Division 22: Mental Health Commission, $721 015 000 —

Ms E.L. Hamilton, Chair.

Mr R.H. Cook, Minister for Mental Health.

Mr T. Marney, Mental Health Commissioner.

Mr L. Bechelli, Chief Finance Officer.

Ms E. Paterson, Assistant Commissioner, Purchasing, Performance and Service Development.

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

Mrs S. Jones, Assistant Commissioner, Alcohol, Other Drug and Prevention Services.

Mr N. Fergus, Chief of Staff, Minister for Mental Health.

[Witnesses introduced.]

The CHAIR: 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. Members should give these details in preface to their question. If a division or service is the responsibility of more than one minister, a minister shall be examined only in relation to their portfolio responsibilities.

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 he 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, 31 May 2019. 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 through the online questions system.

Do we have any questions?

Mr R.H. COOK: Madam Chair, if I may, with the opposition's agreement, I want to make a clarification to the budget, which may or may not impact on the number of questions asked. I refer to page 293 in budget paper No 2, volume 1. There was a clerical error in the "Spending Changes" table relating to the step-up, step-down mental health services at Broome, Bunbury and Karratha. The spending changes presented as occurring in 2019–20 and 2020–21 actually occur in 2018–19 and 2019–20 for the same amounts. In effect, those figures should be moved one column to the left in the spending changes to present the correct position. Just for members' information, if we take those numbers, which are about halfway down that table, and slip them over to the next left column, that provides the actual accurate situation. Apologies for that error.

The CHAIR: Thank you. I give the call to the member for Churchlands.

Mr S.K. L'ESTRANGE: I refer to page 292 of budget paper No 2, volume 1. Why did the Mental Health Commission underspend its budget in 2018–19 by $9.175 million?

Mr R.H. COOK: I thank the member for the question. Obviously, a lot of the expenditure or the contracting which the Mental Health Commission undertakes is with not-for-profit organisations or non-government organisations. Often, these contracts are subject to negotiation. That sometimes impacts upon the start of those contracts, and there is often a lag in terms of when we anticipate those contracts will come to life and when they actually do come to life. Sometimes we can have underexpenditure around some of those programs. I will ask the Mental Health Commissioner to make some clarifying comments.

Mr T. Marney: Thank you. There are three main areas of underspend for the commission in 2018–19 expected in health services purchasing—that is, where we sought to purchase a particular service, but have not been able to establish that service within the year. That goes particularly to issues around youth forensic services. We have been engaged in discussions and negotiations with health service providers throughout this year in an attempt to increase the level of service provided for severe and persistent mental illness among young people who are in contact with the justice system. Obviously, that is a complex service, which requires fairly niche infrastructure. We have not been able to identify the infrastructure, but we continue to work with health service providers to identify a suitable location and, indeed, a suitable service model. That is one element.

The second main element, which is not unusual, is the independent community living strategy, which is a community-based support program for individuals that provides both accommodation and support for those

individuals. The support is in three tiers in terms of need—high, medium and low. What we have sometimes found in that program is that over time, with successful support and the stability of accommodation provided for those individuals, their needs improve; in fact, quite positively, they recover. Their support needs decline throughout the year, and some even exit the program. That means we have savings from that program throughout the year. We then have an assessment and prioritisation process through clinical services, which results in a lag in people coming into the program, or, indeed, topping up supports for other people. That is an area of underspend and an area that we are focusing on fairly heavily in terms of better understanding that throughput, how that interacts, and how we can maximise the benefits of that for individuals. I think, in all, it is actually a good news story, because it shows that individuals are recovering more quickly than we had budgeted for, so that is quite a positive.

Those are probably the two main areas of underspend. As the minister said, there are also a number of programs which were procured during the course of the year that involve a ramp-up to commencement of service. A major example is the residential rehabilitation beds in the state's south west that we have procured throughout this year. A tranche of 19 of those beds opened in January; another tranche will open at the end of June. The delays to the start-up of those has led to some underexpenditure in that area.

[Ms J.M. Freeman took the chair.]

Mr S.K. L'ESTRANGE: What percentage of the $9.175 million underspend represents those projects that have not come on in the time frame expected, and what percentage represents unallocated funds of programs?

Mr R.H. COOK: Is the member referring to a particular line? I see that total cost of services is still sitting around the $918 million mark in 2018–19 and in the estimated actual.

Mr S.K. L'ESTRANGE: No, I am looking at the total appropriations provided to deliver services. The 2018–19 budgeted amount is $707.456 million; the estimated actual is $698.281 million.

Mr R.H. COOK: Total appropriations does not necessarily reflect moneys expended. If I may refer the member to page 297, which gives a breakdown of the service summaries, we see there that hospital-based services is still sitting at around $392 million or $393 million. To answer your question and to be specific, your reference to it is correct: under community bed–based services and community treatment, there is some underspend. That is associated with those contract lags that I was referring to.

[9.10 am]

Mr S.K. L'ESTRANGE: I will accept that they are contract lags. Many community-based service providers support people with mental health issues. One in my electorate, the Lorikeet Centre, does amazing work. When I visit those types of centres, I see that they could always do with more money to improve their programs and support the people to keep them off the streets and engaged in a community atmosphere. I hope that we are not underspending in areas that could support those types of organisations.

The CHAIR: What is the question?

Mr S.K. L'ESTRANGE: Can the minister assure us that that is the case?

Mr R.H. COOK: I am sure, but I will ask the commissioner to make some further remarks.

Mr T. Marney: When we have contracts in place with the likes of the Lorikeet Centre, all moneys are expended as per their agreed contractual schedules. When existing contracts are in place, it is only when service providers cannot provide the service any longer. There was such a provider during 2018–19 with residential rehab beds. There were 14 beds, for example, but the service provider chose no longer to honour the contract and walked away. If we have a contract in place, we honour that contract, so long as performance is satisfactory, and we pay the full amount in accordance with the terms of the contract.

Mr Z.R.F. KIRKUP: I refer to "Methamphetamine Action Plan—Community Treatment Facilities" under "Ongoing Initiatives" in the table on page 293. I note in the 2018–19 budget, circa $1.457 million was dedicated to that initiative in 2018–19 and then there was some money in the out years. That does not look as though it has been spent. It has been pushed to 2021–22 onwards. I am keen to understand why no money was spent in 2018–19, it has not been budgeted for this financial year and it will not be expended until 2021–22, when previous budgets have committed it to previous years.

Mr R.H. COOK: The methamphetamine action plan recurrent funding for an additional 13 workers in community alcohol and drug services—CADS—community treatment facilities was due to cease on 30 June 2021. However, as part of the 2019–20 budget process, government has approved a further $3.184 million, $1.572 million in 2021–22 and $1.6 million in 2022–23 to provide ongoing recurrent funding. I think that it is essentially to provide continuity of funding for those services. The current allocation is approved through to June 2021. To make sure that I am on the money, I will refer momentarily to the commissioner.

Mr T. Marney: That is correct.

Mr Z.R.F. KIRKUP: To clarify, minister, the money that was previously allocated in last year's budget for 2018–19 and 2019–20 was $1.457 million and $1.494 million. Has that been spent or was that not spent at all?

Mr R.H. COOK: I will ask the commissioner or Liz to cover that one.

Mr T. Marney: That is the money associated with the south west residential rehab beds that I mentioned earlier. We went through a procurement process. The budget allocation allowed for the commencement of services from January for all 33 beds. During the procurement process, we managed to get 19 beds up and running in January. The remaining beds will come on at the end of June. We always thought it would be a possibility in a six-month window given that the service providers needed to find a location to provide the service, get council approval and so on. Indeed, the service provider that commences at the end of June has had some difficulties in that space, but we have worked with it closely to come to an alternative arrangement and make sure those beds are up and running by the end of the month. As at 30 June, we will have added 34 new beds to the residential rehab and detox service offering in the south west.

Mr V.A. CATANIA: I refer to "Continuation of the North West Drug and Alcohol Support Program" under the ongoing initiatives on page 293. I notice that in the 2019–20 budget year there are no funds, but there are funds in 2020–21 ongoing. Can the minister elaborate on the continuation of this service, and whether it refers to the Carnarvon drug and alcohol centre?

Mr R.H. COOK: The continuation of that funding was supported through the response to the Methamphetamine Action Plan Taskforce report. As part of the 2019–20 budget process, the government approved $4.82 million in 2019–20, $1.5 million in 2020–21, $1.5 million in 2021–22 and $1.5 million in 2022–23. That was to maintain continuity of funding for that program. It is funded for the 2019–20 year. It is already funded and it is, basically, to maintain that funding across the forward estimates.

Mr V.A. CATANIA: Is this for Carnarvon or statewide?

Mr R.H. COOK: The Carnarvon one would be included in the north west drug and alcohol initiative.

Mr V.A. CATANIA: Where is this money that was traditionally funded by RforR coming from? Is it out of the health budget or out of royalties for regions?

Mr R.H. COOK: My understanding is that it is still RforR. To clarify, it is from RforR and the sum is around $20.06 million over the forward estimates.

Mr V.A. CATANIA: Can the minister give us a breakdown of what part of the state those funds are in? Like I said, the Carnarvon drug and alcohol clinic is one. Could the minister perhaps give us a breakdown of all the others around the state?

Mr R.H. COOK: I am happy to provide that as supplementary information. The member has asked for a breakdown of the funding for the continuation of the north west drug and alcohol initiative and a breakdown across the regions or down to specific locations.

Mr V.A. CATANIA: I suppose where that money has been allocated.

[*Supplementary Information No A10*.]

Mr C.J. TALLENTIRE: My question refers to spending changes on page 292 and the dreadful problem of methamphetamine. We have touched on this issue and we know the harmful effects of meth on our communities, but I am keen to know more about what the government is intending to do to counter the impacts of this insidious drug.

Mr R.H. COOK: It is an important point. As members know, when we came to office, we launched the methamphetamine action plan. It is a comprehensive program to ensure that we have a suite of initiatives across the three themes associated with drug and alcohol services, which are to reduce supply, reduce demand and reduce harm. Specifically, we had a large commitment to establish a methamphetamine border force for policing. We have already seen the extraordinary seizures that have taken place as a result of the success of that program. Additionally, the idea is that we reduce demand by making sure that we have better education in our schools and better awareness across the community generally so that we can not only put downward pressure on the demand for drugs, but also make sure that people who come into harm's way by virtue of drug or alcohol addiction—specifically in this case methamphetamine—will be able to access services they need.

We had the methamphetamine task force look at what we are doing right across government and asked it to come up with a range of policy responses that we could respond to. As a result of the task force report, we have committed $244.8 million to address methamphetamine issues across WA and $202 million has been committed as part of the methamphetamine action plan. Specifically, as part of the 2019–20 budget, $40.5 million is being provided to the Mental Health Commission and $2 million to the Department of Health for the coordinated and integrated approach to address methamphetamine issues in WA. That includes planning for the expansion of the

mental health police co-response task force or the co-response teams. This fantastic program essentially embeds mental health workers in the police teams that go out to respond to clients who are impacted by methamphetamine or other drugs or mental health issues.

It has been a huge success. My local police station has recently been the beneficiary of the extension of this program, which is run out of the Cockburn station. The first day the station had the program, it received a call from the Alma Street mental health hospital that someone had absconded and asking the police to pick them up. Usually, the police would go and initiate their powers of arrest. That would chew up huge amounts of police resources, and bounce the person straight into a criminal-related response. In this particular instance, before the superintendent could issue the work order to go out and pick this chap up, a squad car with one of these mental health workers had driven past this chap walking on the street, and the worker said "Hang on, I know that guy. We'd better stop, because he should be in hospital at the moment." They went and met with him, got him in the back of the car and took him straight back to the hospital. It was a great outcome for him, and a terrific outcome for the police, because they then did not have to go and arrest the chap and go through the processes associated with that. It provides that nuanced response in these situations, which really improves the way we undertake those activities.

Other initiatives include the development of a specialist youth service, and low medical withdrawal beds in the Kimberley; developing a 10-bed crisis intervention centre in Midland; and the expansion of the transitional housing and support program, with 13 additional beds. The transitional housing and support program is about people who are coming out of drug and alcohol residential services. They go into a transitional service that gets them back on their feet and ready to go out. In addition, we have dedicated some money towards the examination of a compulsory treatment process, and we are looking at the response associated with similar services in New South Wales to see what the evaluation there is with a view to, if necessary, turning that 10-bed crisis intervention centre into a compulsory treatment centre.

[9.20 am]

Mr S.K. L'ESTRANGE: I refer to the service summary table on page 297 of volume 1 of the *Budget Statements*, in particular the first line item, "Prevention". Why is the prevention budget decreasing by 29 per cent between 2019–20 and 2022–23?

Mr R.H. COOK: It is a great question, and it is one that we spent some time on as the budget was crafted. Obviously, the member would agree with us all that prevention is better than cure, and we want to make sure that prevention remains an important part of what we do in mental health. One of the difficulties that we are confronting at the moment—they are not really difficulties—is that a lot of those prevention programs are subject to contracts and grants, and some of those had not been fully negotiated at the time that the budget was finalised, so we obviously could not assume them in the budget without finalising those contracts. I will ask the commissioner to provide more clarity around that.

Mr T. Marney: Probably the biggest component in amongst those contracts is revenue received by the commission to deliver services on behalf of other agencies, including the commonwealth. This includes some of our specific Aboriginal programs—the Strong Spirit, Strong Mind Metro program. That is also not included in the 2019–20 numbers, and my understanding is that the member's question relates to the decline from 2019–20 to 2020–21. Is that correct?

Mr S.K. L'ESTRANGE: Yes. From 2019–20 through to 2022–23, there is a 29 per cent reduction in the prevention budget.

Mr T. Marney: The major point of decline over that period relates to the Suicide Prevention 2020 strategy expiring. During the budget process, the government extended the initiatives under that strategy, with an additional $5.4 million in 2019–20 and an additional $2.7 million in 2020–21 to fund almost all of that initiative through to December 2020, at which point the existing strategy expires. There is a need to develop a new strategy to replace the existing one. The landscape in suicide prevention initiatives has changed substantially since Suicide Prevention 2020 was developed. That was back in 2014–15. The commonwealth, through the "Fifth National Mental Health and Suicide Prevention Plan", has set a new framework for suicide prevention nationally for both commonwealth and state services. There is a need to develop a new action plan to implement that framework. Action planning is going on at a national level, and we will dovetail at a state level with that planning to ensure that our initiatives tie in much more cohesively with initiatives at the commonwealth level. With that will come a funding request as part of the 2020–21 budget process next year, to fund that new action plan, which is likely to include elements of the existing strategy, but also likely to look different in some regards. Nonetheless, that planning work has to be done for a very different environment, and those budget considerations will be had as part of the next budget process.

Mr S.K. L'ESTRANGE: Given the "Western Australian Mental Health, Alcohol and other Drug Services Plan 2015–2025", and the 2018 plan update, set a clear target that the share of Mental Health Commission funding

committed to prevention should reach four per cent by 2020, why has funding not been allocated based on the existing 2018 update plan to ensure that the prevention budget is four per cent of the total Mental Health Commission budget, regardless of what is happening federally? We have a plan, and there was an update to the plan in June last year, but in actual fact, through the forward estimates, the proportion decreases and does not go anywhere near four per cent. It is 1.4 per cent this year, 1.2 per cent in 2020–21, and 0.9 per cent in 2021–22. Based on the plan update of 2018, it would be expected that the commission would have budgeted to try to achieve that target in its own plan, but that is clearly not happening here.

Mr R.H. COOK: The member is correct, that at the moment it does not show that increase across the forward estimates. I attended a federal suicide prevention forum in Broome just last month, and on that occasion it occurred to me that a lot of resources are now being dedicated at the federal level to this work. We need to take account of those resources and, rather than try to duplicate them, make sure that we integrate better with the federal government to ensure that we have a cohesive single approach to suicide prevention. That will obviously be the lion's share of it. We could allocate four per cent of the budget to prevention services, but without having that line of sight around that federal program, it does not mean a lot. The member is correct in saying that at the moment it does not reflect that aspiration around the four per cent. I will ask Mr Marney to make some further comments.

Mr T. Marney: The member's statement is absolutely correct, but it needs to be considered in the broader context that the plan itself, and the plan update, provide an overview of the optimal mix of services. Looking across all elements of the plan, we are not actually meeting 100 per cent of the target of any service mix, but the plan is there to try, over time, to give governments of all persuasions, and budget processes, the opportunity to balance the system in the way that governments feel most suits the community's needs. It is fair to say that we are not meeting that target yet. It would be unreasonable for the commission to defund acute, subacute or community-based support services to shift allocation to prevention when we are in a situation in which we are not meeting 100 per cent of those service needs either. People in distress and crisis need response, service and assistance now, which is the focus of the methamphetamine action plan. We need to maintain focus on those acute services and build the prevention spend over time, rather than shift allocation from within our existing envelope. The challenge of the plan is how to build and balance the system over time. It is a 10-year plan, but I think it is more like a 15-year to 20-year journey.

[9.30 am]

Mr Z.R.F. KIRKUP: The member for Churchlands has pointed out the decrease in funding for prevention. I note that the budget has no new initiatives to respond to the Aboriginal Kimberley crisis. Given the reduction in the spend and that the minister was up in the Kimberley last month, I am keen to understand what new initiatives the Mental Health Commission is looking at to tackle that issue. It is quite a concern if funding is decreasing and no new initiatives have been spelt out.

Mr R.H. COOK: The initial response to the State Coroner's report and the 2016 report "Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas" will be coming out immediately. Within that response is a range of initiatives that we are continuing to fund, such as the Aboriginal family wellbeing program, which I think has a $5 million funding envelope. We have purposely not tried to anticipate the response that the Aboriginal community would like to see without engaging with it across an extensive program of collaboration and co-design, and on the basis of that, getting an understanding of what the delivery models need to look like. The initial response will come out immediately, with the final response coming later in the year. We now need to go through an extensive process of conversation. I am determined to make sure that in our final response to the coroner's report and the message stick report we do not come up with the usual formula, which is for the government to say that it agrees with X number of recommendations and here are some programs that are vaguely related to those recommendations. We need to go to the next iteration of informed programs. Not only will these things be done in consultation with the community, but also they will be co-designed by the community and, by and large, the community will be responsible for their delivery. We know that if they are culturally secure and informed, they will therefore be more effective. Our initial response will come out today. It will point to the recommendations, which the government by and large endorses. Although it will present some programs that fit the bill, the government will start an intensive period of conversation with the community in the Kimberley to find out what the government needs to do, how the government is letting the community down, and how it can do a better job with the community in the future. One thing that occurred to me when I went to the Kimberley for an initial discussion with the community is that there is good infrastructure around that conversation that the federal government is already putting in place. Assuming Hon Ken Wyatt remains Minister for Indigenous Health, I would want to sit down with him and say, "We have lots of resources. You have lots of resources. How can we work together in a joint commissioning approach to make sure we do this stuff better?" It is ridiculous that we have individual programs. As the commissioner said, a bunch of work is being done at the national level on suicide prevention. We want to make sure that we are informed by that as well to ensure that there is a truly nationally driven regional response.

Mr Z.R.F. KIRKUP: I do not want to delay the member for Kalamunda's dorothy dixer. An extensive consultation process was put in place as part of the Kimberley wellbeing strategy. It was outlined initially and the stakeholders were all engaged in the development and implementation of that framework. Given that we often talk about the localised needs of communities in remote settings, how is it that the government's response is now to let those programs remain as they are and say that that framework will stay until we can come up with more consultation and more frameworks? The government has allocated no more money in the budget for it and a more extensive program is not being developed. The minister suggested that Canberra will have a greater role to play. Perhaps I am misreading the minister. The coroner's report was released three months and two weeks ago. It responded to critical issues from 2012 to 2016. Is the government just going to continue to point to an existing framework, which the minister says did not have enough consultation in place although it was clearly designed around local consultation? How is the minister comfortable in saying that the government will keep it there and take some time to develop new programs when it has not allocated any money for new programs?

Mr R.H. COOK: I will ask the commissioner to comment on resourcing shortly. The fact of the matter is that what has been done to date has not worked, which is why we continue to see suicide and mental health illness manifest itself in the Kimberley community. I think it is time that we stopped pretending we have all the answers and sit down with the community and co-design these things. As I mentioned earlier, we have funded the current suicide prevention action plan to the end of 2020 to make sure that programs that are currently in the system continue. But we need to recalibrate and redouble our efforts to make sure that we fund programs that are effective and switch the dial into the future. It would be misguided and foolish for the government to say that it has all the answers, because we would not be in this position if it did. Clearly, we do not. In the time that I have been in this portfolio, I have been struck that there is not a sense of helplessness in the Kimberley community. There is a sense of purpose. People in the community know what works and what they need to do to help heal a lot of trauma and hurt that is in the community, which has led to these dreadful statistics. We need to work with them to co-design and deliver those programs. We could have come out with a range of measures and said that we have responded to the problem and we would probably have got away with that, but I think that is the easy response. We need to undertake a step change in the way we respond to these things and ensure that the community is driving this stuff and that we are standing next to them, not leading them. I will ask the commissioner to comment on individual resourcing.

Mr T. Marney: Additional resourcing was allocated as part of the budget process for the extension of the suicide prevention strategy implementation. In particular, the Aboriginal family wellbeing project was allocated an additional $639 000 to be extended as part of that $5.4 million and $2.7 million. That program is not about —

Mr Z.R.F. KIRKUP: Is that the program the minister said was not working?

Mr T. Marney: No. This is a fairly new initiative by the commission. It was co-designed by Aboriginal people, albeit in South Australia. It is a nationally proven evidence-based model. That will be extended and is part of lifting the capability and capacity of Aboriginal communities to address the causal factors of suicide that they identify as priorities. It is an empowerment project, which, as the minister said, has Aboriginal people and communities identifying and developing the solutions and being equipped to do that. The causes of suicide are incredibly complex. It is not just a mental health or drug and alcohol issue. There are a whole range of social economic determinants, so it really needs community engagement. Alongside and slightly preceding that project, money has been allocated in the budget for the continuation of the network of suicide prevention coordinators. Their job is to embed themselves in the communities, whether they be Aboriginal, non-Aboriginal or multicultural, to understand firsthand what the community's needs are and to respond to that over time through training, support and local community grants. We know that those elements of the strategy work. They are a fundamental piece of infrastructure to identify, in cooperation and collaboration with the commonwealth, the specific initiatives and points of intervention that those communities tell us are required. Getting the co-design with the community is the aim. We have been chipping away at building the infrastructure to be able to do that effectively for a couple of years, and the government has allocated further money for that to continue for the next 18 months.

[9.40 am]

Mr R.H. COOK: I will just provide further information to the member. In response to the message stick report and the coroner's report, activities that are funded in this budget, which will contribute towards the intent of the response, is a sign of continued support for the work of the Mental Health Commission in reducing suicide risk in WA. They include $8.1 million for the Suicide Prevention 2020 strategy; $900 000 for a Kimberley juvenile justice strategy to develop place-based prevention and diversion initiatives for young people across the Kimberley; $6.5 million for the Aboriginal community connectors program to improve community safety and reduce community consequences of alcohol and other drugs and related at-risk behaviours; $2 million for diversionary programs in the Kimberley, including the Kununurra police and community youth centre; $1.3 million for the West Kimberley youth and resilience hub; $20.1 million for the north west drug and alcohol support program, which we have already discussed with the member for North West Central; $914 000 to increase training for

Aboriginal staff in alcohol and other drugs services as part of the methamphetamine action plan; and $1.1 million for the Kimberley family and violence service to continue to assist in responding to family and domestic violence.

The challenge for us is to continue funding this bevy of programs, some of which the community has already told me are great and they want to see funded into the future. It might have a view that other programs are not an effective way to use our money and we should be looking at other initiatives. We will have that conversation and make sure we respond to it properly. The commissioner wants to make a further comment.

Mr T. Marney: Just further in response to the member's question about what has been allocated, moneys are allocated outside the suicide prevention strategy as well. The Kimberley youth service that comes under the Kimberley AOD strategy was identified as needed in initial co-design with the Kimberley community. The government identified a need to address AOD issues in the Kimberley. We went through a consultation process with the community and it said, "Actually, we need early intervention for youth." That is part of ensuring that they get a good start in lifting some of those socioeconomic determinants that may lead to suicide, including problematic AOD use, and they are addressed early. That is an investment of $9 million, which is in the out years because it will take us the next 12 months to ensure we co-design that with the communities and also ensure it dovetails seamlessly with other youth initiatives, including youth justice initiatives in the Kimberley, so that communities are not bombarded with a raft of disconnected services.

Mr M. HUGHES: I refer the minister to page 295 of budget paper No 2 and the paragraph relating to recovery colleges under the heading "Community Support". Can the minister update us on the progress of the election commitment to introduce them?

Mr R.H. COOK: As the member would be aware, this was one of our election commitments in 2017, when we were determined to introduce recovery colleges in Western Australia. We have allocated $3.6 million to progressively establish recovery colleges over four years. Recovery colleges are an important part of providing capacity within our community for people to manage their ongoing mental health issues. They are provided in a non-judgmental environment, with an emphasis on education and building the resilience of the individuals around managing their mental health issues. We pulled together an independent expert panel to advise the Mental Health Commission on how we design the model of service. The member will recall that at the election, we said that one should be based in Perth and one should be based in Wanneroo. It was determined that we need to have a hub-and-spoke model that we will progressively implement statewide over a three-year period. Essentially, the hub will be located in the Perth metropolitan area with satellites allocated in all regional areas of WA—north metropolitan, the south west, south metropolitan, east metropolitan, the great southern, the wheatbelt, the Pilbara, the midwest and the Kimberley. They will utilise an education model to assist people, particularly those who are on the road to recovery from their mental health issues, so they continue to be skilled and have the opportunity, with peer support workers, to undertake their ongoing recovery and build their capacity to manage their mental health. I am really excited about this because it is a non-health model for delivery of mental health services, and I think it should be very effective. It has been very effective internationally and we are looking to replicate that success.

We made an early tender announcement on Tenders WA in April 2019 and that will finish in June this year, with a request to advertise on Tenders WA in June, and that will expire in August. We are anticipating that the contract will be awarded in October this year, with a transition period between November and March, with the service to ultimately commence in July 2020, midway through next year.

As I said, it is an exciting opportunity for us to really switch the way we deliver mental health services. It is an education-based environment, building capacity of the community and relying upon peer support to really make sure that we build resilience in those people who are on the road to recovery. It should be exciting. It is a great election initiative to have delivered.

Mr S.K. L'ESTRANGE: I refer to the number of full-time employees in the Mental Health Commission as reported on page 299 of budget paper No 2, volume 1. I note that the FTEs in the prevention services stream decreased by 15.4 per cent between 2017–18 and 2019–20. What impact has this reduction of key resources—there are other reductions in FTEs at the Mental Health Commission—had on the commission, its staff and their ability to meet demand for services?

Mr R.H. COOK: I will ask the commissioner to provide further analysis. I just want to report that the total number of FTEs under mental health control, clinical and non-clinical, was 271 in 2017–18. That reduced to 259 in 2018–19. The estimated number of total FTEs in 2019–20 is 242. In particular, it has impacted the grants associated with prevention and preventive services. On that basis, I will ask the commissioner to provide further details.

Mr S.K. L'ESTRANGE: Just to clarify the figures, has it gone from 271 down to 242 in 2019–20?

Mr R.H. COOK: The budget estimate for 2019–20 is 242. The total estimated actual in 2018–19 is 251. Obviously, that number will probably float somewhere between 251 and 242 depending on the outcomes of those grant negotiations that I will ask the commissioner to clarify.

[9.50 am]

Mr T. Marney: The member's question was initially specifically related to prevention FTE —

Mr S.K. L'ESTRANGE: And the total. It was almost two parts. I notice a reduction of over 15 per cent on the prevention FTEs, but I also notice a reduction on the whole, and the minister has just outlined what that reduction is.

Mr T. Marney: I will take the second part of the question as being answered by the minister and I will address the first part in further detail. The decline in prevention expenditure that the member highlighted earlier is, as pointed out earlier, associated with some grants that are currently under negotiation from external parties. The biggest one of those is revenue received by the Mental Health Commission from the WA Country Health Service for the Strong Spirit Strong Mind program. At this point, that revenue is only contractually confirmed to 30 June this year. We are currently in negotiations for an extension of that, and without pre-empting those negotiations and putting undue pressure on the other party, we are pretty certain that we will get that money and continue that program, which means those FTEs will continue as well. We have about five to seven FTEs aligned to that revenue stream. The FTEs associated with prevention will change once one of those external contractual arrangements is locked in. It is probably worth getting supplementary information, because the budget cut-off was, from memory, 8 April and a lot of those matters have progressed substantially since then, so the numbers in the budget papers significantly understate the continuation of some of those individual externally funded grant programs, hence the associated FTEs.

Mr S.K. L'ESTRANGE: Shall we take it on notice then?

Mr R.H. COOK: Yes, if the member would find it useful. The supplementary information will be a breakdown of preventive health grants, incomes and programs since the budget cut-off, and the impact on FTEs. Is that okay, member?

Mr S.K. L'ESTRANGE: Yes.

[*Supplementary Information No A11*.]

Mr S.K. L'ESTRANGE: Given what the budget is doing and that the minister will provide us with some supplementary information, what is staff morale currently like in the Mental Health Commission?

The CHAIR: I am not sure that is the same question, member.

Mr S.K. L'ESTRANGE: It relates to FTEs decreasing, and without seeing the supplementary data, I still have to ask the question.

The CHAIR: Okay, make your question.

Mr S.K. L'ESTRANGE: What is staff morale currently like in the Mental Health Commission, and has an employee wellness survey or equivalent been undertaken since the amalgamation of the Mental Health Commission and the Drug and Alcohol Office? What is morale like in relation to the FTE drops; how is that being managed?

Mr R.H. COOK: I will answer that in broad terms and then ask the commissioner to make specific comments, particularly in relation to staff surveys. My understanding is that staff morale is high. After the initial amalgamation of the Drug and Alcohol Office and the Mental Health Commission there was a bedding down period. The feedback I have from staff is that they have got over that period of transition and ultimately the organisation is in the best place it has been since the Mental Health Commission came on board. The reason for that is that the Mental Health Commission has now crafted its strategies across its service areas around alcohol and other drug services, housing, suicide prevention, and overall health and wellbeing. It is an organisation, or an agency now, that has a very clear mandate and a clear strategic approach. Staff morale improves once any organisation has its purpose defined and its pathways agreed. I want to take the opportunity to commend the leadership provided by Commissioner Marney in pulling that team together and really taking mental health services in Western Australia forward. I acknowledge the role of the previous government in establishing the Mental Health Commission and ultimately this new configuration, and the focus that has brought on mental health issues in WA generally.

I also just take the opportunity to thank Commissioner Marney, who, as members are aware, will be stepping down next month, so this is his final estimates hearing in this role. As I said, I think he has done an outstanding job in understanding and crafting the mission of the Mental Health Commission and really setting a strategic future for it. From that point of view, he has done an outstanding job in pulling the team together and developing its leadership and vision for the future. We are all very much in his debt for the work he has provided to the Mental Health

Commission and the great work he has done there. On that basis, I ask him to make a comment about the staff and related matters.

Mr T. Marney: I thank the minister for his kind comments, and I reiterate his comments about the fine job the commissioner has done over the years! One of the initiatives we have pursued and piloted within the commission is one under the suicide prevention strategy. We have partnered with the Future of Work Institute at Curtin University to implement Thrive at Work. Rather than do an internal climate survey, if you like, which is historically what most organisations would do, we have an interactive process—a co-designed process with staff—to address internal issues. We have made a number of changes in response to that. That program will be ongoing. It has an implementation phase over the next couple of years. That is the broad climate within the commission. Having said that, we have lots to do. The Parliament demands a lot of us and the community, rightfully, demands a lot of us, so it is a fairly high-pressured, high-paced place, but that is the way it should be too.

I feel very much for the individuals who year to year have their contract in jeopardy awaiting renewal of funding for another 12 months. There are a number of staff within the commission in that situation. It stresses me that they are in that circumstance, and I empathise with their uncertainty. We are doing all we can to negotiate those additional agreements to ensure certainty of their employment going forward. It is a handful of staff. I have to say that in conjunction, in parallel, with the normal process, we are going through the process under the government's policy decision and also under the Public Sector Commission's instruction—I think it is instruction 23—to review all short-term or repeat contract arrangements of staff to come to a reasonable judgement about whether they are likely to continue; and, if so, to provide those employees the opportunity to be made permanent. We are about halfway through that process at the moment and it is picking up some of these issues. Obviously, if we overspend our salaries budget, it is not a good look in here either, so we have to juggle that, but, as I said, I empathise with those whose jobs are dependent on external revenue sources that have not yet been confirmed for the forthcoming financial year.

Mr V.A. CATANIA: I refer to significant issues impacting the agency on pages 293 and 294 of the *Budget Statements* and the methamphetamine action plan. I believe $40.5 million is dedicated to that action plan. I know I have asked the question about the north west drug and alcohol clinic and how its funding is a continuation of that of the previous government. I refer to comments made by the then opposition leader, the now Premier, back in 2016, I think, when he said there was a drug dealer on every corner in Carnarvon and something needed to be done about the drug issue. Can the minister please enlighten me about the new initiatives coming out of the $40.5 million and where they are in regional WA? Can the minister provide me with a breakdown of funding continued from the previous government? Can the minister also provide a breakdown of the new money in that $40.5 million, the new plans and where they are in regional Western Australia?

Mr R.H. COOK: I appreciate the comments the member has made. The member is right that communities such as Carnarvon are vulnerable for a number of reasons. Firstly, as the member would have heard the Commissioner of Police comment, the number of meth labs across Western Australia is almost zero. That is a good thing, but the reason it is also alarming is that, as the Commissioner of Police reports, we have wide, open borders on our coastline and no grey ships based in Western Australia patrolling them.

[10.00 am]

Mr V.A. CATANIA: Or police boats in the north west.

Mr R.H. COOK: As a result, coastal communities in regional Western Australia are very vulnerable to the influx of methamphetamine coming by way of our exposed coastline. One of the important responses for that is in the creation of the meth border force, which is, off the top of my head, 250 extra police dedicated to the task of trying to turn off the tap of methamphetamines in our community. In places such as Carnarvon, where there is essentially one road in and out, we have that police capacity to intercept and try to reduce the availability of the supply of illicit drugs, particularly methamphetamine, in those communities. I hope the huge uplift in police seizures is an example of the success that the methamphetamine border force is having. The member for North West Central is the local member, so he will have a better hands-on feel of the impact that that is having on that community. As he knows, reducing the supply is a huge task, but it is one that we have committed significant resources to. The number of seizures, as announced by the Minister for Police, is testament to that work. It is important that we have that program or that body of work going on, while at the same time making sure that we continue to support the community through strategies such as the north west drug and alcohol support program. It is important that we ensure that we continue to resource those sorts of programs, which support the community by reducing not only demand, but also, and most importantly from my perspective as Minister for Health; Mental Health, harm by virtue of the services that we provide.

Mr V.A. CATANIA: I thank the minister for that, but I would like to know the breakdown of that $40.5 million and the new initiatives, particularly in regional WA, given the fact that the north west drug and alcohol support

program was established by the previous government and the government is continuing to fund that program. Out of that $40.5 million, what is the government continuing from the previous government and what are the new initiatives in regional WA? The minister could provide that through supplementary information.

Mr R.H. COOK: We might even be able to just tack that on to supplementary information A10, which was the member's earlier question about the breakdown of the north west initiative.

The CHAIR: You cannot tack it on. What are you going to give as supplementary?

Mr R.H. COOK: Supplementary information A12 will be a breakdown of the $40.2 million under the response to the methamphetamine action plan and those programs that are a continuation of existing programs and new initiatives.

Mr V.A. CATANIA: And where are they based, which is part of the other question, too.

Mr R.H. COOK: And regionally based—yes.

[*Supplementary Information No A12.*]

Ms E. HAMILTON: I refer to page 296 and the heading "Community Support" and "Other Significant Issues", in particular the community step-up, step-down services. Can the minister give an update of the rollout that is happening with the step-up, step-down facilities, where and when they will be available, and how they are working with current programs assisting communities as well?

Mr R.H. COOK: Where they will occur is much easier than when they will occur, but I am very happy to provide information on the step-up, step-down facilities that will make a major contribution to community-based residential care in regional communities. It is based upon the successful programs that we have in Joondalup, which is a 22-bed facility, and Rockingham, which is a 10-bed facility. We opened Albany's six step-up, step-down beds in November last year. I had the opportunity to meet some of the residents at that facility and it is greatly appreciated and very successful. We have allocated a total of $22.4 million for the construction and commencement of operation of four regional community step-up, step-down services from 2019–20 to 2020–21. They are based on a plan that includes a 10-bed facility in Bunbury, which we are expecting to be open early next year; construction has already commenced for that. We are expecting to open a 10-bed Kalgoorlie service later next year. A six-bed service in Broome is being progressed. A six-bed service in Karratha is also being progressed with the support of the City of Karratha, but it is making torturously slow progress through the planning process. I think we have now settled on a location for that, and are looking at getting on with that facility as quickly as possible. It is important that we have these services in regional communities, because it means that people can get that quality residential care in the communities or regions in which they live. That means that they are closer to their loved ones and support networks, but it also means we are building the capacity of the workforce and the services in those communities. Having seen the facility at Albany, I am really excited about what these services can provide.

By way of further advice, step-up, step-down is as it sounds—it is for those who are stepping down or coming down from an acute or hospital episode in relation to their mental health issues, or for those who are struggling to cope with their mental health issues and need to step up. It is fair to say that the stepping down is going better than the stepping up in Albany, but that is about continuing to work with the communities so that they understand the opportunities from this service. I should have mentioned that we are also providing a 10-bed service in Geraldton. That will complement the expansion of the emergency department at the Geraldton Health Campus, which also includes an acute mental health service, so we can see that playing an important role in that community.

It is very pleasing to see that the kit has arrived—not a moment too soon.

Mr S.K. L'ESTRANGE: Before I ask my question, minister, I am conscious of the time and the changing over of staff. I have only two more questions on mental health to ask.

Mr R.H. COOK: Sure. I will keep my answers as brief as possible.

Mr S.K. L'ESTRANGE: No, I am more interested in maybe not having a dorothy dixer, so that we can get to the health section sooner.

Mr R.H. COOK: Yes, I am hip; that is cool.

Mr Z.R.F. KIRKUP: As well written as they are!

Mr R.H. COOK: What about the answering of them, though, please?

Mr Z.R.F. KIRKUP: The answer is okay.

Mr S.K. L'ESTRANGE: My first question of the two final ones on the Mental Health Commission refers to page 295 of budget paper No 2, volume 1. There is a section titled "Forensic Accommodation (Youth and State)". The "Western Australian Mental Health Alcohol and Other Drugs Services Plan 2015–2025" update of 2018 highlighted

that there was a need to increase mental health acute and subacute forensic inpatient beds by 55, based on 2017 actual levels, to reach 2025 optimal levels. Has funding been allocated to address this requirement; and, if so, how much? If not, how does the government intend to address this requirement by 2025?

Mr R.H. COOK: I thank the member for the question; it is a great question. It is a source of extreme frustration that we have not been able to develop those forensic youth mental health beds to date. It is one reason that we have some of that underspend. To put the member at ease, we are now looking at the medium-term strategy, which is around the decommissioning of Graylands, but utilising some of the land at Graylands as a youth forensic mental health facility. We have dedicated I think $3.3 million under the health portfolio towards the decommissioning of Graylands. That is still on track for a final decommissioning phase in 2025, and in the context of that process, we are looking to develop those youth forensic beds. It is a real gap in our mental health services in Western Australia. Successive governments have attempted to fill that gap and we have looked at a number of options. None to date have actually presented, so we are going to look at developing those at the Graylands site.

Mr S.K. L'ESTRANGE: Does the minister have an idea of the amount of money that will be set aside for those 55 beds?

Mr R.H. COOK: I will ask the Mental Health Commissioner to make a comment on that.

[10.10 am]

Mr T. Marney: I do not think that it is a total of 55 beds for youth. No, that will be part of the business case process and the detailed planning that will be done in conjunction with the Department of Health, particularly the North Metropolitan Health Service, in the next 12 months to feed into the next budget process. We do have some money. As I mentioned before, we have held back some money to purchase a forensic service. In the absence of a suitable facility to provide an inpatient service, we will actually be providing a greater allocation in the upcoming budget year for forensic specialist services in the north metro health service to provide an in-reach specialist youth forensic service into Banksia Hill Detention Centre. While we are waiting for that planning and for the inevitable construction that will be required, we will be increasing in-reach into Banksia Hill. From memory, it will be double what it is now.

Mr S.K. L'ESTRANGE: The minister's answer referred to the divestment of Graylands Hospital, and an amount of $3 million has been allocated for the planning, decommissioning and reconfiguration of mental health services. What extra funding will be required to complete the project? Given that the business case for this project is complete, why has that amount—whatever that amount is—not been included in this budget?

Mr R.H. COOK: Ultimately, it is down to the service planning for the model of care that will be provided elsewhere and for those services that will continue at Graylands. It is detailed work and, obviously, we will need to make allocations in the budget across the forward estimates. It also comes down to negotiation with Treasury, because we are endeavouring to utilise some of the resources of the divestment of that land to fund the expansion of other mental health services in other parts of the community. It is a sort of chicken-and-egg thing from that point of view. An amount of $3.3 million is in the budget this year so we can do that detailed planning. Ultimately, we will see the funding for that progress across the forward estimates in coming budgets.

Mr S.K. L'ESTRANGE: Last year, we asked this question about Graylands, and I think the minister told us then that a business case was due to be completed within a couple of months. I assume that that business case is complete.

Mr R.H. COOK: It is my understanding that that is the case, and that is why it is informed by the $3 million.

Mr S.K. L'ESTRANGE: If there is a business case for the divestment of Graylands, what is going to happen to the people who are currently being looked after at Graylands? For example, as part of that decommissioning, what is the proposal for the Frankland Centre? Where will those patients be moved to? There are also other patients, so what percentage of those patients will be moved to community-based services and what percentage will be moved to hospital-based services? I presume the business case will contain a proposal for what will be done with Graylands. Is there any chance the minister could table the business case in addition to providing an explanation today?

Mr R.H. COOK: I cannot table the business case but I can let the member know this: there are a number of different theories on what can be done with the patients at Graylands. I have heard that up to one-third of those patients could be accommodated in a secure community setting. Other people have said that a lot of those patients, ultimately, would continue to need to be accommodated in a hospital setting, for want of a better description. For instance, we recently announced an allocation of resources—I think, it was $80 million—to establish 20 new beds at the Fremantle Hospital site this year. Part of that is for the transitioning of beds away from Graylands. The member will hear more announcements about that style of bed to come out of the Graylands precinct and to be placed within health service provider areas within the community. In addition, some community-supported accommodation will need to be built for patients who are able to be transitioned out of Graylands and into a community setting. The $3.3 million that we have allocated in this budget is for the next phase of that

transitioning process. I appreciate that it is taking a long time. The member said that he had asked this question last year. I remember asking this question at the beginning of 2009.

Mr S.K. L'ESTRANGE: The difference, though, is that I was not here then. The minister said last year that he would have a business case within a month or two. The minister has now told me that there is a business case, so all I am asking is that he communicate that plan.

Mr R.H. COOK: The business case is not around the models of care; the business case is more around the divestment of sections of that campus and the funding of alternative accommodation. The allocation of that $3 million is the next stage of that process. There will be more announcements about things, such as the creation of those extra 20 beds at Fremantle Hospital as well as an expansion of community-supported mental health services. Ultimately, as we move closer to decommissioning, there will be a greater amount of planning work around the models of care and the location of those services. I understand the member's frustration. I share it as well. I am comforted that we are still looking at the horizon for full decommissioning by 2025–26. The member will see a lot of activity in this space in the coming 12 to 24 months.

Mr S.K. L'ESTRANGE: I refer to page 295 of budget paper No 2, volume 1, and the reference at the top of the page in point 11 to a new mental health patient flow model. Has any funding been put aside for establishing mental health observation areas, increasing the number of acute mental health beds and identifying accommodation and community services support needs? If, yes, how much; and, if not, why not?

Mr R.H. COOK: Yes, we have an extra, I think, $18 million in acute mental health services for an extra 20 beds at Fremantle Hospital. That was for acute mental health services. What was the other area?

Mr S.K. L'ESTRANGE: It was mental health observation areas.

Mr R.H. COOK: Yes, there is $11 million in the budget for the creation of the mental health observation area at Royal Perth Hospital and the $5 million four-bed facility at Midland Public Hospital. That is in response to the Methamphetamine Action Plan Taskforce report. We are continuing to look at opportunities to extend the mental health and alcohol and other drug response accommodation services at Sir Charles Gairdner Hospital.

Mr S.K. L'ESTRANGE: Has money been allocated to Sir Charles Gairdner Hospital?

Mr R.H. COOK: No, not at this stage. The member will recall there was a flurry of promises and commitments from both the federal government and the federal Labor opposition before the federal election. In one declaration, there was some money for that. I do not know where that is at. We are waiting to see the outcome of that. Just for the member's information, the proposal at Sir Charles Gairdner Hospital is that the current mental health observation area will be relocated and that space used in a similar way to what was developed at Royal Perth Hospital—that is, the toxicology urgent care unit. That will be a small area for people who are impacted by alcohol and other drugs coming into the emergency department, so that they can be more appropriately cared for and accommodated in that area. A mental health observation area is being shifted as part of that. We are continuing to look at the costs associated with that. That is important work, because the cohort of patients coming to our emergency departments is changing, as the member is well aware. More patients impacted by mental health issues and more patients impacted by alcohol and other drugs, particularly methamphetamine, are now coming to EDs. That requires a renewed response to how we service and care for those patients. We have to make sure that we have better infrastructure and, as a result of that better infrastructure, that not only do staff have better resources, but also we move those services away from other patients and members of the public in the emergency department so that resources can be focused on the needs of other patients. The commissioner has also reminded me that we are getting a four-bed facility at Geraldton.

The appropriation was recommended.

Meeting suspended from 10.19 to 10.25 am