first dot point refers to the various capital works and building of mental health units or beds at Sir Charles Gairdner Hospital, Midland Public Hospital et cetera. Graylands Hospital is undergoing significant reform as a result of policy initiatives. Has the number of sexual assaults at Graylands increased since the closure of the Dorrington ward? What is the number of sexual assaults reported this financial year and what is the number of sexual assaults reported over the two preceding financial years?

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

**Mr T. Marney**: In terms of recent developments at Graylands, there has been a transfer of some beds particularly from the Hutchison ward, and they have been replaced in part through some Hospital in the Home beds, but further transfer will occur as the Midland Health Campus is established, which will involve the transfer of nine beds from the Hutchison ward. In terms of the incidence of sexual assaults, I do not have that information ready to hand. That information would normally be reported to the Office of the Chief Psychiatrist. I would be happy to provide that information by way of supplementary information.

**Ms A.R. MITCHELL**: Can the member clarify what information he wants provided?

**Dr A.D. BUTI**: The supplementary information I seek is in three parts: has the number of sexual assaults at Graylands increased since the closure of the Dorrington ward; what is the number of sexual assaults reported this financial year; and what is the number of sexual assaults reported for the two preceding financial years?

**The CHAIRMAN**: Is the parliamentary secretary happy to take that?

**Ms A.R. MITCHELL**: Yes, I am.

[*Supplementary Information No B68.*]

**Mr R.H. COOK**: I refer to paragraph (h) on page 397 of the *Budget Statements*. My question relates to the outcomes and key effectiveness indicators as detailed on page 397. I am particularly interested in the percentage of closed alcohol and other drugs treatment episodes that are completed as planned. I am particularly interested

in the cannabis intervention orders and cannabis intervention sessions that were legislated for in about 2010 or 2011. Is that the outcome that relates to one of those particular services? What has been the success rate of the compulsory cannabis intervention sessions both in terms of the number of people and the level of recidivism?

**Ms A.R. MITCHELL**: I will ask Mr Guard to answer, but I think we will have to get a supplementary to get that detail.

**Mr N. Guard**: The figures here refer to all alcohol treatment episodes, a component of which is the cannabis intervention sessions.

**Mr R.H. COOK**: That is the only thing I could find in the *Budget Statements* to hang off that question!

**Mr N. Guard**: These figures are an indicator overall of the quality of treatment outcomes. If we can engage someone in treatment, keep them in treatment and complete the planned treatment, that is a good indicator of likely longer-term success. Effectively what these figures report are the percentage of closed episodes that were completed as per the plan for that episode. Sometimes they are not closed because the person is incarcerated, leaves of his own will, while some people unfortunately die, and that is why we do not get that 100 per cent piece. Specifically in relation to the cannabis intervention requirements are the number of people who have been through the cannabis intervention requirement. If that is what the member is after and the trends in that, I can provide those figures, but I will have to do it as supplementary.

**Mr R.H. COOK**: One of the debates around the time that that legislation went through was about the effectiveness essentially of rehabilitation services and in that context it was about cannabis and the effectiveness of compulsory rehabilitation. I am interested to see what statistics are available to demonstrate whether or not they are working.

**Mr N. Guard**: The statistics that I can provide will include the number of people who have booked to attend a cannabis intervention session and the evaluation that we have on what they say about the effectiveness of those sessions. That is what I can provide. The member would probably need to go to Western Australia Police for the broader detail about the number of people who are offered the opportunity to attend, those who accept and those who do not. All I can provide is the treatment component.

**Ms A.R. MITCHELL**: Can I clarify what we will provide the member?

**Mr R.H. COOK**: Yes please, because there are two aspects. It is my understanding that two types of people attend these sessions. The first involves those who turn up voluntarily, while the other involves those who are compelled under the act to undertake rehabilitation sessions or intervention.

**Mr N. Guard**: A cannabis intervention session?

**Mr R.H. COOK**: That is correct. For example, when they are caught in possession of a small amount of cannabis, the police will give them the option of attending a cannabis intervention session or potentially going to a court, if that is what they want do. Our part of that particular legislation is around providing the cannabis intervention session for those who elect to attend and book a session.

**Mr R.H. COOK**: It would be great if I could have the stats in terms of those outcomes.

**The CHAIRMAN**: Could you reiterate what you will be providing?

**Mr N. Guard**: We will provide the number of people who attend the cannabis intervention sessions and whatever information I can find about the evaluation of what they say about the effectiveness of those sessions.

[*Supplementary Information No B69.*]

[8.20 pm]

**The CHAIRMAN**: I am allowed to ask a question from the chair. If this has already been dealt with in my absence, please say so and I will read it in *Hansard* tomorrow. I refer to the table at the bottom of page 393 of the *Budget Statements* and to the item "Fresh Start Recovery Program". The estimated actual amount for 2014–15 is a dash, which would suggest that it received zero funding this year. It then goes to $700 000, $300 000 and $116 000. My understanding was that in the past Fresh Start received about $1 million a year from government funding. Was that from a different government department? I do not understand these figures, because it seems a huge cut or that it is an incomplete figure. Can that please be clarified?

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

**Mr N. Guard**: The figures in the budget paper represent the additional grant funding over and above the government's core funding. The previous grant funding expires in June 2015, so the figures in the paper are the additional grant funding over and above the core funding into the out years that the government has approved.

**The CHAIRMAN**: Thank you; that was very helpful.

**The appropriation was recommended.**