Division 74: Mental Health Commission, $677 058 000 —

Mr I.M. Britza, Chairman.

Ms A.R. Mitchell, Minister for Mental Health.

Mr T. Marney, Mental Health Commissioner.

Mr D. Axworthy, Acting Assistant Commissioner, Policy, Planning and Strategy.

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

Ms M. Falconer, Chief Financial Officer.

Mr A.S. Gaspar, Chief of Staff, Office of the Minister for Mental Health.

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 minister 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 minister 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 minister's cooperation in ensuring that it is delivered to the principal clerk by Friday, 3 June 2016. I caution members that if a minister 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.

[Witnesses introduced.]

The CHAIRMAN: I give the call to the minister.

Ms A.R. MITCHELL: Mr Chairman, before I start, could I just make a statement? It is relevant to a couple of members and the portfolio. It is very brief.

The CHAIRMAN: Okay, minister.

Ms A.R. MITCHELL: Tomorrow the member for Armadale and the Minister for Local Government; Community Services; Seniors and Volunteering; Youth will together ride from Margaret River to Perth to highlight the blight of domestic violence. As part of the ride they will be raising money, which will go to women's refuges. Violence against women is abhorrent and shameful. It is incumbent on all of us to work together to change the culture amongst some that violence against women is acceptable. I would like to take this opportunity to place on the public record my support for the member and the minister for their efforts and to wish them well for their ride against domestic violence.

Dr A.D. BUTI: Thank you, minister. I refer to page 851 of the budget papers and the "Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025". What is the estimated additional funding required to deliver the outcomes of the plan?

Ms A.R. MITCHELL: I will ask the commissioner to answer that one.

Mr T. Marney: As I understand the question, it is: what is the estimated cost for the implementation of the plan?

Dr A.D. BUTI: The additional funding required to deliver the outcomes of the plan.

Mr T. Marney: In order to arrive at the additional funding, what is first required is a definition of "cost". Cost is determined by, in many respects, the model of service. The 10-year plan is very comprehensive in terms of the range of services, going from inpatient services through to community-based beds and community support services. The exact models of service which determine the cost are yet to be developed for most of those actions, because one of the key principles of the plan is that those models of service need to be developed in consultation and even in co-design with consumers, carers and families. Therefore, it is very difficult to put a cost estimate of any liability on discrete actions because we do not know what the model of service will be. The second element of the question was around what is the additional funding requirement. The plan itself is referred to as funder neutral. It can be funded by the state, it can be funded by private entities, it can be funded by non-government organisations and it can also be funded by primary health. In working towards implementation of the priority actions of the plan, we are actually working with all those sectors to identify their role in funding elements of the

plan as well. A case in point would be dealing with support services post-discharge from acute hospital settings. We are working very closely with the WA Primary Health Alliance to establish and expand our existing co-funding of services. We already have joint funding of services and we are working closely in partnership as they plan for their rollout of procurement and service reconfiguration post–1 July. It is very difficult, in fact it is almost impossible, to put an accurate figure on what the aggregate additional funding requirement would be. It may be more feasible to do that for specific actions within the plan once that consultation and co-design process is progressed further.

Dr A.D. BUTI: Would I be right in assuming that a business case has not been prepared as part of the annual budgetary process with regard to the plan? If a business case has been prepared, would the minister be able to give us an outcome of that application and also table the business plan?

Ms A.R. MITCHELL: Firstly, the plan is quite extensive. It is not one business case for the whole plan. There are business cases for sections within the plan that will come forward at the time that is appropriate. I think the commissioner would agree that it is not possible to present a business case for the plan, but for the items within the plan, as we see fit to bring them forward, those are certainly being developed. I will ask the commissioner to add to that.

Mr T. Marney: Yes, as part of the budget process there were a range of business cases developed for the early actions in the plan. As the member would probably be aware, there is a suite. The actions are broken into three time horizons—end of 2017, end of 2020 and end of 2025. As part of the budget process that is before us now, a range of business cases were submitted for funding. The outcomes of the successful ones are obviously in the budget papers before the member. A few of those are noteworthy, such as the methamphetamine strategy and additional rehabilitation and detox facilities, as well as other initiatives dealing with emergency department presentations and so on. That is an example of a business case that was developed and then progressed through the budget process. Another is the expansion of care for older adults in aged-care settings. They are just a couple of the business cases that were submitted in the process. From memory, there were around nine business cases submitted. Obviously, given the state's financial circumstance, not all of those could be accommodated, but we continue to work with Treasury and stakeholders around firming up those business cases that were not approved to better address their concerns and make sure they fit with overall government strategy. Because those business cases are continuing to progress through government's decision-making processes in terms of the Economic and Expenditure Reform Committee and cabinet, they are subject to cabinet confidentiality and are not able to be released at this point.

Dr A.D. BUTI: Has a ministerial submission been made to cabinet seeking additional funding for the implementation of the plan?

Ms A.R. MITCHELL: As I have just outlined and as the commissioner has further outlined, there has not been one business case submission for the total funding of the plan because it does go through to 2025. It is important that we determine which things we can bring on and which need to be brought on as quickly as possible or within that shorter time frame, and we will do that. That is ongoing and continual. It is not something that happens just once a year. It is ongoing; it happens throughout every discussion that is had about what needs to come forward and what needs to be done. As the commissioner said, perhaps we were not successful in the last processes, so we are improving those submissions to make sure that we get them through.

[9.10 am]

Dr A.D. BUTI: Has any additional funding at all been granted for the parts of the plan that have been approved?

Ms A.R. MITCHELL: Everything that the commission does is in line with the plan so, yes, in a general sense, there certainly has been an increase in funding for mental health through the commission, and also through the ability to provide assistance to other agencies. There has been a massive increase in mental health issues over the last few years. Mental health issues are out there, obviously, and the amount of work that we need to do in the area is, unfortunately, growing. Therefore, there are definitely increases in elements of the plan and support for areas. Yes, we would always love more; there is no question about that. There is always more to be done. It would be great if we could do it all in the next 12 months, but we are moving it as we can to go through and get the results that we need in as many areas as we possibly can. I will ask the commissioner whether he wants to add any specific areas that have been quite impressive.

Mr T. Marney: The plan emphasises the need to shift the balance across the system to greater community support and community beds. The budget decisions provide further clarity for subacute services in Bunbury, Karratha and Broome. Rockingham should be up and running within the next 12 weeks. Those elements of the plan are being progressed. There is also additional money for non-acute community long-stay programs, youth-focused counselling and, as I mentioned, the Western Australia meth strategy treatment service, which is probably one of the greatest areas of shortfall of supply with respect to need identified in the 10-year plan. In

addition, the overall service delivery agreement that the Mental Health Commission has with WA Health will see growth out of the budget of 2.9 per cent. That is an $18 million increase. We are pursuing a range of specific projects within Health. They include the youth community treatment service out of Fiona Stanley Hospital, which is a new model of service that targets a new cohort of demand that we know is in significant need, particularly in the Rockingham–Peel region. Our funding to non-government organisations will grow by 1.4 per cent, which continues to pursue the rebalancing of the system between the absolute need for inpatient acute beds and a continuum of service to support people transitioning back into the community or trying to keep them well to avoid unnecessary admissions to acute settings. That is in the mental health space.

In the alcohol and other drug space, non-government–organisation purchasing will increase by 7.3 per cent as a result of this budget. Alcohol and other drug programs and awareness campaigns will grow by five per cent, and again there is a strong emphasis in the 10-year plan on early intervention and prevention, and, indeed, stigma reduction.

Mr D.J. KELLY: Can I take the minister to the allocation for community treatment on page 858 of the budget papers. The 2015–16 budget allocates $313 million for the net cost of service delivery for community treatment. The estimated actual spend detailed in the budget papers for this year puts expenditure at only $304 million, which is an underspend of approximately $9.7 million. In August 2014, the Mental Health Commissioner stated —

> "Individual services are fairly drastically under-supplied, we probably only have 30 per cent of supply we need in those community-based services,"…

That is a quote from Mr Marney. Regarding the underspend, why was the decision made to cut funding by over $9 million for this year? What programs or treatment services were not delivered this year as a result of that cut?

Ms A.R. MITCHELL: The information the member is requesting refers back to another area. I will locate that information as we have a specific answer for the member. Mr Marney now has that information.

Mr T. Marney: There are two elements to that decline. It was certainly not a decision to reduce service provision in that area. The member's statement is correct; in community support, we are falling more short of needs than in any other area. Community treatment is slightly different. These are, if you like, the health service-based outpatient services. The reason for the decline between the 2015–16 budget and the 2015–16 estimated actual is mainly due to the re-profiling of the youth community treatment service out of Fiona Stanley Hospital that I mentioned. It is a new service that has been worked up in the current financial year. The development of the model of service and the recruitment of appropriate staff have been delayed. That led to a shifting of savings or unspent money in the current year into 2016–17. The money is not lost out of the system; it has just taken the South Metropolitan Health Service a little bit longer to develop the model of service and then to recruit appropriate people to it.

Mr D.J. KELLY: Is the commissioner saying that that accounts for the whole $9.7 million underspend?

Mr T. Marney: No; that is about $2 million. Another component is a decrease in overhead allocation of $2.2 million. There has also been a decrease in the non-government human services indexation rates for non-government organisations, which affect all our NGO contracts. The member may recall that a decision was made as part of a midyear review to reduce the indexation rate for NGO cost growth at a whole-of-government level. That flows through to all our NGO contracts.

Mr D.J. KELLY: I have a further question. Given that the commissioner previously stated that we are 30 per cent below what is required, what is the current estimated undersupply of community-based services?

Ms A.R. MITCHELL: I will ask Mr Marney to continue his discussion on that one.

Mr T. Marney: Estimating the population need for services is a pretty complex task. We did that at a point in time for the development of the plan. One of the actions in the plan is to redo that work every two years. To do that on an ongoing basis, to get an annual snapshot, would be prohibitively expensive for resourcing within the commission. The population would probably not shift that greatly. Principally, there are two determinants to identify that need. One determinant is epidemiology—the prevalence of conditions within the community—and the other is population growth. As part of our budget settings, we do seek to grow services by at least population growth to try to keep pace with that need. We do not know whether there is any change in prevalence within the community, but we would not expect that to happen in a 12-month period. However, the clear intention is to update that modelling every two years.

Mr D.J. KELLY: The commissioner made the comment in August 2014, so am I right to assume that the department will have done that two-yearly update by August 2016?

[9.20 am]

Ms A.R. MITCHELL: I will ask the commissioner to respond.

Mr T. Marney: The plan was not finalised and released until December 2015. The modelling was up to date as at that point, so we will be looking to update the modelling by December 2017.

Mr D.J. KELLY: The total funding allocated in the 2015–16 budget papers includes allocation for community treatment for 2016–17 set at $389 million, but this budget allocates only $381 million—a difference of $8 million. Has this funding been redirected in any way to deliver the meth strategy?

Ms A.R. MITCHELL: Can I just check which page the member referred to to get those numbers?

Mr D.J. KELLY: I am still on page 858.

Ms A.R. MITCHELL: Which line item is the member referring to—community treatment or community support?

Mr D.J. KELLY: I am looking at the total funding for community treatment.

Ms A.R. MITCHELL: I will ask the commissioner to respond.

Mr T. Marney: Without going through a reconciliation of that work, the assurance is that the methamphetamine initiatives are all funded with new money to the commission.

Mr D.J. KELLY: I refer to community treatment on page 858. For the financial year 2016–17, $68 million of income is listed. Can the minister identify the source of that income? My last question, to save time on this point, is: what is the value of lost federal funding for the forthcoming 2016–17 financial year?

Ms A.R. MITCHELL: Obviously, whenever federal funding is not available to us anymore, it is an issue. We always have to make sure we do not leave things in a mess. We obviously negotiate, work through and realign matters to make sure that we provide a service where appropriate. We cannot always jump in and totally replace funds that might have been there, and that is where some changes always occur. I am going to ask the commissioner to be specific in answering the second part of the question.

Mr T. Marney: Particular areas of loss of funding from the commonwealth include—this is probably the biggest one—the assertive community treatment action, for which the current money expires on 30 June. That funding is annual funding of $2 million—so that drops away. We have also had funding reductions from 2014–15 to 2015–16 of around another $2 million associated with specific commonwealth programs—for example, the national perinatal program. Those are really the biggest items. There are some other commonwealth revenues that drop away, particularly in the community support space—that is just under $3 million—and there are some other minor variations of about $500 000.

Mr D.J. KELLY: The other part of the question was the $68 million listed as income for 2016–17 under community treatment. Can the minister identify the sources of that income?

Mr T. Marney: It comes from various sources. It is predominantly commonwealth; there are alcohol and other drug-related grants, including from other agencies. For example, the alcohol interlocks grant is from other agencies in the state sector.

Mr D.J. KELLY: Is it possible for the minister to give a breakdown by way of supplementary information for that $68 million in income?

Ms A.R. MITCHELL: That is possible. We will provide further information about the income gained.

[*Supplementary Information No A60.*]

Dr A.D. BUTI: I am still referring to community treatment on page 858 of budget paper No 2. It states the following —

> Community treatment provides clinical care in the community for individuals with mental health, alcohol and other drug problems.

In last year's budget, there was an allocation of money for youth community treatment of something like $2.453 million. There is no mention of youth community treatment in this year's budget, so there are really two questions I will ask: can a breakdown of the allocation for 2015–16 be provided; and is there any funding in 2016–17 and the forward estimates specifically allocated to youth community treatment?

Ms A.R. MITCHELL: I can assure the member that youth is a major focus for any treatment that goes on, because obviously we want to assist. Youth is always a focus for us very much in treatment and prevention, because we want to assist people very early in the process, rather than waiting for it to come on. Therefore, it

may be treated differently rather than having a specific aspect that occurred originally. I will get the commissioner to respond on last year's figures.

Mr T. Marney: That was in part addressed in the answer to the previous question. The youth community treatment stream implementation has been delayed in 2015–16, but that therefore has been rolled over into 2016–17. From memory, the allocation is $1.9 million for 2016–17. That service is up and running at the moment and scaling up to its full operation early in the next financial year. The second element of advance in terms of youth community treatment is to have a regional-based youth community treatment team as well, for which there is a current proposal for hubs in Bunbury and the Pilbara that would provide youth community treatment outreach across the regions. The member will not find that listed as a separate line item because that is one of those areas that is an early priority in the 10-year plan and has been implemented through reconfiguration of existing resources.

Dr A.D. BUTI: The commissioner mentioned $1.92 million. That is over $500 000 less than the allocation in last year's budget, which the commissioner just said had been delayed to this financial year. As I said, that is over $500 000 less. Can the minister give an answer about why there has been a reduction? Also, Mr Marney said that the youth community treatment will now be operational this financial year, so will there be that service delivery from Fiona Stanley Hospital?

Ms A.R. MITCHELL: If I could first say that there has not been a reduction; the money has been spread over the two years and allocated across the areas involved in the youth treatment plan. Youth treatment at Fiona Stanley Hospital is certainly part of that process, and, as we say, we are making sure we have the best staff working in that area, because people need to bring a unique set of skills to those sorts of nursing fields and things like that. The funding is growing and it will grow, but it is there and is definitely part of our youth treatment program.

Dr A.D. BUTI: Where actually in the budget is the allocation of this money for youth community treatment? It is not mentioned at all in this year's budget papers. The minister says it has been delayed—that is okay; it may be delayed—but surely it should appear in the budget papers for this year or in the forward estimates?

[9.30 am]

Ms A.R. MITCHELL: I will ask the commissioner for further information.

Mr T. Marney: I will ask one of my team to track down the actual page that that is referenced on, but it will appear as a re–cash flowing item of $1.905 million of the total $2.5 million budget for 2015–16 and $1.905 million will be transferred into 2016–17. The total expenditure will remain the same. As I mentioned, some of the $2.5 million budget is being expended at the moment as the service is being ramped up. There has been no removal of funds. The time frame has shifted from one financial year to another. Just over half a million dollars will be expended in the current financial year and the remainder through 2016–17. I will try to find a page reference for at least that $1.905 million. It is there somewhere; I just cannot remember where.

Dr A.D. BUTI: Will the minister provide it as supplementary information?

Mr T. Marney: We should be able to do it as part of the proceedings.

Dr A.D. BUTI: I refer to the spending or the allocation of money for the youth community treatment that was allocated in the 2015–16 budget and is now being spent in this financial year and beyond. Am I right in saying that that plan includes delivery of services from Fiona Stanley Hospital; and, if that is the case, could the minister table or provide by way of supplementary information details of that plan?

Ms A.R. MITCHELL: Member, that is a very broad statement. Can the member be specific about the information that he is looking for?

Dr A.D. BUTI: Were youth community treatment services to be delivered from Fiona Stanley Hospital; and, if so, what is the plan for the delivery of the services? What is the detail of the delivery of services from Fiona Stanley Hospital for youth community treatment?

Ms A.R. MITCHELL: The first part of the answer is yes, Fiona Stanley Hospital is part of that plan for youth treatment. The second part —

Dr A.D. BUTI: Can we have details of the actual plan for the delivery of services for youth community treatment from Fiona Stanley Hospital, either tabled or by way of supplementary information?

Ms A.R. MITCHELL: I am probably struggling to understand—when the member says Fiona Stanley Hospital youth treatment and then community treatment, it becomes very fluid.

Dr A.D. BUTI: My question was originally: is part of the youth community treatment being delivered from Fiona Stanley Hospital?

Ms A.R. MITCHELL: Yes.

Dr A.D. BUTI: What are the details of that delivery of service?

Ms A.R. MITCHELL: I will say first of all that when we are talking about people, we do not have a general plan. We have specific care plans for people, and it varies on numbers and who is involved and such things. It is not easy to say that this is how it will be. We have the principles rather than the details. I will check whether Mr Marney wants to say something specific that can satisfy the member's question.

Mr T. Marney: Broadly speaking, I think the member is asking for the model of service out of Fiona Stanley Hospital for youth community treatment.

Dr A.D. BUTI: Yes.

Mr T. Marney: In essence, it mirrors existing community treatment services in that Fiona Stanley Hospital will take referrals from either general practice or acute inpatient settings for individuals, who will then work with the community treatment teams on the implementation and further development of their discharge plans, which are their recovery plans post discharge, or their mental health plans as initially developed in consultation with their general practitioner. The community treatment team will usually run with an individual, assessing their needs, regular follow-up with the individual and their family and carers around implementations of their care plans, assessment of their progress in recovery from their illness, and looking at what other services and supports need to be put in place for that individual on a longer term basis. The engagement with the hospital-based community treatment team is typically a six to 12-week engagement with a series of appointments and follow-ups. It is really about transitioning people to longer term better mental health and/or the necessary supports in the community for them to stay well.

The difference between the normal community treatment service and the youth community treatment service is that we know that 75 per cent of the development of serious mental illness manifests in the 16 to 25-year-old age cohort. Clearly, that is a period in life that is not only developmentally crucial, but also, if I can say, quite packed for an individual's social, cognitive, mental and emotional development. That age cohort needs something very different from an over-25 age cohort in both the treatment and care they require and the natural supports around them, whether positive or otherwise, such as friends, family and so on. The ongoing development of care plans and implementation of those plans is very different from that of an adult cohort. This community treatment is the first in the state. Hence, it has been a bit of a soft implementation in the current year. Next year, after that model of service has been developed and trialled on new referrals to Fiona Stanley Hospital's mental health services, it will also extend to existing clients of that service. I hope that gives a bit of a sense of how the model of service works. It is also an assertive outreach service. The youth team are working very closely with services in Rockingham and Peel to address concerns in those areas around youth mental health and, unfortunately, suicide.

Dr G.G. JACOBS: I draw the minister's attention to spending changes on page 850 of the *Budget Statements* and the line item "Sub-Acute Services in Goldfields". The step-down, step-up facility based in Kalgoorlie, which is to also service the goldfields, is very important for community out-of-hospital services. What is the status of funding of this facility and the plans for its development?

Ms A.R. MITCHELL: I thank the member. I particularly acknowledge the member's interest in this area. I note the member for Kalgoorlie is also in the chamber, so I am pleased that both members are here. I will make some opening comments and then pass to the commissioner. As we already indicated, the commission regularly reviews patient demand around Western Australia. Although it might have been said that that will occur in the next budget, with the review of the patient demand, it was determined that there is definitely a longer term need to support such a facility in Kalgoorlie, and other areas in the state probably require it sooner than the goldfields area. Inpatient care in the goldfields is being catered for with that six-bed mental health facility at the hospital, and they are doing a very good job. We are monitoring that, including reviewing the demand. We will continue to do that for the goldfields. We have combined hospital inpatient beds with other mental health service partners in the goldfields, such as the goldfields community Alcohol and Drug Services, headspace and Centrecare. They are also providing excellent service to people in the goldfields at this point in time. It is being monitored. We are watching the demand. But at this stage the priority for the demand is in other areas of the state. I will just ask the commissioner whether he would like to make a further comment on that.

[9.40 am]

Mr T. Marney: There is clearly an emerging need in the goldfields. As the minister said, it is a question of priority and also the state's fiscal capacity and the capacity of the commission to implement a range of subacute step-up, step-down facilities. There are four on the go at the moment. The history of the commission has not been favourable in the timely delivery of those. We need to be cognisant of how much we can actually deliver those facilities at one point in time. There is a need to also phase those facilities. As the minister just said, at this point the government has identified the priorities as Bunbury, Karratha and Broome, so that is where we are focusing our efforts. We hope to have Rockingham opened within the next 12 weeks.

Dr G.G. JACOBS: I draw the minister's attention to the "Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025". It is stated on page 117 of the plan —

> Currently, there are no mental health **community beds** in the Goldfields, and modelling shows that to meet demand, a total of 21 beds are required for the region by the end of 2025.

How will the minister meet what is in her own plan? That paragraph continues —

> The State Government has announced the establishment of six community beds in Kalgoorlie/Boulder …

The member for Kalgoorlie is here, and I represent parts of Boulder. How do we contribute to the 21-bed requirement? The minister knows more than anybody that an inpatient unit is great for an acute episode, but it is how people transition back into the community that is really important. That is the difficult game. People who will become ill, but not acutely ill, will need to go into an inpatient facility and their admission can be averted. The Kalgoorlie–Boulder region also services my area of Esperance and the northern goldfields. I cannot see how it would not be a priority. Along with the former Minister for Mental Health, some years ago I stood on a patch of ground at the facility it was going to be on.

Ms A.R. MITCHELL: The member was referring to a separate document from the budget papers, but I am happy to respond.

The CHAIRMAN: I was listening for the question, member. You made a statement but I do not think you asked a question.

Dr G.G. JACOBS: It is a follow-up to the substantive question I asked previously.

The CHAIRMAN: Thank you, member. I just wanted to make sure.

Ms A.R. MITCHELL: I am just clarifying for the Chairman, who may not have been aware of the documentation.

Dr G.G. JACOBS: He is a very astute man; he would know.

Ms A.R. MITCHELL: The question the member asked also had a time line in it—it says by 2025. It is certainly not our intention to wait until 2025. The commissioner has indicated how decisions are made, making sure we get them up quickly, and that other services are available to people in the goldfields to improve their situation. We will be doing that and, as I said, monitoring the situation very, very closely.

Mr R.H. COOK: My question relates to the heading "Western Australian Meth Strategy" on page 852, particularly the $14.9 million over two years, including the 60 additional beds that were announced in May. I note the commissioner's earlier response that the $14.9 million is entirely new money. Are these completely new beds, adding to the total number of mental health and detox beds, or are these a mixture of some new beds with allocation to some beds that are currently in existence but not being staffed? If they are all completely new and additional beds, can the minister give us a breakdown of where the bed numbers will be allocated around that $14.9 million? The key question is: is the minister substituting current beds utilising this new money?

Ms A.R. MITCHELL: The member has gone into a couple of areas. There are currently 365 beds in the system. These 60 extra beds amount to a 20 per cent increase. There is a service being provided—community treatment and acute. Some have been identified but there are some that are still being worked through because obviously the announcement was not finalised at the time. I will ask the commissioner, if he can, to indicate where he is sure the commission can put the beds and the areas in which that has still not been determined.

Mr T. Marney: I think the member's question is about beds that physically exist at the moment but are not operational.

Mr R.H. COOK: That is part of it. I am aware, for instance, that six beds at Fiona Stanley Hospital are not operational. Is the idea to now activate those beds, or are we talking about entirely additional new beds?

Mr T. Marney: I will have to split apart bits of the question. The six beds at Fiona Stanley Hospital are the unopened youth beds. They are mental health beds, not drug and alcohol beds. They are not part of the methamphetamine strategy. To answer what will no doubt be a supplementary question: the purchasing framework that the commission is implementing for 2016–17 will allow for the opening of those six additional youth beds. That is that kind of side question. In terms of the rehab and detox, and withdrawal beds associated with the methamphetamine initiative, there are a range of service providers, predominantly non-government service providers, that we draw upon to provide 356 beds at the moment across the state.

Ms A.R. MITCHELL: I think I said 365; it is 356.

Mr R.H. COOK: It is 356; okay.

Ms A.R. MITCHELL: I got my fives and sixes around the wrong way.

Mr T. Marney: It is almost one a day! Part of the implementation of that initiative will be basically a competitive tender process to identify who has the capacity to provide additional services from their existing facilities across the state, with a view to using the 10-year plan to guide the distribution of beds across the state. The plan identifies some particular priorities in the south west, but in terms of a bed in the system that is providing service to individuals, they will be all new services added to across the state.

Mr R.H. COOK: The minister mentioned that the commission has identified some areas where it wants to see these beds commissioned. The commissioner mentioned the south west. Does the commissioner have an idea at this point, in relation to the 60 beds—there are 52 rehab and eight detox beds in that mix—of the regional allocation around those, or is it still early days?

Mr T. Marney: At this stage it is envisaged that 32 beds will be located in regional WA. That will include four detox beds in regional WA. At this stage the commission envisages that the other four detox beds will be in the northern corridor of the metropolitan area. The remaining rehab beds will be spread across the metropolitan area, so 20 across metro.

[9.50 am]

Mr R.S. LOVE: I refer to "Spending Changes" on page 850 of the budget papers. The mental health court diversion program has been allocated over $3 million in each of 2016-17, 2017–18 and 2018–19. Could the minister provide some information about the mental health court diversion program and the allocation?

Ms A.R. MITCHELL: I must admit that I was unaware of how powerful and successful this program is. I was very pleased that we could make those allocations for the next three years. It shows our support for people who are often not totally caught up in addiction, mental health issues and things, and we can give them a chance to get out of it. This is a voluntary treatment program that can, depending on the length of time before these people need to appear in court, make a significant change to their mental and physical health, and the treatment program may be taken into consideration at their court appearance. They still have to go through the court process—they do not get out of that—but that treatment program and their successful participation in it will be considered. At the same time, if they choose to opt out during the treatment program, they can. Once again, the numbers surprised me. I think 898 children and 934 adults went through last year, because the two courts have two different programs. Those numbers show that it is well worthwhile.

Mr R.S. LOVE: I have a supplementary question. Is this program provided in rural and regional areas of the state, or is it strictly limited to the metropolitan area?

Ms A.R. MITCHELL: Member, at the moment it is in the metropolitan area only. We would like to see that considered further out, but it would have to be done in conjunction with the legal profession and service providers. At the moment we have a service provider that supports the treatment program in the court system. A couple of factors would need to be taken into consideration, but if there is a need, we would certainly want to see how we could do that.

Mr D.J. KELLY: I refer to "Agency Expenditure Review" on page 852 of the budget papers. It was determined after the midyear review that the Mental Health Commission would have to make savings of $28.5 million between the 2016-17 and 2019–20 financial years. How will these savings be made, and will any of the savings be made from the hospital bed–based services or community bed–based services, community treatment or community support? Where will the savings come from?

Ms A.R. MITCHELL: Because that is quite an operational question that is right across how we are going to make those changes, I will ask the commissioner to respond.

Mr T. Marney: The bulk of the savings will be made through Mental Health Commission internal savings, and grants and subsidies. They will not impact on community support in that regard. None of the savings will be made through hospital-based services—either bed-based or community treatment services. They were, if you like, ring-fenced from that process. In terms of the savings overall, the bulk of the savings will be achieved through the removal of funds that have been unallocated within the commission. Those funds had an intended purpose at a point in time, but they have not yet been committed to a particular program or service, particularly in the non-government space. Only a handful of services will be directly impacted, and they are in the non-government organisations. It will be a limited number of contracts that I have examples of. The Mental Illness Fellowship of Western Australia physical health grant will no longer be provided. At a point in time that grant was relevant. We now have different requirements around physical health for the treatment of people with mental health issues across our services, so we do not really need to supplement with another standalone service on top of that.

Mr D.J. KELLY: How much of the $28.5 million in savings will be made by reducing the grants to non-government organisations, and which organisations will they be?

Ms A.R. MITCHELL: I will ask the commissioner to continue his response.

Mr T. Marney: In terms of active contracts that will not be renewed, the total saving from that over four years will be $1.9 million out of the $28 million. It is a fairly small percentage.

Mr D.J. KELLY: How will the other $26 million or $25 million-and-something be made up?

Ms A.R. MITCHELL: I will ask the commissioner to continue.

Mr T. Marney: I could go through the list of contracts and initiatives impacted, but if the member is —

Mr D.J. KELLY: Would the commissioner like to provide it by way of further information?

Mr T. Marney: I am happy to provide a list by supplementary information, yes.

Mr D.J. KELLY: Will that list total $28.5 million?

The CHAIRMAN: What are you going to provide, minister?

Ms A.R. MITCHELL: I am going to provide a list of organisations that will have their grant reduced or ceased.

[*Supplementary Information No A61.*]

Mr D.J. KELLY: I have a further question. In the earlier part of his answer the commissioner said that some of that $28.5 million would be achieved through money that had previously been allocated for another purpose but was not yet spent. How much of the $28.5 million falls into that category, and for which purposes was that money previously allocated?

Ms A.R. MITCHELL: Once again, I ask the commissioner to continue his response.

Mr T. Marney: I will give some examples, and then —

Mr D.J. KELLY: Can the commissioner give us the global figure first, and then maybe break it down?

Mr T. Marney: Out of the total unallocated moneys or expiring grant agreements, which are, by definition, not intended to roll over, the total saving over the four years will be $5.4 million.

Mr D.J. KELLY: Was the commissioner going to tell us which ones they are?

Mr T. Marney: I can give some examples, and then put a supplementary question proposal back to the member.

Mr D.J. KELLY: If the commissioner is happy to give them all by supplementary, I am happy to accept that.

The CHAIRMAN: Are you happy to provide supplementary information on that?

Ms A.R. MITCHELL: Yes, we are happy to do that.

The CHAIRMAN: Can you confirm what you are going to provide?

Mr T. Marney: We will provide a breakdown of all areas of savings associated with the $28 million AER initiative by area, grants and subsidies, Mental Health Commission own savings, and savings from services and contracts; and also identify the areas that were either due to expire and not renewed in any case, or those areas in which the moneys were yet to be allocated.

Mr D.J. KELLY: I am happy with that.

[*Supplementary Information No A62.*]

Dr A.D. BUTI: On page 856 of the budget papers, I refer the minister to the line item "Average Cost per Purchased Bed-day in Hospital in the Home Mental Health Units" under "Hospital Bed Based Services". For 2015-16 the budget was $1 001 and the estimated actual cost was $1 381, and the 2016–17 budget target is $1 393. Three lines above it is stated that for 2015–16, the estimated actual for the average cost for a bed day in a subacute specialised mental health unit was $1 352, and the budget target is $1 383. Why is the Hospital in the Home service much more expensive to deliver than the subacute specialised mental health service? Why does the delivery of this service appear to be so over-budget?

[10.00 am]

Ms A.R. MITCHELL: While that response is coming, we believe that it is very important to have the Hospital in the Home as a critical part of that transition. The support systems that may be required are not necessarily in-house all the time, but there is a genuine commitment to get the best treatment possible for people. Sometimes that may be a bit more expensive than the cheapest treatment. It is critical we look at all these options. Moving people to a situation that will help in the transition back to quality, normal living in their environment is far more important. I will ask the commissioner to give the details on the financials.

Mr T. Marney: Essentially, the difference relates to the degree of acuity. Hospital in the Home beds are an acute setting and, therefore, more akin to an acute inpatient setting and associated cost profile. The others are subacute and, therefore, a less intensive model of care. An additional factor is at play; that is, the Hospital in the Home model of service for that program is fairly new in Western Australia—new in that also it is being expanded. Models of service like that tend to take a few years to bed down to strike the right balance in intensity of support. Clearly, with Hospital in the Home, initially the risk-management focus is very conservative until there is demonstrated evidence of the service risk profile and the care needs, especially given we are dealing with acute-care needs, but in a community setting for someone. There is a little bit of learn as we go and probably overdoing it a little initially—hence the cost profile—and then there is the difference between acute and subacute need.

Dr A.D. BUTI: How many Hospital in the Home beds were opened in 2015–16? In June 2014, the then minister said that the Hospital in the Home program would be implemented progressively to a total of 24 beds. I am wondering how many beds were opened in 2015–16 and how many Hospital in the Home beds were funded in 2016–17?

Ms A.R. MITCHELL: The member is seeking the number of beds opened and how many were funded.

Dr A.D. BUTI: How many were opened in 2015–16 and how many were funded in 2016–17?

Mr T. Marney: In 2015–16, there were 16 Hospital in the Home beds associated with Graylands, a further eight associated with Selby and 18 associated with Sir Charles Gairdner Mental Health Service.

Dr A.D. BUTI: How many were opened in 2015–16?

Mr T. Marney: Yes.

Dr A.D. BUTI: How many funded for 2016–17?

Mr T. Marney: All those Hospital in the Home beds continue through 2016–17, so they are all funded.

Dr A.D. BUTI: How many of those Hospital in the Home beds are dedicated to youth between the ages of 16 and 24?

Mr T. Marney: None of those beds are dedicated to youth at the moment.

Dr A.D. BUTI: In 2014, the then minister said in her statement that eight Hospital in the Home beds would be dedicated to youth between the ages of 16 and 24. That has not been achieved.

Ms A.R. MITCHELL: We are happy to answer that but we are making sure the most appropriate people get that service. The commissioner may have more specific information.

Mr T. Marney: As we discussed before, it is certainly the intention to expand that specific youth model of service into the Hospital in the Home service. As the Hospital in the Home service has been rolled out, essentially, at an operational level, it has been decided not to, if you like, compound the challenge by implementing two changes to the model of service at once. Operationally, the service has chosen to implement adult Hospital in the Home. Once that model of service is bedded down and comfortable operationally and in terms of its risk profile, we will extend it at an operational level through to youth Hospital in the Home service.

Dr A.D. BUTI: Therefore, at the moment the minister's statement in Parliament has not been followed through. The minister might take that as a comment. Youth relates to a follow-up because the dedicated Hospital in the Home for youth beds are not there. Regarding youth admissions to hospital, it appears from notice from last year, as the minister stated, the number of separations from an adult mental health inpatient service where the patient was younger than 18 at the time of admission, has risen from 41 separations in 2011–12 to 191 in 2014–15, an increase of 366 per cent. Can the minister provide the number of children separated from an adult inpatient mental health facility or ward from 2015–16 to date?

Ms A.R. MITCHELL: I will have to provide that as supplementary information.

The CHAIRMAN: Are you happy to provide that. Please restate that for the *Hansard* record and I will give it a number.

Dr A.D. BUTI: The minister will provide the number of children separating from an adult inpatient mental health facility or ward from 2015–16 to date.

[*Supplementary Information No A63.*]

Dr A.D. BUTI: Regarding the hospital bed-based services, the estimated actual full-time equivalent staff budgeted for 2014–15 is 95; for 2015–16, it is 88; and the 2015–16 estimated actual is 104 but the budget target is 98. There appears to be a reduction in employee numbers. Is that true and, if so, why?

Mr T. Marney: Did you say that the number is moving from 95 to the budgeted 88, to an estimated 104 and back down to 98?

Dr A.D. BUTI: Yes.

Mr T. Marney: They are our internal Mental Health Commission FTE staff. They are not direct consumer-facing FTE. It is a mixture of our policy and planning people, performance evaluation and so on. Essentially, that is in line, in some respects, with the level of activity through 2015–16 associated with the mental health services plan and the implementation thereof associated with business case development and submission to government. As I am sure the member will appreciate, between the finalisation of the 10-year plan and the budget process, we had to get our rollerskates on to get those business cases through. Post that we are back down to what is more, I guess, a steady state staffing level. We will have been able to review our functions and will rely predominantly on attrition to come back to more of a steady state staffing level.

[10.10 am]

Ms E. EVANGEL: I refer to page 854 of budget paper No 2 and the table under the heading "Outcomes and Key Effectiveness Indicators". Can the minister please provide some more information relating to the correct take-up measures for alcohol and other drug campaigns amongst target populations?

Ms A.R. MITCHELL: This is an area that I think is very, very exciting and important because the Alcohol.Think Again campaign has been going on for quite a long time. A lot of evaluation has been done on the effectiveness of that program and the outcomes have been very promising. The most recent research shows that fewer 12 to 17-year-olds drank alcohol in 2014 than they did in 2011; fewer young people are consuming alcohol at high risk levels; and young people are delaying taking up alcohol. There has been quite a steady improvement in that there have been reductions in the take-up of alcohol, the amount of alcohol that people are drinking, and the frequency with which people drink. It has also been interesting to note that parents have responded that they now understand more about the harm alcohol can do to their children and that they should not be providing alcohol to young people under the age of 18. Additionally, secondary supply laws have come in and have given parents greater confidence in saying that they are not going to provide alcohol. Apart from the legal aspect, they have a lot more confidence about that rather than being talked into it because everyone else—such as their children's friends' parents—is doing it. It has been quite a comprehensive approach; we are seeing results, and we will continue very hard with that approach. We also have telephone support lines for both young people and parents. People have different questions and they need to be able to find out where they can go to get treatment and what sort of treatment might be required, so it is a very comprehensive approach and one that is working, and we will continue to focus on it.

Mr R.H. COOK: I refer to page 851 of budget paper No 2 and the third dot point from the top of the page in which reference is made to 136 new and replacement mental health inpatient beds. I have a series of questions, but my obsession here is around eating disorders. My first questions are: how many of the 136 beds are reallocated mental health beds as opposed to completely new and additional beds that increase our capacity? Will any of those 136 beds be dedicated inpatient beds for adults with eating disorders, given that Western Australia is the only state in Australia without dedicated public inpatient beds for adults with eating disorders? To provide some background to these questions, in March 2015 I was told that the business case for the unit—which was to be based at Sir Charles Gairdner Hospital—was close to being finalised. During last year's budget estimates hearings, I was told that the business case was still being finalised, and in October last year I was told that the business case was still yet to be finalised. There is an extraordinary fudging of what is, I believe, an essential mental health service in Western Australia. First of all, with respect to those beds, are they new beds or reallocated mental health beds; and where are we at with an inpatient adult eating disorders service?

Ms A.R. MITCHELL: I know this sounds difficult, but at this time we cannot give the member a dedicated time line on that. The work is being done; I am just getting a bit more information as well, but there is not a dedicated time line on that at this point, although it is recognised that there is a significant part to play in that sphere. Even though it is not heard about quite as much as it used to be, it certainly still exists as a mental health issue. Back in March I attended a conference in Fremantle for a number of people, including carers and clinicians. Sitting there and listening to what the situation is, how they fare, and how they relate with each other in their own peer support networks was very, very interesting. I will ask the commissioner whether he has any further information on that.

Mr T. Marney: We will very soon see the establishment of an eating disorders community treatment service, an outpatient treatment service in an adult setting, which we do not have at the moment. With regard to the inpatient setting, one of the reasons it has been difficult to establish a dedicated unit is probably due to some clinical issues and model-of-service issues. Certainly, from the commission's perspective, we are very keen to see a dedicated inpatient eating disorders unit. That is being worked through with the North Metropolitan Health Service, but at the moment, in many cases of people suffering from eating disorders who need inpatient care, their care requirement is actually predominantly physical care rather than mental health care. The mental health services are provided as in-reach into general wards where people are treated because of the severity of the physical health consequences of their eating disorder illness. We are continuing to work through that clinical model of service issue, but it certainly remains a priority to ensure that that service is being met, whether it is in a standalone inpatient setting or through consultation and liaison services into general wards by eating disorder specialists.

That is probably testing the extent of my clinical expertise; if we are forced to rely on that, we are all cactus! But I would be happy to provide an update on that clinical dimension if that would assist. It is still very high on the radar.

Mr R.H. COOK: Just to clarify, I am at the right shop, am I not? It is the Mental Health Commission that I ask this question of? I have asked the Minister for Health and previous Ministers for Mental Health, and I have never been given a straight answer around the preparation of the business case, so first of all, apologies if this is the wrong place to raise my inquiry, but this has been fudged for a while. My understanding was that we were looking at an approximately four-bed unit inside Charlies; in terms of the model of care, it was going to be a unit inside the tertiary hospital because there is a recognition that there is a very big physical dimension to the treatment that people would receive. I have been the shadow Minister for Health for nearly eight years now, and this was one of the early issues I bumped into in my time in politics. It is beyond me why this is taking so long. Can the minister confirm that what we are looking at is an approximately four-bed unit in Charlies; and can the minister please give me an update as to where the business case is at?

Ms A.R. MITCHELL: I will ask the commissioner to respond to that specific question.

Mr T. Marney: To be quite honest, I could make something up and the fudge would continue, so what I would rather do is take that question as supplementary information and actually consult with the North Metropolitan Health Service to get an accurate assessment from a clinical perspective of the current view of the preferred model of service. I will provide that as supplementary information, along with the status of the business case.

The CHAIRMAN: Are you happy with that, minister?

Ms A.R. MITCHELL: Yes.

The CHAIRMAN: If you could just clarify for the record what will be provided, we will give it a number.

[10.20 am]

Ms A.R. MITCHELL: We will be providing information on the status of the business case and the current view of the preferred model of service for an in-bed inpatient facility at—is that at Sir Charles Gairdner, or anywhere?

Mr R.H. COOK: I will have it anywhere! Can the minister also provide the anticipated time line for the introduction of that service?

Ms A.R. MITCHELL: We will provide the time line as well. The member is right; because it involves both Health and Mental Health, it does get quite confusing.

[*Supplementary Information No A64.*]

Mr R.H. COOK: I appreciate the government's policies around splitting mental health services from health services. As the member for Eyre will attest, ever since I have been in Parliament I have had a frustration about whether we should ask these questions of the Minister for Health or the Minister for Mental Health. It is very difficult to get a straight answer out of you guys at times—it really is.

Ms A.R. MITCHELL: Chair, can I clarify with members opposite, we have a number of portfolios to get through and we have just spent one and a half hours on one portfolio. If there are only a few more questions, that is okay.

The CHAIRMAN: The member for Bassendean.

Mr D.J. KELLY: I refer to the outcomes and key effectiveness indicators at page 854, and in particular the outcome "Accessible, high quality and appropriate mental health and alcohol and other drug treatments and supports". In the 2015–16 budget, a target of less than 12 per cent was set for readmissions to hospital within 28 days of discharge from acute specialised mental health units. In the 2014–15 budget, the actual was 13.6 per cent, and in the 2015–16 budget the estimated actual was 17.1 per cent. Is the reason that figure is so

high the lack of community-based treatment and support services; and, if not, what is the reason for that high figure?

Ms A.R. MITCHELL: I will ask the commissioner to respond.

Mr T. Marney: One of the intentions of the step-up, step-down facilities in particular is to help people transition to the community in a sustained way post-discharge and thereby help avoid unnecessary readmissions within that 28-day horizon. We are very much looking forward to the Rockingham facility coming into operation, as well as the commitment to implement new services in Bunbury, Karratha and Broome. That will, hopefully, assist in that readmission performance. A couple of system developments have also impacted on that figure. As the member may be aware, the service at Fiona Stanley Hospital is a short-assessment mental health service; it is not a longer-stay service. If a person is discharged from that shorter service but then readmitted almost immediately to Charlies or somewhere else for a longer term stay, that can technically throw up some data aberration. Similarly, the mental health observation area, which is a very short stay admission, may be followed by a longer-period readmission somewhere else. Therefore, some technical data issues are associated with those new models of service that have come into place. To be honest, we need to understand not only the data issue, but also the service quality outcome for the individual over time that is associated with those shorter lengths of stay. A similar data issue is associated with people who are discharged from an inpatient facility and potentially readmitted to a Hospital in the Home setting. Those admissions and technical issues across different classes of service are causing some distortion to the data. However, in broad terms, if we were meeting a higher level of need in community support and community bed treatment, we would hope that the readmission rates would come down, and that will certainly be a key objective of those services as we implement the 10-year plan going forward.

Dr A.D. BUTI: I refer to page 856 of budget paper No 2 and to the following statement under the heading "Hospital Bed Based services" —

> Hospital based service include acute and sub-acute inpatient units, mental health observation areas and hospital in the home.

On how many occasions in 2015–16 did Armadale hospital need to lock the doors of the open wards because of the overflow of involuntary mental health patients from secure wards?

Ms A.R. MITCHELL: We do not have that information but we can provide it by way of supplementary.

[*Supplementary Information No A65.*]

Dr A.D. BUTI: On how many occasions in 2015–16 did public hospitals need to lock the doors of the open wards because of the overflow of involuntary mental health patients from secure wards?

Ms A.R. MITCHELL: We will provide that by way of supplementary information as well.

[*Supplementary Information No A66.*]

Dr G.G. JACOBS: I refer to page 852. Some questions have been asked previously about the Western Australian meth strategy. The funding for that strategy is $14.9 million over two years. Can the minister provide the specific funding for each of the items listed on page 852—the expansion of existing alcohol and other drug community-based treatment services, the clinical liaison nurse positions, and the community-based low medical withdrawal and residential rehabilitation beds, and the other items on that page?

Ms A.R. MITCHELL: The member would be aware that because that announcement was made only recently, some of that detail has not been set out yet. As the commissioner indicated previously, there is a competitive tendering process in some areas. However, where we can make a response, we are happy to do so. I will ask the commissioner to elaborate.

Mr T. Marney: I will run through the various items within the strategy that fall under the accountability of the Mental Health Commission. The first item is to provide targeted early intervention and harm reduction strategies, information and support for families and local communities. That, essentially, is a continuation of the Drug Aware methamphetamine campaign. That is a component of the initiative, but it is not funded with new money; we already have money for that. The second item is to expand the public education campaigns. The funding for that initiative is $540 000.

Dr G.G. JACOBS: Is that new money?

Mr T. Marney: Yes. That will specifically target 17 to 20-year-olds, in order to achieve optimal program reach. It is worth us all remembering that with both that campaign and the Drug Aware campaign, broad-based, population-wide campaigns run the risk of normalising drug use of any form. Therefore, our campaigns are targeted, through social media mechanisms, at people who are at risk. That means that most of us will not actually see evidence of those campaigns ourselves because the campaigns are very much targeted towards those

who are either using or at risk of using. There will be an expansion of school-based programs; that is a further $500 000. There will be a continuation of harm reduction resources for at-risk groups and communities—that is not new money; the commission will do that within existing resources. There will be information, education, support, harm reduction and referral through peer support workers targeting at-risk young people in high-risk settings; that is a further $400 000. There will be an expansion of the overdose prevention and management program peer work, which will continue within existing resources. The community treatment specialist methamphetamine clinic within existing alcohol and other drug services will receive a further $530 000. That will be centrally based at the Mental Health Commission's Next Step Drug and Alcohol Services in East Perth. There will be an expansion of specialist methamphetamine community-based prevention and treatment services to provide an additional 13 full-time equivalents through the existing statewide network of community alcohol and drug services and drug and alcohol youth services—that will be $3.7 million over the period. In terms of community-based beds, there will be an expansion of existing low medical withdrawal beds at a cost of $1.5 million and an expansion of existing residential rehabilitation services at a cost of $4.62 million. In terms of hospital-based beds, there will be an expansion of clinical nurse liaison positions in tertiary hospitals to provide timely review for people presenting with AOD-related problems. That has funding of $2.28 million. Then there will be workforce development to provide training and support for AOD workers to build their confidence in working with high-risk methamphetamine users and a capacity to provide longer term treatment and support, which is a further $160 000. The telephone support line for specialist information and referral will receive $304 000. A range of other initiatives are also being pursued within existing resources, such as the development of compulsory treatment options for consideration by government and, of course, communication of all these initiatives and where people can get help. We will build into the budget for the overall strategy, funded from existing resources, the development and implementation of a comprehensive evaluation of the program to see whether it is actually achieving its intended objective.

[10.30 am]

Dr G.G. JACOBS: In relation to the community-based low medical withdrawal and residential rehab beds, there was a global figure for the state of, I think, 60 beds—that number is in my head—and then there was a distribution of those for the metropolitan area and regionally. Is there any indication of where those beds will go, particularly in relation to the regions?

Ms A.R. MITCHELL: I think we gave that information just before, but we are happy to provide it again.

Dr G.G. JACOBS: I must have missed it; I must have been asleep. Sorry. I am obviously particularly interested in where the beds will go as far as the regions are concerned and which centres they will be based in. I am particularly interested in the goldfields–Esperance region.

Ms A.R. MITCHELL: I absolutely understand that member.

Dr G.G. JACOBS: Can that information be provided for me?

Ms A.R. MITCHELL: Yes, we are happy to do that. Commissioner?

Mr T. Marney: Out of the total 60 beds—the member was correct; there are 60—eight will be low medical withdrawal detox beds and 52 will be residential rehab beds. Four of the withdrawal beds will be in regional areas, but it is yet to be determined where they will be located. Thirty-two of the residential rehab beds will be in regional areas and the distribution of those will be guided by two things; firstly, the modelling in the 10-year plan and where the identified need is as a result of that modelling, and, secondly, the capacity of the sector to provide those services. In part it will be driven through the response to the procurement process for those additional beds, but with significant consideration given to where the identified need is in the population of regional areas. Given the pragmatics of getting these things up and running and expanding them, in part it is going to be driven by the preparedness of existing service providers.

Dr G.G. JACOBS: So as far as a region is concerned, who puts the order in? Can we put our order in? The commissioner referred to the "Better Choices. Better Lives" document that goes to 2025. Obviously the commission will be guided by that, but it will also be guided by the fact that there is perhaps a role for the community to say, "We will help you on how this has got to look and these are the services we can wrap around this to actually make it work."

Ms A.R. MITCHELL: I pass to the commissioner to respond on how that process works.

Dr G.G. JACOBS: Can the community have input into that?

Mr T. Marney: That process will include consultation with the community and certainly with our community alcohol and drug services, which have a network across the state, to get their view. We will also get input from our potential client base for those services and of their families and significant others as to where those concerns

are. So there will be a consultation process around that, bearing in mind that government's clear expectation is that the commission responds fairly rapidly around this to address what is clearly a clear community desire and need. In terms of the political process as to how the community puts its bids in, I will hold off from answering that one and will leave that to others.

The CHAIRMAN: Any further questions?

Dr A.D. BUTI: One answer was going to be provided to me on the allocation of money.

Ms A.R. MITCHELL: Yes, we were, too.

Dr A.D. BUTI: It was in relation to the youth treatment program.

Ms A.R. MITCHELL: We will have to provide it as supplementary information.

The CHAIRMAN: Minister, can you state exactly what will be provided?

Ms A.R. MITCHELL: I will see if the member can —

Dr A.D. BUTI: The supplementary question is in regard to the allocation of funding for the youth treatment —

Ms A.R. MITCHELL: It was the cash flow statement and where the $1.9 million was.

Dr A.D. BUTI: Yes, that $1.9 million that has been allocated. What are the details of that allocation?

Ms A.R. MITCHELL: We think we have found it.

The CHAIRMAN: So the commissioner can answer now?

Mr T. Marney: Yes.

The CHAIRMAN: Right; proceed.

Mr T. Marney: We have found that we cannot find it. It is actually buried in cash flow movements from year to year in the cash flow statement. The answer to the question is that $1.905 million has been transferred from 2015–16 into 2016–17. The remainder of the allocation was spent in 2015–16.

Dr A.D. BUTI: On what? What is the detail of what it was spent on?

Mr T. Marney: It was spent on the establishment of the youth community treatment service, both on the development of the model of service and then the recruitment of staff for the service.

The appropriation was recommended.