PUBLIC ACCOUNTS COMMITTEE

REVIEW OF AGENCIES' RESPONSES TO AUDITOR GENERAL REPORT 4 OF 2019–20

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 18 AUGUST 2021

SESSION ONE

Members

Mrs L.M. O'Malley (Chair)
Dr D.J. Honey (Deputy Chair)
Ms M.J. Hammat
Ms H.M. Beazley
Mr H.T. Jones

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Hearing commenced at 9.34 am

DR DAVID RUSSELL-WEISZ
Director General of Health, Department of Health, examined:

DR DUNCAN JAMES WILLIAMSON
Assistant Director General, Clinical Excellence Division, Department of Health, examined:

MS JENNIFER McGRATH
Commissioner, Mental Health Commission, examined:

DR SOPHIE DAVISON
Chief Medical Officer Mental Health, Mental Health Commission, examined:

The CHAIR: Thank you all for coming this morning to the forty-first PAC, first hearing, I would guess you would say, so welcome. I am Lisa O'Malley, I am the Chair of the Public Accounts Committee for this term. I will begin with an opening statement, the formalised part of the proceedings. I would like to first of all begin by acknowledging that we meet today on the lands of the Whadjuk people of the Noongar nation, and pay my respects to elders, past, present and emerging. On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the committee's follow up of the Auditor General's report, *Access to state-managed adult mental health services*. I am the member for Bicton and Chair of the Public Accounts Committee. I will ask my committee members to introduce themselves, beginning with the deputy chair.

Dr D.J. HONEY: My name is David Honey, I am the member for Cottesloe.

Ms H.M. BEAZLEY: I am Hannah Beazley. I am the member for Victoria Park.

Ms M.J. HAMMAT: I am Meredith Hammat, member for Mirrabooka.

Mr H.T. JONES: I am Hugh Jones, the member for Darling Range.

The CHAIR: It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything that you might say outside of today's proceedings. If you would like to begin by perhaps introducing yourself and your role for the record.

[Witnesses introduced.]

The CHAIR: Before we begin with our questions, the committee questions, do you have any questions or would you like to begin, perhaps, with an opening statement?

Ms McGRATH: I do not have an opening statement but I did provide some paperwork—just some documents that are relevant, mostly all public documents anyway, but we might refer to them today, so I just thought that might be easier.

The CHAIR: We probably have not had quite a chance to read them yet.

Ms McGRATH: No, no; that is okay. It might be that you will look at that down the road or something like that. It just might be easier.

The CHAIR: Absolutely. Would anyone else have an opening statement for us?

Dr RUSSELL-WEISZ: No. I think we are happy to go straight into it.

The CHAIR: All right. I will kick off as the chair. The area of interest in particular I would like to begin with is the governance and the new governance structure. I have received, which is referred to—on Friday, 13 August 2021, the Minister for Mental Health announced a statutory review of the Mental Health Act 2014. I will simply just identify that. I am not going to ask questions on that to begin with. What I wanted to do was just to pre-empt, I may ask some questions on that in a moment. If I can go back to the work that has been done in the time since the Auditor General's report was tabled. If you would like to speak a little bit, each of you, or perhaps you would like to begin with, on the governance and in particular the Mental Health Executive Committee that has now been formed. Would you like to, first of all, begin with a bit of a broad discussion around what is happening in regards to the new governance?

Ms McGRATH: I will start and then Russ might want to add some information. As you know, there was the clinical governance review and there were some recommendations that came out of that in terms of governance around roles and responsibilities—that sort of thing. Immediately, there was a fact sheet that was pulled together, and I think we provided a copy of that with our original report that talked about the roles and responsibilities of all parts of the sector—whether it was ministers' roles, Minister for Health, Minister for Mental Health, whether it was the MHC's role, Department of Health et cetera. That was just to give some clarity. That has been on our website since some time in 2019—late 2019 I think. Then one of the significant things that we did as a result of the outcomes of the clinical governance review was set up two different governance mechanisms, one being the Mental Health Executive Committee that you mentioned which is really the committee to bring the public health system, apart from mental health, together. That is chaired by myself, the DG of Health is on that, in the role that James plays.

It has all the CE's of the five health service providers, so east metro, north metro, south metro, WACHS and CAHS. It has, as the deputy chair the Chief Medical Officer, Mental Health, which is Sophie's current role. That is the mechanism that has been brought together around the public health system. We also, at the same time, brought together the Community Mental Health, Alcohol and Drug Council which was to bring together members of the community sector. This is our first version about the government governance that we want across the whole sector. Our vision would be that within a couple of years, that we would actually have one committee that would bring both together, but this was a starting point to start to bring all the sector together and have some government governance.

[9.40 am]

It has been in place for a bit over 12 months now, so the committee met I think five times, or it might be coming up to the fifth meeting. We meet quarterly. We have mechanisms in place to ensure both of those committees know what is being talked about and discussed and often the same discussion is had at both committees and we provide information backwards and forwards because it is important that we get that connection. The aim of that was to be making sure that we have leadership for the whole mental health sector because the commission itself provides services in the non-government sector and in the public health sector. Ultimately, we want a system that is working together and is linked. That was the mechanism we put in place. The other thing that was put in place was the actual creation of Sophie's role, which is the Chief Medical Officer, Mental Health, which was a really important thing for the commission. Previously, we did not really have that leadership from a clinical perspective. That has been really critical in helping bring the sector together. I might stop there. Do you want to add to that?

Dr RUSSELL-WEISZ: Chair, I think Jen has explained that really well. I think from our perspective what has changed over the years, having seen the iterations—the Mental Health Commission is different in Western Australia to any other jurisdiction because it purchases, so it is in a sense like a Department of Health; it is called a Mental Health Commission, but it buys services off the health service providers. So, it is end to end, but it also buys services from the community and sub-acute sector; it does policy but it also does purchasing. Other mental health commissions tend to do policy and strategy. I think there were two things—I think, substantially good things that happened—we had a new Mental Health Act in 2014 and we had a new Health Services Act in 2016, complemented by a new Public Health Act as well at the same time. There was a lot of legislative reform. The Mental Health Commission will have service agreements with the health service providers. We will try not to do too many acronyms, but let us say, take one of our seven health service providers, the South Metropolitan Health Service. I will have a service agreement with them which outlines all the services I expect them to do—the safety and quality initiatives, the clinical performance and the financial performance. It tells me how much activity I am going to buy, but it is the same thing that the Mental Health Commission will do for mental health services. We have worked very closely together over the last couple of years to make sure that we are trying to make that as easy as possible for health service providers because, in a sense, they get two service agreements. When a patient turns up in our emergency department, that comes under the Department of Health. Now, they may have a mental health condition and then they actually end up in a mental health ward or need mental health inpatient treatment, and that comes under the commission, because the front line need to see it is actually a very holistic service.

I will also say that the other real positive in this is the clinical leadership, Sophie Davison as the Chief Medical Officer, Mental Health, has brought to the mental health environment because we have always had a Chief Medical Officer in health, and that Chief Medical Officer is broad and looks at it from a professional perspective, and comes under Dr Williamson, to my right, but I think it was really important to actually have mental health leadership for what was an area that we were seeing significant demand. You have seen burgeoning demand right across the world and across the country in specific areas, way above age-weighted population growth, way above what anybody probably would have predicted, and made worse by COVID. I think the clinical leadership then has been a real positive to the health service providers and to the community. I think it is not just about hospitals; it is very much about that continuum of care from community through to what I would call sub-acute, where patients are looked after in facilities that are not hospitals, and right the way through to hospitals. It is a very complex environment. You would have seen some of the difficulties we are having at moving patients out of our hospitals who do not want to be in hospitals. It is a very fraught environment to navigate between NDIS, transitional care, aged care, community providers, and community providers who can look after significantly sick patients. It is an environment where the Mental Health Commission and the department have to work very closely together. I will just add those few comments to Jen's.

The CHAIR: That is amazing—the amount of work that has been done in that space under incredibly difficult circumstances.

In regard to the recommendation in the Auditor General's report, recommendation 1 sought that clarity of roles, and certainly in speaking to that you are noting those changes. There was an MOU that was developed.

Dr RUSSELL-WEISZ: Yes.

The CHAIR: Also, beyond that, where can we actually find specifically the information around those roles and who is responsible for each? Is that in the fact sheet? Is that as an addendum?

Ms McGRATH: Yes. There is a fact sheet which is on our website. I thought we attached it, but maybe we did not. We did? Okay. Yes. There is that fact sheet which was the first time we really made it clear because there are a lot of different parties involved. We have a head agreement that is between the MHC and the Department of Health which sets out responsibilities as well.

One of the other things that I forgot to mention, which is a really important bit because it is about leadership and roles and responsibilities, was the setting up of the Mental Health Leads Sub-Committee, which actually reports to the Mental Health Executive Committee. That is where we have senior people from each of the health service providers who are responsible for mental health come together, which is chaired by Sophie, to drive that leadership at the local level. I am sure we will get to today the future and what the services look like and how we reform the mental health sector. Having that local leadership at the level of health service providers is really important, so that is another important part of the mechanisms that we have put in place that we are maturing as we move forward.

Dr RUSSELL-WEISZ: Just to add to that, chair, if the health service providers were here, they would say we need to be as integrated—we are two different bodies—but we need to be as integrated as possible because when patients come up to our emergency departments or come up to outpatients, they do not necessarily just come in with a mental health issue; they come in with mental health and a physical issue. I think we have seen that, especially during the COVID era as well.

Ms McGRATH: That leads committee also helps with the whole system, so health service providers have their own responsibilities, but from a mental health perspective, we know that we need to look at it from a system perspective because we do not have people just turning up at one health service provider, they will turn up at others and because of where we either have our resources and we have our services, sometimes we have to work across so it is really important to look at it from a system perspective. Yes.

Dr D.J. HONEY: Thank you very much, and thanks for coming because within the whole of Western Australia, you are probably the group that is under more pressure than pretty well everyone else in the state, so thanks for your time. First of all, Dr Davison, it would be very interesting to hear about your role and I guess the first steps you have taken since you have recently come into that role.

Dr DAVISON: Thank you very much for that opportunity. As Jen, the commissioner, said, my role is kind of part of the bigger chain, so I do not see my role on my own as changing the whole of the mental health system. It would be good, but you know. My role has been very much to make sure that there is some clinical leadership within the Mental Health Commission, but also I see my role very much as making sure there is good communication with the health services, with the clinicians, and also with the Department of Health, so bringing everybody together in a more systems approach. In practical terms, how I do that is I am Deputy Chair of the Mental Health Executive Committee and the Community Mental Health, Alcohol and Other Drug Council. Also, I chair the mental health leads which is a really good chance to get together all of the local leadership at that health service level, but also within the Department of Health, to have a chance to really discuss things across the system because currently the health service providers all have their own responsibilities and work their own area, but, as Jen said, patients move between areas. As all the data from the Auditor General's report showed, people can go from emergency department to emergency department.

[9.50 am]

It has been a really good chance to bring everybody together to really think about how to drive change in the system. It is a system under pressure. There has been hugely increasing demand. Then, further to that, in terms of the role of trying to really move the system forward and transform the

system so that we move much more to keeping people well in the community, I have been taking a lead on three of the main projects within the MHC that we are doing. There is the infant, child and adolescent task force, which has an independent chair and is a ministerial task force, but I am providing the Mental Health Commission lead within that, which is looking at, really, trying to work out exactly what the infant, child and adolescent mental health services should look like going forward: what change is needed, how we can meet demand of families and children across the system, and working very closely with the Department of Health around the data and the modelling, which is where the Auditor General's report becomes relevant in relation to that.

Then there is the Graylands reconfiguration task force, which the DG may want to talk about, given that that is a cabinet-appointed task force and is being run out of the Department of Health, but I am intimately involved in that and particularly talking a lead from the Mental Health Commission's point of view. Then we are doing another large piece of work, looking at community mental health services and emergency responses to really work out across the system. Once again, like the infant, child and adolescent, it is about what they need to look like, how they need to operate to not just meet this hugely increasing demand, but also actually meet the needs of the people of Western Australia. I think I will probably leave it there. You may have other questions about the project.

Dr D.J. HONEY: I do have a follow-up question. I think you have an impossible task almost and, in fact, a couple of you have alluded to this increase in presentations. My understanding is that the rate of increase of presentations and then consequential suicides is increasing linearly to the point that suicide is becoming the major cause of death of men, or it is, and for the general community it is a rising issue. It is going to that root cause. I was really interested in that preventive part. How much of the effort of the group, if you like, goes into the preventive side? When I looked at the structure, and I know you obviously have to deal with the consequences of mental health and so there is a huge focus on service delivery, but I just wonder, and it is an opportunity perhaps for you to say, is there enough resourcing and is there enough effort and focus? Do you have the time and resources to focus on that preventive side? Because it seems that whatever we are doing—and I am not blaming you or seeking to say you are the cause of it—in the community is not getting some asymptote or even decline in presentations.

Ms McGRATH: I am happy to start with that and I am sure the DG would also like to add to it. Our 10-year plan sets our high-level direction, which is about balancing the system. When we say balancing the system, that is let us move to keeping people well in the community so that they spend less times in hospitals. That is at the very, very highest level. Over the last few years, that is absolutely where we have been trying to get to. The 2021 budget and the recently announced 2021–22 budget is really encouraging in terms of some significant resources in terms of community services. Now, there is still a long way to go, but we are heading in that right direction. Every day, I guess, we have to balance both. If we have people who are in crisis right now and they need hospital care, we have to be managing that. We are trying to get that balance right, but, ultimately, we need to be focusing as much as we can on community services.

In terms of—I will come back to that as well—you talked about suicides. Suicides are always going to be something that we need to be focused on. I think people probably are aware, but twice as many people die by suicide every year than they do on the roads. We talk about roads a lot, and I am not saying that we should not either, but there is a lot of work to be done there. Also what we know is that it is not always a health issue, or a mental health issue. Most evidence and data shows that 50 per cent of people take their life for non-health or mental health reasons. It is a very difficult one to tackle. There is no one single thing that will help, but there is a lot of stuff that we are doing in that space. We actually need to see that it is not just a health issue, but a whole-of-government issue, and we take the lead role across government in that space. We can talk more about that if

you want to. In terms of services within the community, as I mentioned, the 2021–22 budget, for example, recently announced $495 million in mental health for the next four years, which is absolutely fantastic.

The good thing about that is that around 370 million of that is for services in the community, so the real focus is services in the community. Yes, there is still some additional beds and other services within the hospital system, which was required to actually help us with those increasing demands we have now, but we know that the long-term solution is to keep people well in the community. The $370 million was encouraging; $120 million of that was for young people, and we can talk more about that as well. Rather than go into any detail, do you want to add to that, Russ?

Dr RUSSELL-WEISZ: I think, member, the other thing to add is that it is really obviously a very good question on prevention and it underpins the sustainable health review. The first enduring strategy of the sustainable health review was prevention and the second was mental health. So, out of everything—out of every area—it picked out mental health because we could see the burgeoning demand. I would have to say—and I might ask James to comment here—we are not as clear, I do not think the research—and it is not necessarily an Australian thing; I think it is everywhere—we are not quite as clear, let us be honest, why we are seeing this massive demand. I think we probably just need to be really clear about that. We know certain things. We know that if we are seeing people with increased heart disease or increased diabetic presentations, we know why that happens. We know what smoking does and we know what fast food does. We have a lot of data on that, but for mental health, we do not know everything.

I think the other thing to say here is that we are very much focused on prevention, but we also have to recognise that when people come in with acute psychoses, when they come in significantly unwell, they are not appropriately treated in the community. They are treated, and we need the capacity to be able to treat those patients in an acute setting, not necessarily at one acute setting; it is not all about Graylands. Because, as I said, there is a continuum for that. Really, those acute psychotic patients need really in-depth medical treatment and then they need to be supported. I think one of the things, as Jennifer said, is about that balance. It is also not about a jump from just acute—Graylands, to community. There is a gap in the middle, and I know I use the wrong terms, but it is that what I call "sub-acute" space. It is that space in relation to facilities that we are—there are community care units being built and we are looking at secure units being built that actually have a—so people transition, because if they transition too quickly, they bounce back, and if they transition slowly, with the right support—but I would say that we have seen a burgeoning of eating disorders and we have seen a burgeoning in child and adolescent mental health. I would not say anybody has the answers. James may want to comment on what some of the research is showing.

[10.00 am]

Dr WILLIAMSON: Yes. I think the origins of mental health disorders seem to be occurring earlier. Obviously, adverse events in childhood can have long-term consequences, if you speak to the health economists. We had David Bloom over here not so very long ago telling us that if you really wanted to make an impact in terms of disability adjusted life years, which is a measure of the impact on the health system and people's health in general, you would intervene in early childhood—exposure to family and domestic violence and these sorts of things. As an adolescent, it is hard to imagine how one would not be depressed. If you switch on the television, you hear about COVID in the eastern states or you might have family in Europe; you have the climate crisis, which the next generation is inheriting, essentially; you have concerns about the role that social media might play, although the evidence for that in terms of the aetiology, the causation of mental health problems, is not particularly firm; and of course you have the consequences of educational interruption as well. We

have not seen it so much here, but certainly there has been some interruption to tertiary education, et cetera. I think there are a number of stressors, and we have to say that society as a whole has a role to play in addressing some of the potential contributors.

In terms of the research that we have done here, I think an important study was the so-called DETECT Schools Study which we initiated in May last year. It was part of a larger study where actually we were anticipating the spread of COVID within schools. So there was a significant component that looked at how we might track the spread of COVID in young communities because at that time there was very, very little known about it. In fact, because we have not had COVID here, the greatest learning from that particular study related to the psychosocial consequences, which we measured through a series of surveys. We administered more than 33 000 surveys to school children in 79 public schools here in WA, plus their parents, plus their teachers. What we found was in the 12-18 year age group, there had been a very significant increase in what one might call emotional distress. The tool that we used was a utility index called the child health utility index, or CHU9D that, essentially, measures emotional distress in that particular age group; it is very well-validated.

We had comparative information from the national studies using the same tool back in 2014 when about 14 per cent of that age group had evidence of significant distress. That is now over 40 per cent in the group that we are looking at here.

Dr D.J. HONEY: What were the two years, sorry?

Dr WILLIAMSON: 2014 was when the national study was done, which included WA. That is, if you like, our baseline.

Dr D.J. HONEY: That was 14 per cent and the last one was?

Dr WILLIAMSON: Last year we did two surveys with similar results in June and October. There was a slight increase in the measure of psychosocial distress between June and October, but not nearly as great as the increase that we saw between 2014 and now. Of course, it is difficult to attribute all of that to COVID. You can hypothesise as to what the contribution of that was, because there had been such a long, six-year intervening period during which there were significant changes in adolescent mental health in the community anyway. I think that study is about to be published. It has been in the media so it is in the public domain, but it is going to be formally published shortly. That dataset forms the basis for what would be a fantastic opportunity to do some intervention to remeasure after you have developed some targeted interventions to try and address that problem.

The CHAIR: In actual fact, I think that leads us beautifully, if we do not have any other questions related to recommendation 1 or where we are at?

Ms H.M. BEAZLEY: I had a couple, and it is probably more logistics as I am trying to figure out if there is any in-house barriers or challenges to achieving what I think is the consensus in terms of what is needed in the mental health space, and in the health space, and particularly in what you refer to as the sub-acute care and that transference from acute care to community. I am wondering about your head agreement. Does the government structure feed into your head agreement, or is your head agreement broad to not have to go into specifics and you can move inside it?

Ms McGRATH: It is broad. Yes, absolutely. Basically, the MHC, CMC or our mechanisms actually to drive the change, make the decisions and then drive the change from there.

Dr RUSSELL-WEISZ: Just as an example, yes, it is very broad, the head agreement, but when we are talking about submitting budget submissions, we will not do them independently and we also do not do service agreements independently of each other. I would actually say there are no turf wars, but if there is an issue that you have to – it sits a bit with health and a bit with the commission, we

just resolve it together. I do not really see that as having been an issue for the department or the commission.

Ms McGRATH: Actually, the current mechanisms that we have put in place have actually helped some of the issues that we might have in the past. It is not perfect yet, but the maturity of the system, I think, from my point of view, is we have moved a long way to actually having that. For whole system of change, we actually have to be working very, very closely together and bringing the sectors together. Yes.

Dr RUSSELL-WEISZ: I probably would also say, for the health service providers, if they were here they might say, look, it would be good to get one service agreement, they do not particularly like two, and we are working on how that can be done. The department—all the modelling on mental health demand, on beds or something, that is done between us. The Mental Health Commission has not duplicated it. We have a whole team of modellers that do that work, as the health department should.

Ms H.M. BEAZLEY: My other query in this space is there is a lot of priorities, plans, strategies, there is a lot floating around, and reading through them, they are all great, but my concern is where they are at a friction point with each other. Is there anything you have identified? Even the update plan of 2018—I was looking through that, and some of the assumptions of lower population in WA, lower presentations by Aboriginal people to hospitals in certain areas—it seems counterintuitive to what is actually being presented.

Ms McGRATH: At the highest levels, we have our 10-year plan which is high level direction. What we did, and the Minister for Mental Health last March, 2020, announced the mental health priorities for the next four years because that plan is big and it will take a long time to achieve that. The aim was to actually say, "What are we going to focus on in the next four years?" That has been the work that we have been doing and reflects some of the initiatives that have come out of the last two budget processes. In particular, how we then drive—because one of the other recommendations of the OAG report was we need an implementation plan of the big plan. The first stage was let us determine the priorities. Some work has happened and we have a safe place strategy which was about supported accommodation which is a really important part of that transition, getting people out of hospitals and into the community.

That work was done and a phase 1 implementation plan was done, but three pieces of work which Sophie has mentioned earlier, the results of those pieces of work are detailed, costed, phased implementation plans which will actually tell us and give us guidance of about, okay, what do we do first, and they are all interrelated. Just remembering what they are, reminding us what they are. The infant, child and adolescent—the public health system of zero to 18-year-olds; the work we are doing around the Graylands reconfiguration, which is about forensic, but also about the long-stay patient beds that we have there, under that. Then the third piece of work, which is the community treatment emergency response; what does that look like going forward? That piece, I will just mention, is really, really important. Of the nearly $800 million that the commission commissions services from the health service providers annually, about half of that is community treatment—the outpatient type services that health service providers provide.

That is where we know there is a significant amount of demand on, but also what do the contemporary models of care look like in that space. The outcome of that, which we are working on until about March/April next year, we will have a final report. Really, we will outline what does our system need to look like going forward, and it could look so different to what it does now. That work has just started in the last month or so. Health service providers are very much involved in that, but really trying to vision what does the system look like going forward. Overall, it is a long answer to

say that it is not just about more services that are needed and in the community, but they need to look different into their community and integrated with hospital services and then NGO services as well.

[10.10 am]

Dr RUSSELL-WEISZ: I would just like to add to that because your question was about friction, I think—your point. If I go back—I have been in the system long enough to go back to when the Mental Health Commission was formed—I think, and this is my own personal view, is that it was because hospitals tended to gobble up most of the money at that stage in those days, and the community did not get the investment for that very point you made about prevention, about community treatment and about support. I think that has really gone a long way to rebalancing, but what we are seeing with the demand that we are seeing is there needs to be that equal investment across the spectrum. We have not even really talked yet about forensics, so forensic mental health right the way through to support at primary healthcare, which we do not control. I think that has become really apparent to the system. People in the hospital would say that actually it needs as much as the community does as well. It is a rebalancing, but it is a growth everywhere.

Ms M.J. HAMMAT: Just a couple of questions, just a fairly straightforward one. You talked in your overview about the Mental Health Executive Committee and the membership and you referred to the Community Mental Health, Alcohol and Other Drug Council. Can you tell me who is on that council?

Ms McGRATH: Yes. Remind me if I forget someone. We have our two peak bodies, which is WANADA and WAAMH, they are represented; we have WAPHA, Learne Durrington; we have Colleen Hayward who is our chair of the Drug and Alcohol Advisory Board for the Mental Health Commission. We have —

Dr DAVISON: The Chair of the Mental Health Advisory Council.

Ms McGRATH: Yes, the Chair of the Mental Health Advisory Council and —

Dr DAVISON: We have the CEO of CoMHWA, which is the Consumers of Mental Health WA.

The CHAIR: Sorry, who was that last person?

Dr DAVISON: CoMHWA, and we have a consumer representative and a carer representative who are the same consumer and care representative who are also on the Mental Health Executive Committee and the Mental Health Leads Sub-Committee, so there is that continuity of consumer and carer input across —

The CHAIR: Is that reflecting the contribution of the lived experience, because you talked to that in —

Ms McGRATH: Absolutely. Yes. I should have mentioned that earlier. We have that across all of those.

Dr DAVISON: I am on it, too.

Ms McGRATH: Yes, and Sophie. Sophie is the chair[1] of that as well.

Ms M.J. HAMMAT: My second question was in relation to your comments when you talked a bit about the system maturing; that is the sort of terminology you have used. In terms of the structure of governance, which was outlined, and you have very helpfully provided that pictorial representation which is great, thank you, is the governance structure really the one that you feel that you will need going forward and the maturing is just going on around how it interacts and how

[1] Dr Sophie Davison is the Deputy Chair of the Community Mental Health, Alcohol and Other Drugs Council.

the services are provided? Or when you talk about maturing, are you also perhaps contemplating that maybe this governance structure is not what you need when you look forward into the future?

Ms McGRATH: I think it is a bit of both. I think there is a survey out at the moment of members of both the CMC and the MHEC to say: how is it going? It has been in existence for 12 months. From my perspective, it is starting to really embed. One of the things it is starting to do is change how my people in the commission work because it is about how we bring those things to those committees to actually then help in terms of then driving change. So, yes, it has only been in existence for 12 months, but the long term is about the development of leadership and then the driving of the change, because it is, in one way, easy to make the decision to do something, but implementing it is what is really difficult. Going forward, those mechanisms will be about helping to drive change—so the outcomes of those three important pieces of work. Those committees will be actually partly responsible and a driving force to drive that over the many years that will take.

I see that we will get feedback from the last 12 months. I would want to hope that maybe in another 12 months' time we might be to a point that we can say, "Okay, let's review again and see where we are at." Because, ultimately, you would want both of those committees actually as one committee and even having greater engagement. What I did not want to do is set up something that was the ideal, but we just were not ready for it because we were coming from a pretty low base in having any governance. When I came into this sector two years ago, it was just so messy and unstructured; that was my feeling of it from everywhere else I have been. It was really a sensible and practical way to start. I think that it is not where I want it to be, but I think it is about being practical and realistic. This is all about change, really, and how we get to that next bit.

Ms M.J. HAMMAT: That is good, but it also goes to the relationship between yourself and the Department of Health as well and that heads of agreement.

Ms McGRATH: Yes. Absolutely.

Ms M.J. HAMMAT: Is that something that is also maturing, or do you feel that that is where you want it to be?

Ms McGRATH: I do not think we are going backward, are we?

Dr RUSSELL-WEISZ: No, I do not think so. I think there are lots of other players in the health service providers as well as statutory authorities, and they —

Ms McGRATH: And their boards.

Dr RUSSELL-WEISZ: And their boards. It would be interesting, if you pose certain questions to them, what they would see as the interface. They obviously have a lot to do with us, with non-mental health, but they would probably see that some things can be streamlined, which I think could be streamlined without changing the head agreement. I think the head agreement is broad enough to say work together Mental Health Commission, health service provider and Department of Health. I think there are some, not quite flaws, but some challenges in the fact that you do get two service agreements and you cannot box patients or episodes of care into one or the other. But that is more a feature of activity-based funding, which is how we are funded from the commonwealth and how every state is funded. That is something between the commission and the department.

Ms McGRATH: One thing I will just add is if you compare—Russ mentioned this a bit earlier—how we are structured in WA compared to other states, we are way more mature than any other commission. All other commissions in Australia are really policy-type offices. They find it even more difficult, and they are sitting as part of—all their mental health services then sit under a health system. Even if you read the Productivity Commission's report on mental health and you look at the royal commission in Victoria around mental health, the reform that needs to be taking place is stuff

in the community. Often that is more difficult to happen if it sits just within a health context. As a system, we are more mature, but are we there yet and can we do more? Absolutely, we need to, and it is that evolving thing.

Mr H.T. JONES: David mentioned the preventive space and Dr Williamson mentioned the impact of childhood experiences on mental health et cetera. I do not want to go down a rabbit hole, but just for my own information, with schools, interaction with the education department, school psychologists and chaplains et cetera, does your governance cover all that, and can you maybe just talk about that?

Ms McGRATH: Absolutely. Yes. This is a space where we want to get more into. I would have to say, probably two or three years ago we were not really doing anything in that space at all. But where we are now, absolutely we are in that space. We work very closely with Department of Education. An example will be part of the work that we are looking at in the infant, child and adolescent task force. So, yes, that is about public mental health services, but it is about the interface that it has with all other parts of the community. Now, schools are a captured audience for zero to 18-year-olds, are they not, and we know that is where there are plenty of issues. I was at education for four years and education is very good at running their own system and can be quite insular. But what we are trying to do with education now is actually work with them. What sort of systems and supports do they need within their school, that is actually then integrated into the rest of the system that is outside to be able to help?

That is an outcome that we will be looking at as part of the infant, child and adolescent task force. Next week, actually, we are bringing together the Department of Education, the independents and the Catholics, to look at this. All of those sectors are really keen to see what we can do in schools. The recent election commitment is around getting 100 psychs into schools. That is a fantastic opportunity around how can we—what supports within a school, because those 100 sites will not be able to sort everything for zero to 18-year-olds at all. All they will probably do is identify more kids that need more services, and that is not necessarily a bad thing, but it is if all the supports are not there outside. We know we have a long way to go to do all of that.

The other thing we are doing is, obviously, we have very sad circumstances when young people take their lives, and we have processes in place where the commission and health service providers we are working with support schools. I was actually out at a school the other day helping a school that needed some support in this space, and Russ's representatives were there as well.

That is where we need to absolutely work closer. As I said, schools have a bit of a culture of, "Okay, no, we will do it all ourselves; we can do that", because they are big. But the reality is they cannot and they should not have to because there are supports outside to link that up. That was a long answer, but we are in that space and we want to be doing more in that space.

[10.20 am]

Dr WILLIAMSON: I should just acknowledge that the DETECT Schools Study that I mentioned earlier on was a close collaboration with the Department of Education—that would be obvious from the nature of the study—but the academic input was from TKI, Telethon Kids Institute, and the expertise there. It also involved all of our HSPs et cetera. I mentioned this would be a great platform to then step off and design some intervention studies. One of the concepts that we are mulling over at the moment is to have, if you like, an application which has been developed by TKI which would produce the evidence-based interventions that the clinical psychologists in the schools might find applicable to their particular cohorts. That is the sort of collaboration that we are trying to do through the service platform as well.

The CHAIR: If I could pick up on that, in regards to collaboration which I think is obviously a major game changer, and bring it back to recommendation 2 around data, in particular the mental health and data repository, which does sound like a potentially really powerful tool. How is that? Has that been implemented? How is that going with that implementation, and also is it somehow based on the data analytics conducted by the Office of the Auditor General in their review?

Ms McGRATH: I might get James to talk about how that is going and Sophie can add in about what we are going to be using it for into the future as well.

Dr RUSSELL-WEISZ: Just to start, I think we have led Australia in data linkage. I think other states have caught up a little bit, but we are just seeing—I got presented the other day, we are not mental health, but some of the data linkage we are doing with COVID. COVID has been a disrupter. We have had to develop systems very rapidly—our contact tracing system, our VaccinateWA system. We now have really very mature, real–time data linkage systems that we need to continue to evolve, but it has been a strength of WA. The Auditor General's report was a real clear moment for us that we actually needed to use that sort of expertise in this mental health area. But I might go to James to talk about particularly mental health.

Dr WILLIAMSON: I have to say, when I first heard about what was happening in the Auditor General's office, I was very excited to particularly look at those longitudinal patient journeys that they had been able to do, which was no mean feat because it required linking together at least four different datasets. As the director general has mentioned, we were leading in the area of data linkage. That was something that we could add to that dataset. What it allowed us to do is identify very high users of the system. It is usually the 80/20 rule we talk about; it turned out to be more the 90/10 rule from the data that was presented there. This obviously provided an opportunity to try and identify who might become a high user of the mental health services at an earlier stage so that more directed interventions could be applied which would be more cost effective. That was the concept behind it.

The data analyst who constructed that dataset in the Office of the Auditor General was employed by the Department of Health for a number of months immediately after the report was published in order to establish—to work with our team who obviously have a lot of expertise in this area, but to make sure that there was a seamless transition of that dataset and the concepts behind it into the department. We have now established that. I acknowledge Rob Anderson, who is one of the other assistant directors general, whose team have really been putting this together. We now update that on a regular basis. It was a snapshot as it was under the Auditor General, but now it updates regularly and it has become our first health service enduring data linkage repository. It is being used. The director general mentioned GRAFT—Graylands—divestment program. Both the forensic and the non-forensic requirements of that have been modelled.

There was a bit of discussion yesterday about a disparity between some numbers. Usually what we do is we measure demand for health services. What we are trying to do now is to begin to move more to modelling need for health services because obviously there is a group of people who need the health services who might never actually present for those health services. Those are some of the things that we are introducing too. We have begun to use some new technology. The method of data linkage that we used before was based on probabilistic mapping but there are completely new ways of structuring data. I am particularly talking about graph databases which allow data linkage to be done just as efficiently, if not more efficiently and much faster. We are now experimenting with those and we are getting linkage matching which is even surpassing the traditional methods that we have used before. We are hoping by using that graph technology, we

will be able to get answers much more efficiently, much more rapidly, to inform some of the projects that we have.

It has also been informing the infant, child and adolescent inquiry that is being conducted at the moment. Again, I am not party to the full details of that, I am not a member of it, but I am assured that the information from that dataset is being used to model what those services might look like going forward.

Also very excitingly, and in an effort to try and tap into some of that graph technology, we have established a mental health project through the digital health CRC. This is a partnership between the Department of Health, a number of the HSPs, including WACHS, it includes Curtin University for their data science expertise, it includes WAPHA, where they have considerable expertise in mental health and analytics, and it also includes a private provider which is linked to Professor Michael Small who is one of the world experts on network analysis. There is the opportunity there to use this dataset again and take it to the next level in terms of the analytics that could be applied to it. The idea is to try and predict who might be heavy users by looking for clusters using unsupervised machine learning, and then begin to look at what their outcomes are, whether we can predict what the outcomes are, and what interventions might be effective.

Ms H.M. BEAZLEY: I have a couple of questions. I will ask them one at a time to give you a chance to compute. I understand that data is being used to determine what you have written as "What good care looks like" at the ED level. I am just wondering if it is also being used to research what good care looks like outside the ED–acute care and that sub-acute model?

Dr WILLIAMSON: Yes. The good thing about it is it follows the trajectory all the way through. It has to move in and out of all of these different areas. So you might have community into emergency department, in-patient bed, back out into the community again. That whole journey is mapped.

Ms McGRATH: Sophie, do you want to talk about how it is being used in those three important pieces of work that we are actually doing, which is about what should the system and the models of care look like? Basically, that data is used to help inform those pieces of work.

Dr DAVISON: James has alluded to it already. All three of those projects are looking very much at trying to model what services should look like, how they can meet needs, not just looking at past demand and activity. The Mental Health Commission is working very closely with the Department of Health modelling team and is using that data as part of that modelling to work out what services should look like, and very much looking not just in the ED, but in the community. Certainly, there is some other work that was done as part of the Young People's Priorities for Action where we then linked it also with the social impact data, so some Education and Communities data to look at the thousand top young users for mental health services which has yielded some really important, helpful information about what their needs are and what their trajectories are and what they need. That is also going to inform some of the infant, child and adolescent task force and where we have gone to try and get some more of that—it is called SIDR; social impact data resource—to look at the needs of children and young people.

The strength of the link data repository stuff is that it really does go across the system and shows people's trajectories in and out of EDs, through the community inpatient and the lot. And, ultimately, working with the Department of Health because we have these three projects across the system, using the data to really get a look at the whole system and how it actually interacts, so we are not just looking at EDs or just looking at inpatients or just looking at community. Ultimately, we are trying to get a seamless service for people.

[10.30 am]

Ms H.M. BEAZLEY: James, you touched on the partnerships with Curtin, and I picked up on some of your responses that were submitted to the committee previously, about the Co-ROAMERS, I am presuming that is what it is, research project. I understand that that is due in September and I am wondering if that is going to inform the mental health strategy that is due next year and how that timing works out because it seems quite close for one to inform the other comprehensively.

Dr WILLIAMSON: Yes. Well, essentially, the work is going on in parallel to an extent, so we have got an idea of where the strategy would be going and at the same time we are doing this more detailed piece in collaboration with Curtin. So we have outsourced that piece which will then inform the development of the final strategy. It is not an either/or, or necessarily a sequential piece, but they are going on together in parallel. I think it is really important because we established the future health research and innovation fund last year. We now have an advisory council which has endorsed a strategy and a series of priorities. I do not think it is any secret that one of those priorities is mental health. We need to make sure, through the development of this strategy, that the mental health researchers are in the best possible place to avail themselves of some of the competitive funding that is going to be available through this fund.

Ms M.J. HAMMAT: You reflected a bit in your opening comments about the recent budget announcement, about $495 million into mental health, and the previous year's budget as well, so I know one of the Auditor General's findings reflected on a lack of funding to drive the implementation. I am just interested in your reflections, when you have been very positive about the commitments that have been made to date, but would you like to expand a bit upon that? I guess the question goes to does that remove that barrier in terms of implementation?

Ms McGRATH: It is fantastic, and obviously government have got a focus on mental health in a priority area, which is absolutely fantastic. I guess what I would say is that the issues that we are facing in the mental health sector have been created over a number of years—well, decades, you could maybe say. Funding in budgets for the next couple of years will not allow us to totally fix it, so we will continue to need to, and all these pieces of work that we have been talking about, look at how we are going to change the system going forward. It is about with the same amount of money, so right now, our annual budget is over $1 billion, so there is a significant investment in there and we need to look at how we can use that better. That is the work that we are doing; what are the right models of care that are going to give us the best outcomes for consumers. It is about different, but it will be more as well. Because we know that there is demand, it is going like this, and again, why is it going like that? But all over the world, I think that is one of the things that we probably need to reiterate, that this is not just happening here, this is happening all over Australia and the world.

Yes, we are working on looking at the fundamental reasons for that. The direction is more in the community—more services there. I think what government is committed to already is a really, really good start and we, within 12 months, will have very clear plans about how we continue over the next—I will make it up—decade, that we need to continue to again mature the system and transform the system. It is not just about more. That would be my point, is that it is long term. If you look at Victoria, which is no different to us, no different to most other states in Australia, they have signed up to the results of their royal commission, which is going to be a significant increase in funding annually for mental health, but also it is a long-term thing for them as well. Yes.

Dr RUSSELL-WEISZ: If I can add to that, I think it has got to be in that context of the broader system. The broader system, if I look at where we see our current pressures, which are huge at the moment, people are staying longer in EDs and there are a number of reasons for that; this is mental health and non-mental health. There are higher acuity, higher complexities; they are sicker. We have bays

taken up in our emergency department where people do not move because they are waiting. Many of them are mental health; they are waiting for a bed in the system. It needs to be multi-factorial. I think even if there was a heap of investment in mental health capacity—I do not mean just hospital capacity; I mean it right across the spectrum—we need the workforce. The workforce is a huge challenge at the moment. It is not a funding issue; it is a bodies' issue. We need to support our workforce who have been through an extraordinarily difficult 15 months, 18 months, and for them to see some light at the end of the tunnel, that there is other workforce coming in, and that is what we are doing.

The budget announced an ED workforce package, which is great, but we need—in mental health, it is also quite hard because while we are recruiting more nursing graduates into mental health, you actually need a whole suite of different types of workforce. You know, attracting psychiatrists to rural and remote areas, mental health nurses to rural and remote areas. When I was a clinician in the north west, we did not have a dedicated facility. There is a dedicated facility in Broome, an acute unit in Bunbury now, but it goes down. While we talk about expanding services, they absolutely depend on the right workforce. They depend on the right workforce. It is not just doctors, nurses, allied health—it is broad. An observation is we need to be able to navigate the system much better, and that is not just the state system at all, it is commonwealth and state. It is treacle and for some of our great staff on the front line, when they are saying, "I've got a patient in front of me, who doesn't need to be in hospital, but I'm actually not sure if they need NDIS, if they need just supported housing, if they need a clinical services wraparound, if they need a community care unit, if they need a secure unit but on a transition to a community care unit."

It seems simple, but we have a really good arrangement with the Department of Communities, where we have people from the Department of Communities assisting our health service people, so our social workers, to navigate the system because they know it better than us. Because I do think sometimes our staff will go, "I've got a number of patients I've got to look after, this is too hard to navigate this system." I think it is what it is, but we have got to make it easier because I still think at the moment we have done so much work on our long-stay patients at Graylands. We moved—in working with the commission, not all mental health, some needed just housing—28 out, really long-stay patients over the last few weeks, only to be replaced by 34. Which will be hard, not blaming the patients here, but we put those wraparound services into them. Some of it sometimes is as basic as housing. I am just saying that navigation of the system has to be easier for our staff to actually then find solutions. It is not just about capacity and community and hospital, it is about workforce, it is about our long-stays, and it is about avoidance; it is about that prevention piece as well, stopping them getting into hospital because there are very, very good services in the community.

One of the things that came out of budget this time is our active recovery teams—is that right? It is another acronym, ART, and those are active recovery teams to go in and support patients who are having a mental health crisis in the community to stop them reaching hospital. I think it is just multifaceted. There is no silver bullet here and every jurisdiction is feeling the pain. We are not an orphan.

Ms McGRATH: I will just add to that. Those three pieces of work which cover big parts of our system, they are all interrelated, pick up on all those things that Russ has said. All of those, the implementation plans will be about how can we do this in a sustained, planned, sensible way because even if we had the money overnight, you are not going to make it happen because it is about change. It is also about having the right staff and implementing needs to be for a long-term sustainable change because there the easy wins have already happened; I think that it is connected.

Dr RUSSELL-WEISZ: To add, we are optimistic, I think. In some ways, if you look back, we had the issue with aged-care patients in our hospitals, we still do, but 10 to 15 years ago, it went up to about 170 people waiting for transitional care or aged-care placements. That is now down to basically manageable levels. It is a little bit worse in country areas, but we work with the commonwealth, with other agencies, to try and get a system that worked, to get people out into the most appropriate care locations. This is, I think, more difficult, but we have to address it.

[10.40 am]

The CHAIR: I think I was intending to kick you out earlier than you were intended to be. We have until 11 o'clock. I was steamrolling ahead.

Dr RUSSELL-WEISZ: Sorry, must be something in this water.

The CHAIR: I think that leads into a good opportunity, when we are talking about funding, as to the potential effect of the impending national agreement, how that could impact, if you could talk a little about that?

Ms McGRATH: Yes, absolutely. We are working closely with Health and with the commonwealth. We are working through that now. Just so everybody knows, there will be a national agreement for health. At the moment the mental health stuff comes under the health agreement, so this will be the first time in Australia that there will be a mental health agreement, standalone. There is work going on between the states and the commonwealth at the moment on the head agreement, and then there will be a bilateral process. The commonwealth have already announced, I think it was in May or June, their budget for mental health. It is quite significant. We are starting to get some detail about what that looks like and then what that would look like for us. At the highest level it is consistent with the productivity commission report on mental health, which basically if I explained that, it would be just saying everything that we have already been saying. The good thing is we are absolutely aligned, that in the mental health space at least there is alignment of direction within Australia, and even the rest of world.

Saying that, all states are at different places on that journey and we do things better than some states and we do things worse in some parts as well. The opportunities, I guess, for us in this space are to—what it is about is the missing middle. It is actually not about more services in the health system, they will be staying the same; that is one part, but this actual agreement is about the missing middle. They talk about the missing middle. The Victorian royal commission talks about the missing middle. These are the people who are not getting services anywhere in the state, either from the commonwealth's primary care services or from our tertiary, secondary services in our system. There are people that go to their GP, or other services like Headspace and "No, sorry, you're too unwell for this service, you need to go and find basically a state service." They come to one of our state services and it is, "Sorry, you're not sick enough." So they are left in the middle.

A lot of the things that we have been talking about today are for that missing middle—it is there. The tricky bit is that is both a state and a commonwealth responsibility, so there is some argy-bargy going on around, how is that going to look? But the opportunities for us—I would like to think this is a real opportunity for a system to be better in the longer term, if we end up having joint or collaborative arrangements in place between the commonwealth and the state, because the last thing we want is the commonwealth to dump services in that are not integrated or linked up with the rest of the system. we talked about navigation a minute ago; that will just cause even more pain. It really does not meet the needs of our people here in WA often. People talk about Headspace, and it is pretty much 50/50. Some people think Headspace makes a great impact, fantastic, but there are just as many people who believe that Headspace is not doing what it is and it is a lot of money that goes into it. I am not saying it is right or wrong, but at the end of the day, we do not want more

of that. We want more services that are integrated with our current system or where we are heading with our current system.

I am always positive. I think there will be some real opportunities there and we are doing a lot in that space, but the good thing is it is very much aligned with what we have been talking about.

Dr DAVISON: I was just going to say that getting that missing middle right and the balance of state and commonwealth services so that people have a seamless service also relates to the first question about prevention, because there are different types of prevention. There is preventing people getting ill in the first place—that is a complicated area, an important one, but there is a really important role for services for people who already are becoming unwell, in preventing them escalating so that they end up in an emergency department and being more acute.

The CHAIR: Or once they are out.

Dr DAVISON: So getting that right is really helpful in terms of intervening and meeting people's needs, but also preventing things getting worse and ending up in the acute system.

Ms H.M. BEAZLEY: I feel like I am asking too many questions, but I am going to ask a couple of questions to cover things you have brought up. One, it is an incredibly valid point about the workforce. Do you work with tertiary institutions in identifying the areas that need to have more students come in, and an output at the other end?

Dr WILLIAMSON: I will speak to nursing and midwifery. I will just talk a little bit about general practice as well, but there is a peer group support workforce that is more in Sophie's area than mine. We have a large workforce project on at the moment. We would normally take on about 50 newly qualified nurses into mental health each year; we have added an extra 80 and they will all be on-boarded by the end of this month. We are probably going to have 150 newly-qualified nurses going into the mental health stream next year as well. We are really trying to, if you like, grow our own and have the emphasis on that rather than necessarily bringing them in from overseas, as you might have read in the press. I think we have touched on primary care as being an extremely important workforce. We looked at the presentations to PCH last weekend, where there were 300 people—normally, it would be somewhere around the 200 children who were assessed per day—and 10 per cent admission rate. That is 90 per cent of patients who did not require admission, let me put it that way.

So there is a problem about getting access to primary care and we know that primary care has a vital role in mental health. We have had a GP project on for a considerable amount of time now. We are working together with the colleges, so ACRRM and RACGP, we are working together with HSPs. We are bringing would-be GPs through a program during their early hospital training to ensure that they have been exposed to the critical areas that they need in order to function when they go into community practice. We are working with the universities, I mention the universities there as well. We are doing that work. Those are the two areas that I would predominantly be involved in. The director general also mentioned allied health, which has got an extremely important role to play in mental health and we will be looking at that as well. But in terms of peer support —

Ms McGRATH: And way more than even peer support. We are working with the community sector because as Russ mentioned earlier, the workers that are needed across the whole sector of mental health is quite varied. We work with both the peak bodies, WAAMH and WANADA, and CoMHWA, et cetera. We have some work going on at the moment to see what are the focus areas that we need to look at. Last year we released the workforce strategy plan, I cannot remember what it was called, for the whole mental health sector, which talked about all the parts of the sector which will be needed into the future. Obviously, if we are going to grow more community services, well, what

are the types of staff we need there? Peers are a really important part—other social workers and connectors, whatever we want to call them in that space, Aboriginal workers. There is a lot of work to be done there which we are working across the sector and working closely with health in terms of all the clinical staff. Some of these staff that we will be looking at from the community sector—hopefully, with our new models of care going forward, would be working within hospital services. We have to get rid of that demarcation, "Oh, that's that side and that's this side", it is these services having all of that. There is a lot of work in that space. I was part of the school summit a couple of weeks ago.

The CHAIR: You just answered a question I was about to ask.

[10.50 am]

Ms McGRATH: Yes, and interestingly, I was not the only one who was pushing for a lot of support. We know that in the next five years, if you look at the graph that was given to everyone, where is the growth in jobs in WA going to be needed, and it is in the health and human services sector; mental health are part of it. One of the things we talked about on that day is—well, a couple of things—one for me is that we need to look at how we can make the mental health, alcohol and drug sector an attractive place to work, to start with, because everybody right now knows it is really, really tough, and it is. There is some work around that, but there is also some work around it should not be just about mental health, alcohol and drug sector. We need people in aged care, we need people in disability, et cetera, and it should be attractive to get people into these types of sectors to have a whole career. You do not just go in and you are stuck there. We do not sell it that way, and we should be selling it that way, and we should have pathways and opportunities for people so they can spend their whole career and actually have a great career in that wider space.

So there was stuff that was talked about that from lots of the tables, not just the one that I was pushing it on, which was Mr Dawson's table. I think there are lot of opportunities there in that space to get not just young people into it but people who are changing careers midway. I do think there is a lot of work to be done in that, at all different aspects, but right now it is get more nurses, et cetera on, but also that bigger picture, longer term view.

Ms H.M. BEAZLEY: You mentioned earlier the future health research and innovation fund, and I am wondering what work will be done to identify alignments between the strategy that has been released last year and that fund, and, therefore, the potential to influence, possibly, the projects and research that the fund will invest in, from that strategy.

Ms McGRATH: I will add to that. Could I just start first, only because I was involved—and the rest of the Mental Health Commission. We had four or five people with the Curtin crew last week to talk to us about, well, so what does this need to – you know what I mean, what are your views on this? Sophie is our representative on that piece of work. What we really want to happen is to make sure that it is very much practical, on-the-ground stuff that we can actually use to help inform all the stuff. Sorry to take that. I had not had a chance to talk to you since we have had that meeting, which was a fantastic meeting.

Dr WILLIAMSON: No, you have answered the question. It is very clear that the focus of the fund has to be in the translation of research as well. Yes, we want to foster innovation and we will be making some announcements about how we might do that in the near future. We have got a meeting with the advisory council tomorrow, actually. But we very much recognise that some of the work that needs to be done needs to be in that translational space. The advisory council is aware of that.

Mr H.T. JONES: The question I have will be drilling down further, but yes, I will pass it back to you, chair.

The CHAIR: At the beginning I just briefly mentioned about the announcement into the statutory review of the Mental Health Act 2014, so just a couple of quick questions. I can perhaps leave you with them, if you like, to think through further. Will the process of this review affect the commission's and department's implementation of the Auditor General's recommendations, in the access to the managed adult mental health services report. I will leave it there. Thoughts on it?

Dr RUSSELL-WEISZ: I would say it does not stop the business.

Ms McGRATH: No, no, it definitely does not stop. Because it was new legislation in 2014, was it, this is the first time it is reviewed. There are a lot of things that people have already put in which are around just some streamlining-type things, so I think there are some positives around that. The short answer is, no, it will not. It will only be positive things. But we can provide you more information on that, an update on that.

The CHAIR: Yes, that would be great, as time goes on. The second one is: are there any anticipated review outcomes that may affect the commission's and department's implementation of the recommendations that you can foresee?

Dr RUSSELL-WEISZ: I cannot. I do not want to pre-empt what a legislative review would say, but I cannot see it because I think the Auditor General's findings have been useful to the department, the Mental Health Commission, and it is actually about making it a more seamless journey for patients, so I cannot imagine anything in the review would make that harder.

Ms McGRATH: No. It is aligned to our directions anyway.

The CHAIR: Yes, you are expecting it, anticipating it. That brings us to a close. I will just formally wrap up the proceedings. Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of transcribing errors only. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript of evidence. Can this information be placed on our website?

Ms McGRATH: Yes, absolutely. It is all public information anyway.

The CHAIR: Yes. That is terrific. I do not think we have any questions on notice, do we? There is just a reference to questions on notice. I think we are pretty happy with where we have landed. Thank you very much for your evidence today and we certainly appreciate you taking the time to talk to us and wish you all the very best in this monumental work that you have before you.

Hearing concluded at 10.55 am