STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2014–15 BUDGET ESTIMATES HEARINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 11 JUNE 2014

SESSION TWO
MENTAL HEALTH COMMISSION

Members

Hon Ken Travers (Chair)
Hon Peter Katsambanis (Deputy Chair)
Hon Martin Aldridge
Hon Alanna Clohesy
Hon Rick Mazza

Hearing commenced at 2.07 pm

Hon HELEN MORTON
Minister for Mental Health, examined:

Mr TIM MARNEY
Mental Health Commissioner, examined:

Mr KEN SMITH
Director, Corporate Services and Governance, examined:

Mr ERIC DILLON
Director, Policy, Strategy and Planning, examined:

Mr NEIL GUARD
Executive Director, Drug and Alcohol Office, examined:

Mr SIMON HUNTER
Director, Client Services and Development, Drug and Alcohol Office, examined:

The DEPUTY CHAIR: Good afternoon. On behalf of the Standing Committee on Estimates and Financial Operations, I welcome you to this afternoon's hearing. Can the witnesses please confirm whether they have read, understood and signed a document that is headed "Information for Witnesses"?

The Witnesses: Yes.

The DEPUTY CHAIR: Witnesses need to be aware of the severe penalties that apply to persons providing false or misleading testimony to a parliamentary committee. It is essential that all your testimony before the committee is complete and truthful to the best of your knowledge.

This hearing is being recorded by Hansard. A transcript of your evidence will be provided to you. The hearing is being held in public, although there is discretion available to the committee to hear evidence in private either of its own motion or at a witness's request. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session before answering the question.

Government agencies and departments have an important role and duty in assisting Parliament to scrutinise the budget papers on behalf of the people of Western Australia. The committee values your assistance with this and values your attendance here today. Do any of the witnesses wish to provide an opening statement?

The Witnesses: No.

The DEPUTY CHAIR: I will go straight to questions from committee members and other interested Legislative Council members. I give the call to Hon Stephen Dawson.

[2.10 pm]

Hon STEPHEN DAWSON: I refer to page 396, "Significant Issues Impacting the Agency" and to any of the points that relate to the Drug and Alcohol Office. The merger between DAO and the Mental Health Commission will happen once the bill before this place passes. What estimated efficiencies will come from the merger? I understand that a number of staff positions will no longer

be required as a result of the merger. What estimated efficiencies will be achieved from the merger and how many staff do you anticipate will go as a result of the merger?

Hon HELEN MORTON: Thanks for the question. The decision to merge was mostly around the improved effectiveness of the services provided to people with comorbidity; people with mental illnesses and drug and alcohol problems. It is estimated that 70 per cent of people in residential care have comorbidity and that between 30 per cent and 50 per cent of people in the community have comorbidity. The way services have operated in the past has meant that too many people are excluded from one or the other service because they have comorbidity. The idea of merging the services was to bring about a much greater collaborative effort between the two service streams to ensure that we provide a service that offers adequate services for people with comorbidities. It was never about efficiencies in terms of saving money, although in the process of doing this work, some positions will not be held because the two agencies will become a single agency. For example, I refer to finance, human resources and media positions—the sorts of positions that can provide a service across the new entity. If there are efficiencies of those types, there has never been a request put on us to find those efficiencies and put them back into consolidated revenue or anything like that.

Hon STEPHEN DAWSON: That is not what I am getting to, minister, although I appreciate your answer. I understand the rationale behind it. As you said, there will be a duplication of roles. There are two agencies now with some people doing the same job; some people will not be needed in the new agency. Does the minister have a sense of how many duplicated roles will not be needed?

Hon HELEN MORTON: There have been a couple of different proposed structures that I have looked at. I have not seen a final one yet, but Tim Marney has responsibility for actually pulling that all together so I ask Tim to speak on that.

Mr Marney: As the member would be aware, the rationale behind the merger between Mental Health Commission and the Drug and Alcohol Office is in response to the Stokes review recommendations around working more closely and in a more collaborative, integrated way in dealing with service provision to those who have coincidence occurrence of mental health issues and alcohol and drug issues. Part of the imperative in bringing the two entities together is to actually beef up the areas which they crossover. There will be within the new entity—the proposed structure will have significant enhancement of the policy and procurement areas and also a significant increase in dedication of resource to consultation and engagement with consumers, carers, families and significant others in the formulation and co-design of programs. With that arises an opportunity for the redeployment of some resource internally. The resources that are duplicated across both entities that you are referring to are very much the back office resource functions that the minister mentioned in the areas of HR, finance and to a lesser extent information services and media. We are currently working through the actual structure of individual positions in those areas and what is evident in working through that is due to the fact that we will have an agency of FTE in the vicinity of 400, the HR, the finance processing–type functions will actually maintain significant volume. So, there is probably not much of an implication for positions of very much an operational nature in those areas in back office function. The rationalisation, if it occurs, will occur at higher level—so, the heads of finance, HR and media. At this point, as I said, we are still working through the detail of the individual structure and I am loathe to pre-empt the deliberations of Parliament of the merge of legislation as well, but as we work through that, there will be opportunities as well to address those areas of functionality that need to be enhanced within the merged entity and opportunities for redeployment of some of those people across to other functions for which their skill set, I would have to say, is not unsuited.

Hon STEPHEN DAWSON: Sure. Mr Marney, you are on the record as saying roles like the librarian at DAO may longer be needed, so, obviously, there is a sense of what may go. When do you anticipate having a final decision on the new make-up of the new agency?

Hon HELEN MORTON: If you direct questions through myself in the first instance —

Hon STEPHEN DAWSON: Sorry, minister.

Hon HELEN MORTON: That is okay; I understand. I just wanted to correct one issue that you made and that is that the librarian—that that position has already been—it has already gone.

Mr Guard: The librarian has taken voluntary severance as part of this year's process.

Hon STEPHEN DAWSON: Thank you for that clarification. The second part, minister, was when does the agency anticipate that this new structure will be finalised and we can finally know the make-up of the new agency?

Hon HELEN MORTON: Obviously, the outcome of the legislation is going to be quite a significant determination of that.

Hon STEPHEN DAWSON: I wish you swift passage, minister.

Hon HELEN MORTON: Can you assume that the legislation will go through?

Hon STEPHEN DAWSON: You will be ready to go immediately once the legislation is through; is that what you are telling me?

Mr Marney: We will be significantly progressed to be able to implement if and when the legislation passes both houses. Really it is dependent on the timing of the passage of legislation. I probably would not launch with a new structure immediately because I would want some time to be able to consult with stakeholders of DAO because at this point in time I have not been able to do so because, quite frankly, that would be pre-empting Parliament's deliberation. There will be a need for a transition period and I suspect that to be two to three months before we then flip to a completely new structure. There are elements that can happen seamlessly and without the need, I think, for substantive engagement or consultation, but some elements will require the input of consumers, carers, families, and significant others.

Hon STEPHEN DAWSON: Minister, just before we move on can I have a guarantee that—there is approximately 400 staff in the two agencies now. When this merger happens, there will still be approximately 400 staff. We will not see positions lost out of the agency even though we might see roles lost. We will still see the same number of positions in the agency as a result of this?

Hon HELEN MORTON: The answer to that is that the numbers will not change, but the composition will change but a fair whack of the numbers you are referring to are clinical positions providing services through the drug and alcohol integrated service framework out in the community.

Hon STEPHEN DAWSON: Those positions will come across.

Hon HELEN MORTON: Yes.

Hon STEPHEN DAWSON: One final point on the issue of the merger—you would be aware that there has been some concern in the alcohol and other drug sector regarding the merger, particularly in relation to the naming of the new agency or in relation to the fact that the new agency, the Mental Health Commission, will not have the words "drug and alcohol" in it. Have you given any thought to including the words "drug and alcohol" in the name of—combining with the Mental Health Commission?

Hon HELEN MORTON: Yes, I am aware of that. I have had extensive discussions with WANADA and some of the organisations that sit within that network. I have obviously had a lot of discussion through the Drug and Alcohol Office and with the board of the drug and alcohol authority and so I am very clearly aware of the concerns that have been expressed around the —

Hon STEPHEN DAWSON: Are you sympathetic to the concerns, minister?

Hon HELEN MORTON: I have always been sympathetic to them. At a time when we were looking at the options around the naming, it was agreed that the Mental Health Commission was a name that would continue and that has now been agreed to. It is obviously embedded in the legislation that is sitting in the Parliament at the moment as such.

[2.20 pm]

It does not mean that there will not be an identifiable structure sitting within this new entity that is clearly identified as a drug and alcohol area of service that will be dedicated to providing quite specific and dedicated services around drug and alcohol services. I have spent a lot of time talking to people in the area, particularly around drug and alcohol services. Although people are still disappointed about the lack of the words "drug and alcohol" in the name et cetera, I think they are comforted in the knowledge that there will be quite a clear area of dedicated service within the new structure.

Hon STEPHEN DAWSON: There is no doubt that the more times you say it on the public record it will give them more confidence but at this stage you are ruling out the inclusion of the words "drug and alcohol" in the name of the new agency?

Hon HELEN MORTON: The word we now have is the word agreed to by government.

Hon STEPHEN DAWSON: Thank you, minister.

Hon ROBIN CHAPPLE: I am referring to page 395, "Significant Issues Impacting the Agency" regarding the subheadings "Mental Illness and Aboriginal People" and "Suicide Prevention". Although I congratulate the government at one level for providing $29 million over three years for extending the statewide specialist Aboriginal mental health service and for providing $3 million in the 2014–15 budget to continue the statewide suicide prevention strategy, I ask: what proportion of any or both of those sums is being or will be directed to culturally based programs? I want to point out that culturally based programs are best explained by the recent statement by Emeritus Professor Michael Chandler that —

> If suicide prevention is our serious goal, then the evidence in hand recommends investing new monies, not in the hiring of still more counsellors, but in organised efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives.

If some of the money is to be spent, please provide details of those programs and the extent to which they are funded in each of the budget estimates and forward estimates periods.

Hon HELEN MORTON: I was not 100 per cent certain whether you were talking about the statewide specialist Aboriginal mental health service or the suicide prevention strategy.

Hon ROBIN CHAPPLE: I am referring to both.

Hon HELEN MORTON: Quite a substantial amount of funding has been provided in both those areas.

Hon ROBIN CHAPPLE: Yes; I congratulate you.

Hon HELEN MORTON: If I talk about the statewide specialist Aboriginal mental health service first, I think there is $29.1 million for the following three years for that service. I do not know whether you are fully aware how that currently operates, but it provides a specialist mental health service operating alongside the mainstream mental health services. The specialist Aboriginal mental health service will go into communities, will provide assistance in encouraging and supporting people in the community with about 60 something—I cannot remember the exact number—Aboriginal mental health workers who are now employed in that service. Many of them have subsequently done a tertiary qualification or further education to enable them to have that

qualification. With the support of the mainstream mental health services they are able to provide work within their communities. They are also providing a lot of support in getting Aboriginal people to access and engage with the mainstream services. We have seen more than, I think, about a 141 per cent increase in the number of Aboriginal people who are willing to engage with community mental health services, for example. This specialist Aboriginal mental health service walks beside Aboriginal people as they access the service. I travelled at one stage with the specialist Aboriginal mental health service to a community right out in the Canning Stock Route. The last community before you get onto the Canning Stock Route —

Hon ROBIN CHAPPLE: Kunawarritji.

Hon HELEN MORTON: That is the one.

Hon ROBIN CHAPPLE: This is where the question came from.

Hon HELEN MORTON: Is that right? I travelled out with the specialist Aboriginal mental health service. We had the mainstream service providers with us; there was the psychiatrist and some of the community mental health nurses on the plane. Along with them were the specialist Aboriginal mental health workers. A gentleman from that community was in hospital in Graylands, and his family did not know and did not understand what would happen—was he ever going to come home et cetera? Through that engagement we were able to talk with that family and help them understand precisely what was happening with their family member and when he was likely to be discharged back to the community. That is the sort of role they provide, notwithstanding they also provide quite dedicated community-based services in their Aboriginal communities that they have a responsibility for.

Hon ROBIN CHAPPLE: I go back to what the community has been saying and to a large degree what Professor Michael Chandler has been saying; that is, what the community is missing in this process is people going to the communities who might be other Indigenous people who do not necessarily have the cultural experience of that community. The communities are saying, "We really want to be part of this process and engage from our end, not just your end."

Hon HELEN MORTON: That is happening because all these Aboriginal mental health workers are not located in Perth or Broome, for example. They are located in those communities around Fitzroy, Halls Creek et cetera.

Hon ROBIN CHAPPLE: But not the desert communities.

Hon HELEN MORTON: In the Pilbara they are probably not at that particular community but they seem to have a connection. When I was out there they were well received; they had great knowledge of the families there and they were received by those families. We stayed over for a couple of nights there. There was great interaction taking place between the Aboriginal mental health workers and the families there. Similarly, the suicide prevention strategy is again a service that will be funded for another 12 months providing, I think it is $3 million for another 12 months of that service. We are in the throes of having that fully evaluated at the moment.

Hon ROBIN CHAPPLE: Where is that service going to—that particular $3 million? Is it identified for a number of communities or is it a particular program for Mowanjum?

Hon HELEN MORTON: The ministerial council on suicide prevention is reconsidering how all those funds are to be disbursed in this area. That has not been given back to me at this stage, although there are some broad parameters around how it is currently being allocated. I will continue to say that that is an example of community based, community owned and community determined level of action and initiatives that communities have determined. That particular service has not come from a top-down approach. In Mowanjum, for example, they wanted red-dust healing. They wanted the range of things that they wanted, and that is what they were funded for. We flew people from Mowanjum down to Perth so they could meet with the ministerial council. Some members of the ministerial council have been up there, so there has been a lot of interaction to determine what

the people on the ground wanted to make happen in their community. That is an example of just one of those services that has been provided in those remote communities. Tim Marney can give you more of an outline of where we are going with the strategy in the next 12 months.

[2.30 pm]

Mr Marney: Of the $3 million investment in 2014–15, $1 million is new funding for non-recurrent initiatives to strengthen the sustainability of the community action plans. As you would be aware, the first phase of the "Western Australian Suicide Prevention Strategy 2009–2013" was all about establishing a range of community action plans. It is a little bit nebulous in its title, but when you actually see, on the ground, what they are, essentially they are initiatives generated by the community and by, if you like, natural leaders in the community. They apply to the Ministerial Council for Suicide Prevention for, I have to say, very modest funds to facilitate community engagement and community conversation around defining some of the causal factors in their community for suicide, and formulating actions to actually address those local community causal factors. I think the issues you have raised around the need for locally determined action to prevent suicide is exactly what the community action plans are geared to do, and 2014-15 will see the continuation of that initiative under the auspices of the Ministerial Council for Suicide Prevention.

The Auditor General has reviewed the first phase of the suicide prevention strategy; there has also been a recent Ombudsman review, and there is a substantial evaluation currently being finalised of phase 1 of the suicide prevention strategy. All those elements will feed into the ministerial council's work in investigating what is the most appropriate configuration of the second phase of the suicide prevention strategy, and will inform the government's decision-making with respect to the continuation of the suicide prevention strategy post 2014-15. But I think, from my observation and certainly from the early analysis of the evaluations undertaken, the strength of that program has been the fact that it is community-based and community-driven, and therefore very much targeted at local community and cultural issues.

Hon SALLY TALBOT: Minister, you, I think, in the past have expressed support for the EPPIC model—the early psychosis youth centre model. I will give you a couple of places where you might reference this. I was looking under "Significant Issues Impacting the Agency" on page 394, and I expected to see some reference to EPPIC under "Mental Health Infrastructure" on page 395. You also have, of course, the heading on page 399, "Accommodation, Support and Other Services". I wondered where in the budget I might find some reference to the establishment of an early psychosis youth centre, particularly given that at the end of 2012 the government talked about funding $15.3 million towards that service. I understand there was commonwealth money in there that may have fallen away, but my recollection is that you were expressing support for that model. Is there any reference to this in the budget?

Hon HELEN MORTON: I am not sure if there is a reference to it in the actual papers themselves, but just so that you can be clear about what has taken place I will explain. As you know, I think the commonwealth unilaterally withdrew their funding for that service to be operated by the state, and subsequently gave the funding and—I think a lesser amount of funding but I do not know precisely how much less—to Headspace to undertake the service, and I think they have located it in the northern suburbs. I am not sure —

Hon SALLY TALBOT: Is that fully funded by the commonwealth?

Hon HELEN MORTON: Headspace is, yes. Obviously they have been negotiating with us on how they might put that together, where they might locate it and how they might operate it et cetera, because the services, at the end of the day, have to be complementary to one another. I had discussions with them when they were first getting that funding up and running, and some questions I asked were along the lines of: does that mean that you will take full responsibility for early psychosis services for young people—for youth—in the northern suburbs for example? It was made clear to me that there was a cap on the number of people they were going to see. I cannot precisely

remember what that number was, but I think somehow or other the figure 200 comes into my mind. My question to them was: what is going to happen when the 201st person turns up at your door? Will you continue to expand to take on those services? The answer was, "No; we will be sending them back to you. We will be referring them to your services."

Hon SALLY TALBOT: The state, surely, had already done —

Hon HELEN MORTON: Let me just finish.

In the process of knowing that we had to continue to provide the services that we were already providing for those people, both in community mental health services and other places that we were providing it, and with the knowledge that a fair few of these people would be coming into the subacute services, we have redirected the funding we had into expanding those services.

Hon SALLY TALBOT: Okay; but the state had already done quite a lot of work on the model.

Hon HELEN MORTON: A huge amount.

Hon SALLY TALBOT: Was the whole of that $15.3 million commonwealth money? Surely there was some state money in there?

Hon HELEN MORTON: In the funding coming from federal government?

Hon SALLY TALBOT: Was there not a state contribution towards the EPPIC model?

Hon HELEN MORTON: There were going to be two EPPICs operating in Perth—one in the northern suburbs and one in the southern suburbs—and we were going to allow, or hopefully collaborate with, the commonwealth to provide one in the northern suburbs, and we were going to redirect some of our services and funding to provide one in the southern. Consequently, as a result of not getting the commonwealth funding into the way we had expected to operate, we redirected our funding into other services.

Hon SALLY TALBOT: Can you give us any indication of where that redirection of funding has gone? How much has been redirected?

Hon HELEN MORTON: Tim Marney can talk to that specifically.

Mr Marney: The amount of redirection to other services is $12.8 million, and that has been redirected to the mental health subacute services. In particular that will go towards Rockingham, Broome and the development of goldfields subacute services, all of which were election commitments of the government. They will be implemented over the next, approximately, two years. There were also —

Hon SALLY TALBOT: Could you just tell me again? That is Rockingham —

Mr Marney: Rockingham and Broome.

Hon SALLY TALBOT: Joondalup?

Mr Marney: No, it was Rockingham, Broome and the goldfields.

That money has been reflowed over the forward estimates to fund in part the capital and recurrent costs associated with those three facilities. The ordering of the facility is broadly at this point being Rockingham, Broome and then goldfields. We are well advanced in the development of the Rockingham subacute facility, progressed with respect to Broome, and in the planning phase with respect to the goldfields facility. The $12.8 million has been redirected over the forward estimates for those three facilities. There was an amount of $1.8 million of unspent funds, and that was returned to the government in previous financial years, given that the expenditure allocated to those years was not undertaken and so the money was returned to the consolidated fund.

Hon SALLY TALBOT: Does this mean we are losing our focus on the youth part? "Y" stood for youth. These subacute facilities are for all ages; they are not especially targeted for youth, are they?

Hon HELEN MORTON: Yes, not at all. The 10-year vision for mental health is to create a dedicated youth stream for mental health services across the entire state. Work that is being undertaken right now in the mental health services plan is demonstrating a youth-specific service across the whole state, and the services in the subacutes are from ages 16 onwards. The majority of people are coming in at that age group—around about the 16 to 25-year-old age group—for subacute services. So not at all; the service is continuing to focus around youth-specific services, quite clearly in the knowledge, as everybody else already knows, that that age group is where 75 per cent of the diagnoses of mental illness actually occurs for the first time. There is a very clear commitment to making sure that we develop a very specific youth mental health stream across the state.

[2.40 pm]

Hon SALLY TALBOT: Do you know where any of these youth-focused centres are going to be established? I am not sure whether that is what you are saying; are you saying that you are just going to build them into existing services?

Hon HELEN MORTON: It will be both. For example, Fiona Stanley Hospital will have a dedicated area of the new mental health unit that is youth-specific. That will happen at other places.

Hon SALLY TALBOT: Where else will we have dedicated youth-specific mental health services?

Hon HELEN MORTON: The reason we are discussing it here is because I actually have not seen the first draft of the mental health services plan yet, but it is dependent upon that plan, which shows both the location and the specified amount of service that is dedicated to youth. I will ask Tim Marney to complete those comments.

Mr Marney: The 10-year mental health services plan is based on a very complex, technical modelling of demand and supply of services. It takes demographic and benchmark service delivery metrics and models the extent to which different cohorts in the community and the population over the next 10 years will require and seek treatment and support services. Within that modelling exercise we disaggregate by age cohort as well and the modelling provides a comprehensive view of both the prevalence and location of the demand for youth services, and therefore our supply plan reflects that detailed analysis. The upshot is, as we all know in terms of the business case for dealing with mental health issues in the community, the sooner we intervene when problems arise the better, so certainly a big focus of the mental health plan will be on early intervention, and that will logically pick up the younger age cohorts.

Hon SALLY TALBOT: May I just interrupt you? That age cohort—is it 15 to 24, in line with the original government commitment to the EPPIC model?

Mr Marney: It is actually from birth right through to 24, and disaggregated within that, because there are different service needs within that age spectrum, so we have disaggregated within that zero to 24, 25 age group, and there are specific services geared for different age components within that group, one of which will be the 15 to 24 group.

Hon SALLY TALBOT: Minister, when are we going to see the 10-year plan? Obviously you have not seen it yet, but the people all around you have.

Hon LJILJANNA RAVLICH: Is it going to take 10 years to do? Is that why it is called a 10-year plan?

The DEPUTY CHAIR: One question at a time, please. We cannot have members asking two questions at the same time; it is impossible for the minister to answer any more than one question at one time.

Hon HELEN MORTON: The technical underpinnings for that work I have seen and have been fully briefed on, which is the need information, the demographics, demand for services and

population growth et cetera. I understand all that information and how it has been translated. It is the top level of that document that I have not yet seen, and I believe that that is days away.

Hon SALLY TALBOT: Is it going to be tabled in the Parliament?

Hon HELEN MORTON: Obviously before it is tabled anywhere it will go to cabinet; cabinet needs to endorse it. It then has some stakeholder input that they need to have finalised feedback about, to get some final comments back from those stakeholders, but I would be very proud to table it in the Parliament.

Hon SALLY TALBOT: With the indulgence of the Deputy Chair, just one more question relating to this issue, if I may. You gave us a list that talked about Rockingham, Broome and goldfields, in that order. Obviously the two glaring omissions from that list are Bunbury and Karratha, so I repeat my questions from last estimates: what has happened to Bunbury, and what has happened to Karratha?

Hon HELEN MORTON: Bunbury and Karratha are still in the planning stages; they are coming onstream after the goldfields.

Hon SALLY TALBOT: I think Mr Marney mentioned two years, so can we assume that Bunbury and Karratha are at least two years away? Is there a second tranche of these Step Up, Step Down facilities?

Hon HELEN MORTON: Obviously the 10-year plan might reorganise that time line, if necessary, around Bunbury and Karratha. I would not be at all surprised if it did not indicate that Karratha became a higher priority than Bunbury, for example. I think we will wait until the 10-year plan is out there, and it will demonstrate the priorities for those sorts of services, and the time line in which they will be developed.

Hon SALLY TALBOT: I hate to be cynical, but it does begin to look as if these announcements, which were actually made in the election campaign last year, are going to be re-announced in the next election campaign in 2017, but that would be very cynical.

The DEPUTY CHAIR: I am not necessarily sure that is a question; I will take that as a comment. There are lots of members who want to ask questions; I am pretty sure I will get around to coming back to you, Hon Sally Talbot, for a second go.

Hon NICK GOIRAN: I ask the minister to give consideration to page 395 of the budget papers, following on from the questions of my good friend Hon Robin Chapple on the issue of suicide prevention and the suicide prevention strategy in this state. Minister, you will be aware that Dr Philip Nitschke recently visited Western Australia and conducted a workshop in which he gave advice and instruction on how to obtain the drug sodium pentobarbitone and use it to end one's life. He also offered for sale through his company Max Dog Brewing nitrogen cylinders and explained how they could be used to end one's life in a manner that could not be detected after death if the cylinder was removed. Are you in a position to advise the committee today on what the status of the drug sodium pentobarbitone is under Western Australian law, and why it has that status?

Hon HELEN MORTON: This is a question that I am happy to provide some information about, but it does fall under the Department of Health. Nevertheless, I do have some information about it. In summary, the injections of sodium pentobarbitone—or Nembutal, as it is currently known—is prescription only. Pentobarbitone tablets are also a controlled drug. A medical practitioner may legally prescribe both injection and tablets in the lawful course of their practice in accordance with the Poisons Act and regulations. The regulations authorise certain health practitioners to procure and possess controlled drugs, but does not authorise members of the public to do the same. If a doctor wishes to use sodium pentobarbitone, there would be a requirement to access the medication from overseas, through the Therapeutic Goods Association's special access scheme, and possession of a specified drug may be an offence under the Misuse of Drugs Act; that would be a matter for the police.

Hon NICK GOIRAN: Mr Deputy Chair, if I could just continue with some supplementary questions along the same topic. I thank the minister for taking that question and your indulgence with respect to the fact that they are probably best directed to the Department of Health. Following on from that, are you in a position to indicate if there is any data on the use of that drug in connection with suicides in Western Australia, including any data on the age or other characteristics of those who have used it?

[2.50 pm]

Hon HELEN MORTON: I do not think there is, because I was not able to access that information. There was a high media profile case of a Perth woman that you would know about called Erin Berg, who committed suicide with Nembutal in Mexico in 2008. I was quite heavily involved with the family following that circumstance. There was a coronial inquiry into this matter, and that was finalised in 2013. There have been no listed sodium pentobarbitone suicides reported to the Chief Psychiatrist in either 2011 or 2012. The Chief Psychiatrist receives death reports from patients of mental health services, but not reports of potential suicides from the community generally. Thus the majority of possible suicide cases have no contact with mental health services and are not reported to the Chief Psychiatrist.

Hon NICK GOIRAN: Thank you. Mr Deputy Chair, before I continue, I notice there is a bit of agitation by members with respect to the suggestion of dorothy dixers. I just indicate to you that I did give notice of some of these questions to the minister before today, because they are quite technical and detailed. Any suggestion that they are dorothy dixers provided to me by the minister is incorrect. This is a matter that I have been pursuing for quite some time.

The DEPUTY CHAIR: I understand that, and, at the end of the day, this is a forum for members to ask questions and seek information from government. It is sometimes worthwhile for members to give some notice of the question so that they can actually get a detailed answer. I am aware, Hon Nick Goiran, that this is an issue that is at the forefront of your mind. So just continue to ask your questions and do not worry about the chatter or the interjections.

Hon LJILJANNA RAVLICH: Well, there is no rule against it, and no-one has even raised the issue.

Hon NICK GOIRAN: Thank you, Mr Deputy Chair; I will just continue, then. Minister, are you able to indicate how the conducting of this workshop in terms of committing suicide fits in with Western Australia's suicide prevention strategy?

Hon HELEN MORTON: I will ask Tim Marney to comment on that.

Mr Marney: Obviously, the conducting of the workshop is of extreme concern. The suicide prevention strategy more broadly is about ensuring that people do not seek to take their own lives, and to prevent the desire to do so, and therefore negate the effectiveness or demand for such a workshop actually being undertaken and having any effect on people's behaviour. It is important for all of us to recognise that the suicide prevention strategy has been very firmly focused on ensuring that there is significant and responsible community dialogue on the responsibility of the community to discuss, consider and help prevent suicide at a grassroots level. So very much that would be seeking to ensure that people are aware of how they can seek to help others, and how individuals themselves can seek help to ensure that their strategy, when in consideration of suicidal thoughts, is to seek help to prevent that and to recover, as opposed to seeking assistance to terminate their life.

Hon NICK GOIRAN: This is my last question on this topic, and I appreciate, minister, that again this might best be directed to another agency. Are you able to indicate what steps are being taken by law enforcement agencies to prevent the illegal import and/or supply of this drug in Western Australia?

Hon HELEN MORTON: I understand that this is a police matter. But the comment that I would make in advance of that is that regardless of medical purpose, pentobarbitone is a barbiturate. Long-

term barbiturate use also leads to tolerance and physical dependence. Very few barbiturate drugs or forms of drug remain marketed in Australia, but we still do have some remaining genuine medical uses in Australia. It is used in veterinary practice for euthanasia. It may be used as a sedation or treatment for epilepsy, but it is rarely used in medical practice now. So in terms of the steps being taken by the law enforcement agencies to prevent the illegal import and supply of this drug in Western Australia, that is a question that needs to go to the police.

The DEPUTY CHAIR: The next person on my list is Hon Ljiljanna Ravlich.

Hon LJILJANNA RAVLICH: Thank you. Minister, before I ask the question that I have been allocated, I am going to ask another one, and that is in relation to the expiry of national partnership agreements. We have made some comments in relation to commonwealth funding. Of the 63 national partnership agreements that the state government has with the commonwealth government—it actually has more than that, but of the 63 that presently exist with the commonwealth government that are either due to expire or have expired, how many of those affect the minister's agency of mental health?

Hon HELEN MORTON: Do you have a list of the 63?

Hon LJILJANNA RAVLICH: No, I do not. The minister might be able to take this on notice if she does not have the answer, but I imagine there would be a few of them, because a lot of those agreements pertain to health.

Hon HELEN MORTON: I will confer and see if we have a list off all of the NPAs that affect mental health.

The DEPUTY CHAIR: As the member has indicated that she would be happy for the question to be taken on notice, the minister might want to indicate if she wants to take it on notice.

Hon HELEN MORTON: That is something that we will take on notice at the moment. At this stage we are aware of three agreements that we are focusing on. That is the national perinatal depression initiative; improving public hospital services, of which there are a number of services fall out of that; and a section around the national partnership agreement on homelessness as well that impacts on mental health. But off the top of my head, I cannot remember the other ones.

[*Supplementary Information No B1*.]

The DEPUTY CHAIR: I assume the member would like to have not just the name of the partnership agreement but also the date of expiry?

Hon LJILJANNA RAVLICH: Yes, the date of expiry; the value of the partnership agreement; and the loss of revenue to the state if each of those agreements is not re-signed and they just expire—that is, the shortfall that the state would have to find in terms of funding to maintain the service level across the mental health portfolio.

Hon HELEN MORTON: Okay. So we will look just at the ones that are directly applicable to the Mental Health Commission and the Drug and Alcohol Authority.

Hon LJILJANNA RAVLICH: Yes.

The DEPUTY CHAIR: We will incorporate all of that into B1, and we will expect the answer in due course. The member did indicate that she might also want to ask another question that has been allocated to her, or any other type of question, for that matter.

Hon LJILJANNA RAVLICH: I have got many of them, and I have already indicated two, because I also want to ask the same thing in relation to commonwealth grants, because apparently the feds had not completed their budget at the time the state was doing its budget, and consequently there is about $8.6 million in grants that is normally allocated to the state. What I would like to know, in relation to those grants that affect the mental health portfolio, is: what specific project is each grant for; how much is the value of the grants that may no longer be paid to the state; and what

measures is the state government going to take to ensure that funding is provided so that service levels can be maintained? So, it is the same question for grants. So that you do not get mixed up, the reference point for both of those questions is page 77 of budget paper No 3. "Commonwealth Grants" is one heading and "Expiring National Partnerships Agreements" is another.

[3.00 pm]

The DEPUTY CHAIR: Can I clarify whether the member wants a list of every single grant or only those that have been impacted by the federal budget?

Hon LJILJANNA RAVLICH: Only those that had been received by the state government in terms of mental health.

Hon HELEN MORTON: And drug and alcohol.

Hon LJILJANNA RAVLICH: Yes, or drug and alcohol—that will no longer provided for.

Hon HELEN MORTON: Mr Deputy Chair, some of these are still being negotiated.

Hon LJILJANNA RAVLICH: Yes, sure.

Hon HELEN MORTON: So, obviously, you cannot have it. There are some that we do not know whether they will or they will not be. I think the best thing to do is provide you, as you asked, for the national partnership agreements and the federal grants to the mental health portfolio, which covers the Mental Health Commission and the drug and alcohol authority, with the list of those items that impact on that portfolio; the amounts that were provided up to the end of this financial year.

Hon LJILJANNA RAVLICH: And where you have agreed or where the grant has been given, do not worry about it; but where it is still under negotiation you might want to indicate that it is the case; and where it has been withdrawn, perhaps you could indicate that it is the case also.

Hon HELEN MORTON: Okay. What has been agreed, what has been negotiated and what is not happening?

Hon LJILJANNA RAVLICH: That is good; that is fair.

The DEPUTY CHAIR: I think that will give the minister and the agency an opportunity to respond, and then if there are other issues, you can perhaps ask them through further questions on notice.

[*Supplementary Information No B2*.]

Hon LJILJANNA RAVLICH: Mr Deputy Chair, because I am time poor and I did not get to ask my allocated question, I will put that on notice.

Hon HELEN MORTON: What are allocated questions? I do not know what an allocated question is.

The DEPUTY CHAIR: I am confused about an allocated question. If you want to ask another question, go ahead and ask it, Hon Ljiljanna Ravlich.

Hon LJILJANNA RAVLICH: All right; excellent. I refer to page 399 and it is in relation to accommodation support and other services. My first question is: how many children are waiting for appointments to child and adolescent mental health services?

Hon HELEN MORTON: Is that it?

Hon LJILJANNA RAVLICH: There is more but perhaps you could give me that answer.

Hon HELEN MORTON: Just give me the full gist of it first.

Hon LJILJANNA RAVLICH: All right. Secondly, how many of these children are 12 years or older, and how many are younger than 12 years of age? Thirdly, what is the average length of waiting time for children 12 years and older? Fourthly, what is the average waiting time for children

under 12 years of age? Fifthly, how many of these children are from the non-metro area? Does that help?

Hon HELEN MORTON: Mr Deputy Chair, obviously we would not have that information sitting here at our fingertips, so if the member wants that information, it will have to be taken on notice.

The DEPUTY CHAIR: I think the member did a good job of outlining the areas she would like answered, and I am sure in due course the agency will provide an appropriate answer.

[*Supplementary Information No B3.*]

Hon LYNN MacLAREN: I want to first start by thanking the minister for answering my questions on notice. It has given me some information that was needed, so I appreciate that. One of the questions I asked was about the number of beds in this budget for the new area of the specialist child and adolescent mental health service—known as CAMHS, I guess. The answer was that there are 20 new specialist beds, and I wondered what the total number of beds is and what the estimated demand might be.

Hon HELEN MORTON: Those are the new beds at the new children's hospital?

Hon LYNN MacLAREN: It is at the new Perth Children's Hospital; there are 20 new beds.

Hon HELEN MORTON: That is correct. That is the total number of specialist child and adolescent mental health beds.

Hon LYNN MacLAREN: In the whole state there will be only 20, and they are all at Perth Children's Hospital?

Hon HELEN MORTON: That is all there is, 20 beds. Obviously there are some located at Bentley Hospital. However, when the services from some of those beds transition to the new children's hospital, reconsideration will be given to the best use of the remaining facilities out at Bentley. Whether that will remain as a child and adolescent mental health service or whether it will be one of the dedicated youth mental health services is not yet determined. Obviously the mental health services plan will make clear recommendations on where this will be provided. Are the other areas of work in relation to Fiona Stanley Hospital? Are you asking about the child and adolescent mental health service, which does not include youth?

Hon LYNN MacLAREN: That is right, just the CAMHS beds.

Hon HELEN MORTON: Quite specifically, it is children at a quite young age. The work that is coming forward in the mental health services plan, or subject to that plan, is on the 20 at the new Perth Children's Hospital and the 12 remaining at Bentley.

The DEPUTY CHAIR: Can I just clarify that? The minister indicated that child and adolescent services and youth services are separate.

Hon HELEN MORTON: Yes.

The DEPUTY CHAIR: Is there an actual cut-off date when people move from child and adolescent services into youth services, or is it a bit of a fuzzy date depending on the individuals and the nature of services provided?

Hon HELEN MORTON: Fifteen years is the cut-off point, but can I just make it clear that at the moment we have a mixture of services. For example, at Princess Margaret Hospital, children will be admitted up until 16; and at Bentley Hospital, they will be admitted up until 18. The reason that we need a specific youth mental health service is that people have explained over and over again that it is inappropriate to have young people as young as, say, 12 or even younger, in a facility at the same time as young people who are 17 or 18, for example. There are vast differences in requirements and behaviours between those young people. We therefore have to have a dedicated youth mental health service; that is, ranging from the age of 15 to 25 years, and we have to have a service that is quite specific for the much younger age group up until the age of 15. I will always remember one dad

telling me that when his daughter moved from Bambi services at PMH into a service at Bentley Hospital, it was like comparing chalk and cheese. The differences between the services provided were very great, and he felt that was inappropriate.

Hon LYNN MacLAREN: Absolutely! It makes good sense to have a specialist service for young kids. I guess I am wondering what the plan is for the regions. If we have only these 20 beds in the city, how do we meet the needs of children who are in regional areas? You did note that there are some step-up and step-down services in Joondalup, and plans to be established in other areas, but I was wondering about kids who actually need the beds. Are there any other services outside the city?

Hon HELEN MORTON: The difficult is that in any one of those regional areas there would never be a demand that is sufficient to warrant a dedicated service, in particular an inpatient service at any one time. For issues such as having a dedicated child and adolescent psychiatrist able to provide daily services to those children, you might have, say, two in Albany at one stage or you might have two in Geraldton at one stage. But you cannot actually provide an ongoing, dedicated service to those people with a specially qualified child and adolescent psychiatrist when you have such an intermittent number of people from time to time. I think in providing the answers to some of your prepared questions, we talked about how in some cases if a younger person were to be admitted to a facility in one of the regional centres, we could provide what we call specialling, one on one, for that person while it is determined whether it is in the best interests of that child to stay located in the country or in the remote area with their family and friends et cetera, or to transfer them to Perth.

[3.10 pm]

Now, that can be quite a difficult decision that needs to be considered by everybody concerned, taking the children away from their local environment et cetera. Of course, there are occasions when children are admitted to children's wards in some of those facilities—a non-specialist mental health unit, but a children's ward amongst children, again with special attention to see whether the needs of that child can best be met under those circumstances. But when those have been looked at and when it is determined that the best option for this child, especially a young child, is to be in a dedicated children's inpatient mental health unit—a specialist mental health inpatient unit—that service, like many other statewide services, will be provided at the specialist children's hospital in Perth.

Hon LYNN MacLAREN: Minister, you have also advised that CAMHS currently have 1 518 active clients, which is, I am sure, for many people quite a shocking fact. Any one of them might be eligible for those 20 beds. I wondered if you would like to give us some sense of the urgency in which you would expand services for CAMHS clients.

Hon HELEN MORTON: There are two aspects to my response to that. The first is that we are doing everything we possibly can to keep those children out of hospital. So the level of intensity, the level of service delivery to those children in the home with the family in their communities is our highest priority, providing the level of intensity that we can possibly provide, because quite frequently these children do not need to lie down all day in a bed.

Hon LYNN MacLAREN: No. I imagine that is not good for their mental wellbeing.

Hon HELEN MORTON: Exactly. Their families are usually very willing to be very supportive around the clock, with intensive levels of support being provided through the mental health services that are available. There are two specific services that are being provided at the moment. One is called the acute response team, which assists children of that nature in emergency departments, getting them home and providing them with intensive support in the home, and the other is the ACIT team—the acute community intervention and treatment team—that is again provided by Princess Margaret Hospital. These are services that are absolutely designed to provide intense levels of care to children for short periods of time—say, up to six weeks—before handing them back to a community-based team for children and adolescents. That is the first part of the answer to that.

The second part of the answer to that is that the mental health services plan will outline the growing need for this level of service over the next 10 years and determine the location and what that should expand to and the time frame for expansion.

Hon LYNN MacLAREN: So, minister, just maybe to clarify it, when you advise me that the step-up–step-down services are going to be established in Rockingham, Broome and goldfields, these are currently not scheduled, but is that what you are looking at when you have got the mental health action plan done?

Hon HELEN MORTON: They will take young people from age 16 onwards.

Hon LYNN MacLAREN: That is for the older kids.

Hon HELEN MORTON: That is for the older kids, yes, but one of the things that I would say is that a new approach to providing the first assessment for children and adolescents with mental illness is being undertaken by CAMHS, and that is that there is no wait time for them to have their first assessment. I am just trying to remember the name of the model that they are using. It is referred to as CAPA and I am just trying to remember what the acronym stands for. In essence, it is around rapid assessment of these children, and it enables the children to be referred and assessed, rather than waiting for their first assessment, and then decisions will be made around the priority given to the children after that first assessment, rather than waiting for the first assessment.

Hon LYNN MacLAREN: Okay. Did anyone else have anything on CAMHS? Otherwise I will move to my second area.

The DEPUTY CHAIR: Okay.

Hon LYNN MacLAREN: Thank you. The second area—I just wanted a couple more details on the suicide prevention strategy. I attended the Auditor General briefing on this, along with Hon Stephen Dawson. Obviously, it is good groundwork and it needs further implementation. The one thing that I would like some clarification on is: how are you going to actually target those high-risk groups? I mean, you do not want to appear too clinical in this, but what is our key performance indicator for reducing high suicide risk among those high suicide risk groups, because the way that it seems to be rolling out is that communities come up with an action plan, so it is bottom up, their thinking? We know that there is a problem in our community so they have come up with an action plan, but is there also an overall approach where you are looking at the higher suicide rate and how are we going to knock that down? In particular, minister, you would know and have an interest—Hon Nick Goiran would have an interest in men's health and the high rate of men's suicide, but also suicide in the transgender community and suicide rates in the lesbian and gay communities. So, how do we know that there is going to be a community action plan that addresses those particular high-risk groups?

Hon HELEN MORTON: I will ask Tim Marney to speak in a few seconds, but I just wanted to say in the first instance that the areas of high risk or high rates are known, and it is part of the work that was undertaken to identify which communities and which groups of people, including the transgender groups, that got funding in the first round, because we were targeting specific areas. We really went out looking for action plans around rural, remote, Aboriginality, youth, young people, men in rural areas, and the transgender groups that you are referring to. So it is not as if we just allow people willy-nilly to put up their hand and say, "We'd like to do a community action plan." It actually does have to meet areas of concern or areas of risk that we were focused on. There were some occupational groups, for example, that were demonstrating high levels of suicide, including the veterinarian group. There were other areas of other occupational groups that we were looking at as well. So it is not as if it was just willy-nilly—anybody can put up their hands for an action plan; it was targeted. But in terms of where it goes from here, I would just like Tim Marney to make some comments.

Hon LYNN MacLAREN: I guess I was asking about the evaluation. How do you know that you have got enough programs addressing that particular group?

Mr Marney: Through the Deputy Chair, the Ministerial Council for Suicide Prevention is in the process of, as I think I mentioned before, a substantial external evaluation of phase 1 of the suicide prevention strategy. That will be completed within the next month or so and inform the strategic planning exercise for the ministerial council that will be undertaken in August, and then flow through to recommendations to the minister in terms of phase 2 of the suicide prevention strategy. The evaluation will be a key component of that, as will be the National Suicide Prevention Conference that will be held in Perth in July, as well as a refresh of all of our evidence and data around suicide, including particular cohorts in the population, whether they be cultural, geographically based or GLBTIQ. Whatever it is, we will be refreshing that evidence to then set the process for expressions of interest for community action plans which actually provide guidance up-front as to those priority areas, and also influence the criteria by which those applications are assessed to ensure that those areas of greatest need are given greatest priority by that evaluation criteria. That is kind of like the step-down process for the development of phase 2 and the rollout of the next wave of community action plans.

[3.20 pm]

Hon ALANNA CLOHESY: What were the procurement savings for the Mental Health Commission for 2013–14?

Mr Marney: An amount of $712 000.

Hon ALANNA CLOHESY: How were they met?

Mr Marney: They were essentially met through a significant focus on back office procurement, supplies, consumables, consultancies, travel and the like. They were broadly spread across those areas, which are normally considered and in operational terms discretionary and can be tweaked at different times in the year to tighten up and ensure those savings are realised. I can assure the member that those savings were not met through a rationalisation of purchasing of service. It was through very much the consumables side of the business.

Hon ALANNA CLOHESY: The advisor mentioned consultancies, which is going to be part of my question about what components of that involved an element of service delivery or program delivery or development.

Mr Marney: No element was associated with service delivery or program development. I can cite an example of a significant saving, if the member likes, which will make it more tangible. As part of the now frequently mentioned 10-year mental health services plan, there is a substantial exercise of costing the implications of service delivery for that plan. That process was initially going to be undertaken through a consultancy, more than likely from one of the major accounting firms, and would have run into the many hundreds of thousands of dollars. We were able to assemble suitably capable public servant resources internally. They have since undertaken that exercise with a slight salary increase through our budget, but within our existing expense limit and at considerable savings in terms of consultancy costs. I would have to say, without being immodest, that they have done a much better job than would have been done by the consultants in any case.

Hon ALANNA CLOHESY: That is good to hear. Is it possible to get a sense of what consultancies were not followed through with in terms of trying to reach some savings, or was it all about stationery?

Mr Marney: The one I just cited would be the most material one and that would be in the order of $200 000 to $300 000. So out of the $700 000 target, that gets us halfway there.

Hon ALANNA CLOHESY: I will move on to service appropriations. Can you explain to me the difference between the base component and the community services subsidy component of appropriations of the commission?

Mr Marney: I am glad the member asked that question. The community service subsidy component is separately identified to make fully transparent the implications of deviation in state price for mental health services from the health system as opposed to the national efficient price. The independent pricing authority sets a national efficient price for weighted activity units delivered by the health system. The service appropriation base component is the purchasing of services at that nationally determined efficient price, albeit varied for certain parameters, which are known in Western Australia to cause deviation from that price for justified reasons.

Hon ALANNA CLOHESY: Including geography and—

Mr Marney: Including remote service provision, and wage differential due to labour market pressure would be another one.

Hon ALANNA CLOHESY: So wage differential plays a role?

Mr Marney: In part.

Hon ALANNA CLOHESY: But it does not for the Department of Health. I wonder how that is?

Mr Marney: It certainly plays a component in the recognition of costs from a Grants Commission perspective, so I assume that from a consistency perspective the independent pricing authority also factors it in to an extent, but not to the full extent of our actual wage differential. The remaining component in terms of differential between the nationally determined efficient state price and the actual state price is, if you like, an inefficiency component within our health system. The whole point for separating those two items is to ensure that over time we converge to what is considered to be an efficient price. You will see under the service appropriation community service subsidy component that it begins at $12.2 million, rises to $18.6 million, rises further to $19.5 million, and declines to zero by the end of the forward estimates. Firstly, the movement from 2013–14 to 2014–15 when the subsidy has actively had to increase implies an increase in inefficiency, which reflects a change in the independent pricing authority's price where they actually lowered the efficient price for 2014–15. They have lowered the price and unfortunately our price has gone up and, as a result, the subsidy has increased. Over time, the challenge from a health reform perspective is to ensure that we have in place strategies to bring down the inefficiency component of the price and to ensure that our actual price converges with the national efficient price.

Hon ALANNA CLOHESY: I am mindful of the time but I would welcome an opportunity to discuss the process of doing that a little later, but perhaps not here unless Mr Deputy Chair—

The DEPUTY CHAIR: We are aware that the aim is to get to the efficient price but if, over the next three years, we are going further away from the efficient price, how realistic is it that in the fourth year we will be able to not only stop that trend away from the efficient price but also get all the way back down to the efficient price?

Mr Marney: Obviously, if we track further away from the national efficient price then we need to understand what is actually driving that cost differential. Part of the benefit of having this line item transparently separated as an appropriation is to focus debate on it. I am not sure which Under Treasurer devised this disclosure, but I think it is brilliant. It actually means we have to monitor this and we have to be able to justify any movement in it and whether we are getting closer to or further away from the efficient price. As part of that process, we know that our jurisdictions are modelled as part of the independent pricing model. We therefore know that if this is an average efficient price across the country, then some are doing it above that price, which includes us, and some are doing it below that price. That means we then have to look at what they are doing, how they are doing it and why it is that they are able to operate at a lower cost structure, and benchmark our service delivery against that. It is really forcing that analysis in the system to implement reform. There are pockets

in Western Australia where that is being done and it is being done well. Certainly, with new developments—for example the observation unit at Sir Charles Gairdner Hospital is resulting in lower than average length of stay in the inpatient ward.

[3.30 pm]

Now, that is an efficiency and, over time, that will bring down the weighted average unit price. Similarly, some of the substitution of inpatient beds to Hospital in the Home means we are substituting an acute cost structure in hospitals with a much different cost structure and, ironically, it is actually much more effective as well through a Hospital in the Home program. It is those sorts of initiatives that we can now assess, evaluate and drive further through the system.

Hon ALANNA CLOHESY: I do have more questions, but in view of the time, I pass it over to Hon Stephen Dawson and put on notice that I would like to follow that up further.

Hon STEPHEN DAWSON: Thank you, madam committee member. I move to page 394 and the reference in relation to significant issues impacting the agency and the paragraph beginning "Review of Admission and Discharge Practices". Given the time, I am going to ask some short, sharp ones, minister. You might have to take some of these on notice, and I am happy for you to provide information by way of supplementary. I wanted to get a sense as to how we are going with the implementation of the Stokes review. Are you in a position to give us a copy of the status of each of the recommendations and where they are at? Can you let us know how much funding has been spent on the recommendations so far? I also do not know where in the budget papers I can find the money for the Stokes review implementation, so perhaps you could point that out as well and also how much has been set aside in the 2014–15 budget for the implementation of the Stokes review. Sorry; my head is all over the place today, but that is essentially a copy of the status of each of the recommendations of the review, what recommendations have received funding to date, what has been spent on implementation, what is set aside in the budget for 2014–15 for the implementation of these recommendations and where is the funding allocated in the budget.

Hon HELEN MORTON: I know that this is normally not an appropriate response to make, but each of the recommendations and the status of them are continually updated on the Mental Health Commission's website.

Hon STEPHEN DAWSON: Periodically or continually, minister? I think it is periodically updated.

Hon HELEN MORTON: That is what I mean. It is updated, I think, every quarter. There is an implementation oversight group.

Hon STEPHEN DAWSON: It does say that in the budget papers and I have actually checked the website, but I am looking for a status report to give me today for this month.

Hon HELEN MORTON: I do not have a status report today. I do get a status report on a regular basis, but I do not have it here today. The information is, as I said, updated quarterly on the Mental Health Commission's website. Many of those recommendations were not recommendations that required new money; they were recommendations that required a different way of doing something or better accountability or some of those sorts of things that were required, such as education and training. There were some areas that did get additional funding, and the example I would give is the new transport service that operates in the metropolitan area and Bunbury now for authorised transportation of patients where we do not use the police for the majority of those services anymore. In terms of where those things are shown within the budget, it is not shown in any one particular place; it is across the board. It occurs in inpatient services, it occurs in —

Hon STEPHEN DAWSON: Minister, I am not being disrespectful; I am just conscious of the time this afternoon. Can you give us a breakdown of the recommendations that have funding attached to them and what has been spent on them so far? Is that possible to give us by way of supplementary?

Hon HELEN MORTON: I do not actually think it is possible because they are just built into the budget. It is just funding that is currently operating within the system.

Hon STEPHEN DAWSON: So there is no extra money going into the budget for the implementation of the Stokes review and the recommendations?

Hon HELEN MORTON: Other than the initiatives that I have mentioned already, like the transport service, for example, there was additional funding that was allocated specifically for that.

Hon STEPHEN DAWSON: So the report and the recommendations were not costed by the agency?

Hon HELEN MORTON: It was not done that way.

Hon STEPHEN DAWSON: I know. I am well aware, but you have a former Treasury official leading your agency, so I would have thought a notional figure was attached to it.

Hon HELEN MORTON: If you recollect that the overarching recommendation was the development of the 10-year plan, that has been developed without any additional funding in the Mental Health Commission's budget, for example, but that was the major recommendation—the number one recommendation—by Professor Stokes. That has utilised resources of the Mental Health Commission, but there was not a dedicated additional budget for that specifically as an example.

Hon STEPHEN DAWSON: Granted it is a very important one, but that is one of the 117. So there have been no other recommendations, aside from the transport one, from the Stokes report that received extra dollars in the budget?

Hon HELEN MORTON: I am not saying that is necessarily the case because he talked about—but it was already happening—the need for subacute services, he talked about the need for mental health courts, for example, and he talked about improved collaboration between the justice and mental health systems.

Hon STEPHEN DAWSON: So you do not have a sheet that lists the 117 recommendations and a dollar figure attached, if there is a cost attached to it? It does not exist?

Hon HELEN MORTON: No, I do not. Those recommendations are being implemented and the status of that implementation is known. The dedicated extra money that might be found or needed to make those things happen are found within existing budgets.

Hon STEPHEN DAWSON: Do you have those costs? So, those recommendations have been costed or they have not?

Hon HELEN MORTON: No; I am saying that the majority of them would not have been because they were not extra costs required.

Hon STEPHEN DAWSON: So the agency has no list of recommendations with dollar figures attached where there is a cost?

Hon HELEN MORTON: What I am saying is that by far the majority of that is core business and improvements to core business. It was about better discharge planning. It was about including families more in the involvement of decisions that are being made. There was a whole raft of things. By far the majority of those things were about making sure that there is better clinical practice taking place.

Hon STEPHEN DAWSON: I will move on, Deputy Chair, in a second. Just to be clear, there are no extra dollars in the budget this year for the implementation of the Stokes review.

Hon HELEN MORTON: The implementation of the Stokes review is being undertaken through a whole raft of these things that are in the budget.

Hon STEPHEN DAWSON: But there is extra money or there is not.

Hon HELEN MORTON: It is being fully implemented as part of core business, so you will not find a single line item related to that.

Hon STEPHEN DAWSON: Just to go back to the initial question, it was not a very satisfactory answer in relation to the website. Are you in a position, by way of supplementary, to provide—even if you or your agency takes it off the website and provides it to the committee—the latest status update of the Stokes review recommendations, please?

Hon HELEN MORTON: The best thing I can offer you is that there is an annual report that is hitting my office, I expect, this week and I will be able to provide you with a copy of the annual report that shows you the full implementation status of all of the recommendations. That will give you the best outline of all of those.

The DEPUTY CHAIR: Can I just clarify for the purposes of whether or not we need supplementary information that the annual report the minister is referring to is the agency's annual report that will be tabled in the Parliament?

Hon HELEN MORTON: No, it is not the agency's annual report; it is the annual report of the implementation oversight group chaired by Barry MacKinnon. The deputy chair is Judy Edwards. They are providing me with an annual report. I am being told it is in my office at the moment. I have not seen it, so it is probably there amongst my papers for signing, but it is so timely that it would be the best possible level of information that you could get.

The DEPUTY CHAIR: Again, I am trying to clarify: will we need it by supplementary information or will it be made publicly available either through tabling or other means?

Hon STEPHEN DAWSON: Let us put it down as supplementary and it is something that we are getting back off the minister and we will have it in the next couple of weeks.

[*Supplementary Information No B4.*]

Hon STEPHEN DAWSON: On the same issue just briefly, has any extra funding been set aside in this budget for the implementation of the clinical services plan? That is the mental health services plan.

[3.40 pm]

Hon HELEN MORTON: It is the mental health services plan that we have been talking about.

Hon STEPHEN DAWSON: This is the 10-year —

Hon HELEN MORTON: That has been incorporated into the mental health services plan. Apart from all the growth funding that is already in the budget, the clinical services plan was the first level of growth funding that was needed. That has already been incorporated into our operation and budget. The mental health services plan is the plan that now has picked up any of those additional initiatives that were not funded in the clinical services plan and that is what is going, as I said, to cabinet in the next couple of weeks, hopefully.

Hon STEPHEN DAWSON: The next dot point is on page 399 and the reference to accommodation support and other services. You do not have to turn to the page quickly, minister, because it is a spurious point; I could pick anywhere in the budget papers essentially. I wanted to just ask questions about the Council of Official Visitors and in particular what level of funding is currently provided to the Council of Official Visitors. What funding will be provided to the mental health advocacy service; how many staff are currently employed at the Council of Official Visitors; and how many operational staff will we have at the new mental health advocacy service? I also wanted to ask whether any funding has been set aside for the establishment of the Mental Health Advocate. How much do we spend on the Council of Official Visitors at the moment? How many staff? What funding are we going to have for the mental health advocacy service; how many staff

will that have; and have we got a pool of money that has been set aside to create this new Mental Health Advocate?

Mr Marney: As part of the implementation of the new anticipated mental health act —

Hon STEPHEN DAWSON: Greatly anticipated!

Mr Marney: Greatly anticipated; we look forward to its passage so we can get on with it!

The government has allocated the sum, as I understand it, of $15 million to the implementation of the act. As part of that we are currently working through, in consultation with the substantial reference group, the allocation of the priority projects for implementation and allocation of those resources. The $15 million will encompass the resource requirements of the new advocacy service, but it will have to also encompass various other resourcing requirements, including those of Office of the Chief Psychiatrist, what will be the new Mental Health Review Board and the like. So we are currently working through the process of prioritising and allocating the government's approved funding for various elements of projects that affect a number of entities, including the Department of Health, Office of Mental Health, the Mental Health Commission, the Office of the Chief Psychiatrist, what is now the Mental Health Review Board and the Council of Official Visitors as they morph into new structures with new capabilities.

Hon STEPHEN DAWSON: The new bill will be rolled out over 12 months, so I presume that that decision about the rollout of funds will be decided during that period as well? Do not even answer, a nod was —

The DEPUTY CHAIR: If you are going to ask a question, you should at least give the people the opportunity to respond.

Hon STEPHEN DAWSON: They both nodded, so I thought that was enough.

Hon HELEN MORTON: Hansard cannot pick up the nods; that is the unfortunate part!

The DEPUTY CHAIR: Hansard should note that Mr Marney was nodding!

Mr Marney: The member's comment is correct, but not purely accurate in that as part of the 12-month implementation period we will have to allocate the funds upfront so that people can actually undertake an implementation during that period. Prioritisation and allocation of those funds is actually happening at the moment and should be in place very early in the new financial year so that people can actually get on with the implementation, because as you understand, there is actually quite a bit of work to do to gear service delivery, business process and clinical process ready for the implementation of the bill in 12 months' time.

The DEPUTY CHAIR: Hon Stephen Dawson, I know you have lots of questions, but —

Hon STEPHEN DAWSON: The first part of that question, Deputy Chair, was—this is quick —

The DEPUTY CHAIR: All right, because I have two members who have been patiently waiting here and have not had a chance to ask the question yet. Also, Hon Sally Talbot has indicated she would like to have another go, too.

Hon STEPHEN DAWSON: I did ask and I did not get an answer about the level of funding currently provided to the Council of Official Visitors and also how many staff are currently employed at the Council of Official Visitors. I am happy to take it by way of supplementary if it is not available now.

Hon HELEN MORTON: I am happy to take both of those as supplementary.

[*Supplementary Information No B5*.]

Hon AMBER-JADE SANDERSON: I had a question similar to Hon Stephen Dawson and wanted to ask what level of funding is provided to the Mental Health Law Centre in this year's budget, because I could not see it in that budget papers.

Hon HELEN MORTON: The primary funding for that organisation comes from the Attorney General's office. We have in the past provided some top-up funding and the amount we added in the last financial year. The level we provided last financial year is around about $115 000. We are currently considering how it would go about providing that into the future. For example, it may well be that the services are put out to tender on a contract basis. Some of those funds were to assist with, at one stage, rental of premises and it may be that if there is a move of facilities, the Mental Health Law Centre could move in with some other organisations around mental health that would facilitate a lower rental. Those are the sorts of things that are being looked at right at the moment in terms of whether we do provide any top-up funding on top of what the AG provides or whether the AG will provide the level of funding in full or whether we put it out to tender.

Hon AMBER-JADE SANDERSON: Are you able to outline reason that the top-up funding was required over and above what was budgeted for from the AG's office?

Hon HELEN MORTON: There is quite a specific need for us to see more people provided with legal representation specifically at the Mental Health Tribunal. Unfortunately, the review has demonstrated that we had not seen that achieved for various reasons, so it is a matter of whether the funds continue to go for that reason and not achieve the outcome we were looking for or whether it can be better provided in another way.

Hon AMBER-JADE SANDERSON: So an increase in people needing support of the Mental Health Law Centre, is that you are saying?

Hon HELEN MORTON: We were interested in seeing more people being represented at the Mental Health Review Board.

Hon AMBER-JADE SANDERSON: Similarly, and you may want to take this on notice, is it possible for the commission or the minister to provide a list of funding amounts provided to all non-government service providers in 2013–14 and similarly, 2014–15?

Hon HELEN MORTON: We will take it on notice, giving you a list of all the non-government organisations that have received funding from the Mental Health Commission across the last two years and the amounts they received.

[*Supplementary Information No B6.*]

Hon SALLY TALBOT: Minister, my question also follows on from the issues that Hon Stephen Dawson was raising about the Stokes report. One of the things there, of course, was about the mix between acute and subacute beds, and we notice that it has been reported that this year's budget includes 136 new beds. Could you tell us a bit about those new beds?

[3.50 pm]

Hon HELEN MORTON: Certainly, the 136 new or relocated beds—I have to be very clear about that.

Hon SALLY TALBOT: New or relocated?

Hon HELEN MORTON: Yes. At all times we talk about these beds as being new or relocated. I will tell you in a minute, off the top of my head, how many of them are brand new. The beds being built at the moment are at Fiona Stanley Hospital, Sir Charles Gairdner Hospital —

Hon SALLY TALBOT: I am sorry; these are the new ones?

Hon HELEN MORTON: These are new, as in they are being built now.

Hon SALLY TALBOT: These are an addition to —

Hon HELEN MORTON: Some are and some are not, is what I am saying. You will just have to bear with me while I go through. They are all brand new beds in that they are new. Some are

additional and some are relocated, but they are all new. The new ones are at Fiona Stanley Hospital, and they are all additional.

Hon SALLY TALBOT: How many at Fiona Stanley?

Hon HELEN MORTON: That is an additional 30, and as we have indicated before 14 of those are going to be dedicated for youth, but I do not think you want to go down that track at this stage. At Sir Charles Gairdner Hospital there are—I am just making sure that I have got this right—30 new beds being built.

Hon SALLY TALBOT: These are "new new", not "new old"?

Hon HELEN MORTON: No, these are new beds being built, but they are replacing the beds that are in the old D20 ward of Sir Charles Gairdner Hospital. There is actually a reduction from 36 to 30 there, because six of the beds are being relocated to Midland, which I will talk about next. Out at Midland, there are 56 new beds, of which six are coming from Sir Charles Gairdner Hospital, nine are coming from Graylands and the other 41 are existing beds at the existing Swan District Hospital. Then there are the beds at the Perth Children's Hospital; there are 20 beds there. Of the new beds at the new children's hospital; eight are coming from Princess Margaret Hospital for Children, six are coming from the Bentley Adolescent Unit, which leaves six existing beds at the Bentley Adolescent Unit, and there are six new beds.

Hon SALLY TALBOT: Minister, thank you. That adds up to 136. I think that does add up to 136. So in actual fact, there is no new money.

Hon HELEN MORTON: The Fiona Stanley Hospital beds are all new; new and additional.

Hon SALLY TALBOT: So at Sir Charles Gairdner Hospital, all those 30 beds—in fact if you take Sir Charles Gairdner Hospital and Midland, 86 beds are currently funded in different places.

Hon HELEN MORTON: That is correct, yes.

Hon SALLY TALBOT: The same with PMH —

Hon HELEN MORTON: No, there are six additional beds at PMH.

Hon SALLY TALBOT: You said 20 new—yes, I see, so only 14 already exist.

Hon HELEN MORTON: Six additional at PMH and then the new beds out at Fiona Stanley Hospital.

Hon SALLY TALBOT: And Graylands is losing nine and not gaining any?

Hon HELEN MORTON: Graylands is not gaining any out of that loss of nine; it is a relocation of beds from Graylands to Midland. However, there are hospital-in-the-home beds, which are considered the equivalent of voluntary inpatient units that are increasing. It is currently at eight, but it is going up to 24.

Hon SALLY TALBOT: Hospital-in-the-home is currently eight beds; is that 2013–14?

Hon HELEN MORTON: At 2013–14, yes. In 2013–14 it is eight, increasing to 24.

Hon SALLY TALBOT: Increasing to 24 in 2014–15?

Hon HELEN MORTON: Yes.

Hon SALLY TALBOT: And then the out years?

Hon HELEN MORTON: Well, I do not know where that is going to in the out years yet, but that will be included as part of the mental health services plan.

Hon SALLY TALBOT: Are those 24 all in the metropolitan area?

Hon HELEN MORTON: They are; they are all—actually I should not say that. The first eight at least are in the Mirrabooka–Osborne Park area. They are quite specific in terms of location.

Hon SALLY TALBOT: Of all those 136 beds, are they all acute?

Hon HELEN MORTON: They are all acute. I do not know if you are asking another question though; if you are asking me how many of them are authorised and how many are secure?

Hon SALLY TALBOT: No, that is my next question.

Hon HELEN MORTON: They are all acute.

Hon SALLY TALBOT: Then, secure and non-secure; authorised —

Hon HELEN MORTON: They are all authorised, which means that an involuntary person can be admitted to them. However, within that setting there are some beds that are made more secure than the beds that are used by voluntary patients. They are all authorised.

Hon SALLY TALBOT: What are we going to call them?

Hon HELEN MORTON: We call them secure.

Hon SALLY TALBOT: How many of those 136 are secure?

Hon HELEN MORTON: Let me go through. The information that I have around Fiona Stanley Hospital is that apart from the 14 secure youth beds, eight mother–baby beds—by virtue of the type of those beds they will be secure —

Hon SALLY TALBOT: That is not included in the 14?

Hon HELEN MORTON: No, separately. And there are eight adult mental health assessment unit beds.

Hon SALLY TALBOT: What are they classified as?

Hon HELEN MORTON: They will be more akin to the observation unit at Sir Charles Gairdner Hospital, which is very acute and very short term. The levels of staffing are much higher for observation.

Hon SALLY TALBOT: Is the cost of providing a bed at the Bentley Adolescent Unit, for example, more than providing one at the new children's hospital?

Hon HELEN MORTON: I do not know the answer to that, however the level of funding that goes to one of these beds has been discussed in full today around activity-based funding. It is actually determined by the acuity of the service that is being provided; so a particular bed at a particular hospital is not funded on the basis of —

Hon SALLY TALBOT: Just because we are running out of time, can I rephrase the question: is it possible to tell us—you might have to subtract the 30 at Fiona Stanley that are "new new" and not previously existing elsewhere and the six at PMH that are not previously existing elsewhere—of the number of relocated beds, what is the equivalent cost of providing those beds? That must have been costed. You can take that on notice perhaps.

Hon HELEN MORTON: Yes, I will have to, because I do not have that at my fingertips. You just need to understand the way activity-based funding operates; it is not based on an individual bed, it is based on the acuity of the patient. As that patient is discharged, the level of acuity related to that patient determines what that activity was.

I do have to clarify this, please bear with us for one minute. I cannot provide information that is being asked in a particular way that is information we cannot actually access. I will ask Tim Marney to make some comments on that.

Mr Marney: Thank you, Deputy Chair. We will seek to answer that question to the extent that it is possible. The extent possible is determined by the cost centres that are defined in each area health service and whether or not they actually go down to specific site-location beds. In some instances it will only be possible to go to cost centres at an area health service level rather than a site-specific

level, but we will certainly seek to provide as much information as is available and reliable on the basis of existing cost centre disaggregation.

[*Supplementary Information No B7.*]

[4.00 pm]

Hon SALLY TALBOT: What are the overall number of admissions to specialist mental health units in 2012–13 and 2013–14 to date, so that we can see the relative figures over the those two years, one of which is about to be completed?

Hon HELEN MORTON: That information is obviously available on the basis of weighted activity units. Is the member happy to get the figures on that basis?

Hon SALLY TALBOT: If the minister tells me that is how it is available, I will ask for it in that form.

[*Supplementary Information No B8.*]

Hon SALLY TALBOT: Finally, in light of the recommendation in the Stokes report about the ratio of acute and subacute beds, what is the overall figure for the last financial year when we were keeping those statistics and perhaps for the current year to date on the number of acute and subacute beds overall?

Hon HELEN MORTON: Is that as in beds needed or existing?

Hon SALLY TALBOT: That are existing.

Hon HELEN MORTON: It is clear that the number of subacute beds is 22—full stop. That is all we have in Western Australia at the moment. They are at Joondalup. The number of current operational beds is 717; they are acute beds, and there are currently 22 operational subacute beds.

The DEPUTY CHAIR: I am sorry, but we have got to the stage where I said the member would get one more question. Hon Sally Talbot has asked two more questions, and time has expired. The minister answered that question; I was paying close attention. We have to wind it up there. There is the opportunity for members to put in additional questions and the member can utilise that process.

The committee will forward any additional questions it has via the minister in writing in the next couple of days, together with the transcript of evidence, which includes the questions that have been taken on notice today. Responses to these questions will be requested within 10 working days of receipt of the questions. Should you be unable to meet that due date, please advise the committee in writing as soon as possible before the due date. The advice is to include specific reasons as to why the due date cannot to be met. If members have any unasked questions, including Hon Sally Talbot, I ask them to submit these questions to the committee clerk at the close of this hearing. On behalf of the committee, I thank everyone for their attendance today. Given the time, I take this opportunity to take a break and we will reconvene at 4.15.

Hearing concluded at 4.03 pm

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