STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2016–17 BUDGET ESTIMATES HEARINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 14 JUNE 2016

SESSION TWO
MENTAL HEALTH COMMISSION

Members

Hon Ken Travers (Chair)
Hon Peter Katsambanis (Deputy Chair)
Hon Alanna Clohesy
Hon Rick Mazza
Hon Helen Morton

Hearing commenced at 2.33 pm

Hon DONNA FARAGHER
Minister representing the Minister for Mental Health, examined:

Mr TIMOTHY MARNEY
Mental Health Commissioner, examined:

Ms ELAINE PATERSON
Acting Assistant Commissioner, Purchasing, Performance and Service Development, examined:

Mrs MARIE FALCONER
Chief Financial Officer, examined:

Mr MICHAEL MOLTONI
Acting Director, Performance, Monitoring and Evaluation, examined:

The CHAIR: On behalf of the Legislative Council Standing Committee on Estimates and Financial Operations, I would like to welcome you to today's hearing. Can the witnesses confirm that they have read, understood and signed a document headed "Information for Witnesses"?

The Witnesses: Yes.

The CHAIR: Thank you. If there are no comments that the minister wanted to make by way of introduction, we will move straight to questions. Can members indicate if they have questions they would like to ask.

Hon STEPHEN DAWSON: On page 853, "Hospital Bed Based Services": I want to refer to some answers given in pre-estimates questions. One particular one is that the response provided by the Mental Health Commission stated that there are currently 25 mental health beds not open for patient admission. Where are these beds located and what is the reason that each of these beds is not open?

Hon DONNA FARAGHER: I will ask the commissioner to answer that.

Mr Marney: The total of 25 beds that are currently not in use are broken down as follows: Bentley Health Service, six; Bunbury hospital acute psychiatric unit, one; Fiona Stanley Hospital, six; Princess Margaret Hospital, eight; and Rockingham hospital, four, bringing a total of 25. I will just go through the reasons for each of those beds being unavailable. Firstly, the Bentley Health Service is a child and adolescent mental health service set of beds of six. That inpatient service was converted to an outpatient service that you might be familiar with as the Touchstone program, the rationale being that providing a better targeted outpatient service for young people was better than having them in an inpatient setting, so keeping them with their family and community supports through a more intensive outreach community treatment service rather than an inpatient service. That is the six beds at Bentley. Bunbury hospital—the one bed is rarely used; in fact, it should probably be taken out of the bed count. It is not really suitable infrastructure, but for some reason it is still included in the bed count at the moment, but very, very rarely used. Fiona Stanley Hospital—six beds relate to the youth treatment inpatient setting. As you will be aware, the youth treatment setting at Fiona Stanley is the first youth treatment inpatient setting for Western Australia. There is a total of 14 beds constructed for that purpose, with eight beds currently open. Given it was the first time that we were running a youth model of service, the intention was always to try to get it up and running and get a feel for how that model of service would run. That model of service is coming

along reasonably well, such that we are very optimistic that we will see the additional six beds open in 2016–17. There have been some difficulties in opening those beds both, as I said, from the perspective of bedding down the model of service but also from the perspective of ensuring there were appropriately capable staff for that model of service as well, hence some of the delays along with the level of activity funding that was allocated for that service as part of last year's budget.

Hon STEPHEN DAWSON: Are you saying that there is no money at this stage or this year for those extra beds?

Mr Marney: The level of activity that was funded as part of the 2015–16 financial year is being met by the eight beds that are open. They are actually delivering more activity out of the eight beds than they thought they would be able to, and that is probably due to the different model of service and, indeed, the different model of service at Fiona Stanley, full stop.

Hon STEPHEN DAWSON: Sorry, commissioner, just to clarify: the 14 beds were promised, but funding was available for only eight beds; funding was not provided for the full 14 beds?

Mr Marney: That is not strictly correct. The level of activity that we envisaged at the setting of the 2015–16 budget was such that we thought it would require 14 beds to be open. The implementation of that model of service has shown that the level of activity that the commission has purchased and planned to purchase is currently being met as funded by the commission but with eight beds open. What that means is that the model of service is such that it is actually able, through eight beds, to treat what normally we would have thought in an adult setting would require 14 beds. It is actually doing much better in terms of the number of people and the treatment that it is able to provide than we had anticipated. Having said that, the 2016–17 budget enables further expansion in the volume of activity being purchased. The increased activity that the commission will purchase will see the opening of those additional six beds. But, in short, the budget intention as at the 2015–16 budget was to purchase a certain level of activity from that unit. That level of activity has been met, albeit it has been met with a lower number of beds open than was initially anticipated.

Hon STEPHEN DAWSON: I am sorry; I stopped you, so if you want to continue with those other beds, commissioner.

Mr Marney: Thank you. Princess Margaret Hospital—there are eight beds closed. I think they closed in late April, early May. That is associated with a clinical safety issue around staffing. There has been difficulty recruiting and retaining specialist child and adolescent mental health staff, and that has resulted in a combination of units that were at Princess Margaret Hospital and Bentley into one site in Bentley in anticipation of then the commissioning of Perth Children's Hospital, which will be the single site for child and adolescent mental health services. That is a staffing and clinical safety issue that I believe has been discussed previously. The last item is four beds at Rockingham hospital. Those beds remain closed. My understanding is that they are actually specific older adult mental health beds and there is not the level of demand to warrant opening those bed at the moment, hence they remain closed.

[2.40 pm]

Hon STEPHEN DAWSON: I am aware, again from questions or information provided in this place, that 159 children have needed to be discharged from an adult facility. That is probably in the past 12 months but I have not got that information before me. We have 159 children being discharged from adult facilities, yet we have young adult beds lying vacant. Can somebody explain to me why that is the case; why we are not putting more effort into ensuring that beds that are supposed to house young people are being used and that we are not needing to put kids, essentially, in adult beds?

Mr Marney: The intention is certainly to ensure that consumers in mental health services are placed in the most appropriate setting possible, hence the development of the youth stream at Fiona Stanley which, as I indicated in a previous answer, has been phased up over the past

12 months. With the transition to Perth Children's Hospital, there is substantial work underway at the moment to reconfigure services to ensure that we deal with age cohorts more appropriately, in particular the cohort of 16 to 25-year-olds, which no doubt make up a large proportion of those that you have mentioned of the 159 being treated in adult settings. Seventy-five per cent of severe mental illness first manifests in that 16 to 25-year-old cohort. The developmental phase of those individuals is very different from under 16-year-olds and indeed adults. The need for a specialised model of service to deal with youth treatment is quite paramount. To meet that need, as I mentioned, the eight beds at Fiona Stanley have been opened and we anticipate the remaining six will open as we enter the financial year 2016–17. In conjunction with the establishment of a youth community treatment stream based at Fiona Stanley, we anticipate that the 14 beds at Fiona Stanley, which have largely to date been operating as south metro beds only—as we expand to 14 beds—those beds will be a statewide service. It will enable transfer from other area services through to south metro for that specialist youth treatment, supported then by the youth treatment–community treatment out of Fiona Stanley and supported further by the development of a new hub-and-spoke youth community treatment service through the WA Country Health Service, which will enable much better access to specialised youth treatment across the state.

Hon STEPHEN DAWSON: Minister, if I can ask another question. Also in responses provided to pre-estimates questions, one of the answers stated there has been a net increase of 20 authorised mental health beds over the period from 2012–13 to 2015–16. Given that currently 25 beds are closed, does this mean that Western Australia currently has five less operational authorised mental health beds than we did in 2012?

Hon DONNA FARAGHER: I will turn to the commissioner again.

Mr Marney: I will answer that one off the top of my head, if that is okay, and will stand corrected from those behind me if appropriate. My recollection is that during 2015–16 on average there were 638 authorised beds available per day statewide. That is up from an average of 600 authorised beds in 2014–15 and 608 in 2013–14. A previous minister in this house would speak of 136 new and replacement beds during the current government. Of those, 106 are replacement beds and 30 are new beds. Those are predominantly made up by the new beds or additional bed stock to the system, being Fiona Stanley Hospital.

Hon STEPHEN DAWSON: Does that 638 include those 25 beds that are closed, or not?

Mr Marney: Sorry, the figure is 136 replacement and new beds; so 106 replacement for closures. There has been a range of closures across the system. If you take, for example, Swan hospital has been replaced by a number of beds at Midland —

Hon STEPHEN DAWSON: Sorry, commissioner, I am not being rude but can I stop you there for a moment? The 638 beds that you referred to a second ago that were open, does that 638 include the 25 beds that you have just listed to me that are not open at the moment? Does that figure include those beds?

Mr Marney: They are not included in the 638 because they are not considered open and available. I need to correct myself, I am afraid—it is 100 replacement beds and 36 new beds.

Hon STEPHEN DAWSON: I will move on quickly to another issue. I know the chair wants to move on to somebody else but I will ask this question quickly. In relation to child and adolescent health services, it was reported in *The West Australian* on 4 June that the child and adolescent health service acute response team and the acute community intervention teams are being reviewed and that major job losses are expected. Are these claims correct, what are the details and why are these services being targeted?

Hon DONNA FARAGHER: I will ask the commissioner to respond.

Mr Marney: It is correct that those programs in particular are being reviewed, but that is part of the normal process of reviewing the effectiveness of any programs that have been recently introduced

into the system and, in part, is also a requirement of the contractual obligations under which those services were established. In the case of the acute community intervention initiative, that is commonwealth funded and therefore requires a review. The commonwealth funding, unfortunately, expires at the end of June 2016. The Mental Health Commission was in negotiations with the commonwealth around continuation of that service and carryover of unspent funds for that service, but, obviously, the commonwealth government has gone into caretaker mode so those negotiations have ceased. However, through other funding sources that the Mental Health Commission has been able to identify, we will ensure that that service is able to continue until the end of this calendar year, by which time we are hopeful to have renegotiated an extension of that service with the commonwealth government and secured funding from them. Having said that, the service still needs to be reviewed, as do all services periodically, to assess their effectiveness and efficiency with respect to outcomes for consumers.

Hon STEPHEN DAWSON: By way of supplementary, can I get from the commission the number of staff who are attached to each of those programs?

Hon DONNA FARAGHER: Yes, we can take it on notice. That would be something that the minister would provide.

[*Supplementary Information No B1*.]

Hon ALANNA CLOHESY: The Drug and Alcohol Office has been relocated into the Mental Health Commission and it has all gone smoothly—yes?

Hon DONNA FARAGHER: Yes, it has.

Mr Marney: I think that is both a statement and a question; both of which would be correct.

[2.50 pm]

Hon ALANNA CLOHESY: Question mark!

What were the savings from moving the Drug and Alcohol Office from Mt Lawley to shared accommodation with the—it is all now the Mental Health Commission, of course. What were the savings from moving that office into the one office?

Mr Marney: Technically, there is not a saving due to relocation in part because the former Drug and Alcohol Office owned its own premises, so it did not have a lease cost; it had normal outgoings. To co-locate both agencies, as many in this house would be aware, required the fit-out of a new location, which incurred costs, but that also responded to a circumstance in which the former Mental Health Commission's lease had actually expired. It was in need of relocation because the entity that it leased its premises from indicated that it would not entertain an extension of that lease. In short, the Mental Health Commission was homeless and DAO owned its own home, and both entities very much needed to be co-located. I can say that having everyone in one spot is fantastic in terms of the effectiveness and the efficiency with which people are able to operate and the capacity to learn across both sectors, which is really quite exciting.

Hon ALANNA CLOHESY: Was there any planning work done on the economic impact of taking 300 staff out of Mt Lawley—the local economic impact of moving those staff?

Mr Marney: It was not 300 staff; it was about 100 who were relocated from Mt Lawley. The rest of DAO's employees are spread across the community alcohol and drug services, so they are spread throughout the metropolitan area and also in East Perth with Next Step. I think if an economic study was to be undertaken, and I can assure you that there are good ones and bad ones, the net benefit from an efficiency perspective would be far greater than the cost to the local area.

Hon ALANNA CLOHESY: I meant to the local community.

Mr Marney: Having said that, we are located in a non-CBD location, in East Perth, which is part of a local area itself. The benefit of employees being located in one spot —

Hon ALANNA CLOHESY: That is stretching it very much calling East Perth non-CBD —

The CHAIR: One question and one answer at a time, please. Let the commissioner finish. Has the commissioner finished?

Hon DONNA FARAGHER: Clearly, the benefits of co-location, as the commissioner has indicated, are of enormous benefit to the people and the communities that they work with on a daily basis.

Hon ALANNA CLOHESY: Thank you, minister. What is going to happen to the building in Mt Lawley?

Mr Marney: As part of the business case for relocation, the building was intended to be made available for use by others, either within government or for private sale, and that process is underway at the moment. The government has an established set of processes for property asset disposal. In essence, an asset is posted in a clearing house where other agencies have the opportunity to express an interest or otherwise in the ownership and occupation of that asset. We are currently in that process at the moment. I do understand that there are other agencies interested in utilising that asset. That is where we are up to.

Hon LYNN MacLAREN: First, I will just say good afternoon to the commissioner. Thank you for coming and I hope we will make this painless.

My question is to do with funding for community-based mental health services. I note that the "Western Australian Mental Health, Alcohol and Other Drugs Services Plan", which I will refer to as the mental health plan, states that we need to expand community support services. On page 852, it reiterates that in the agency expenditure review, we were going to try to stick with the priorities that were articulated in the mental health plan. On the next page, page 853, under "Community Support", it is clear that estimated actual for 2015–16 is $6 million higher than budget estimate for this year, 2016–17. I read that as a cut in community support services or a reduction in community support. My question is: why are we cutting the funding to community support if that has been identified as a priority under the mental health plan?

Hon DONNA FARAGHER: I will just say that we are not reducing funding, but I will refer to the commissioner to provide more detail.

Hon LYNN MacLAREN: I noticed there were some changes in how you did the accounting, so I am hoping you are going to explain that.

Hon DONNA FARAGHER: Sure.

Mr Marney: Following the launch of the plan, we have restructured the classification of our expenditure into the structure that the plan articulates in terms of service categories being community support, community treatment and so on, so that over time this place can track exactly what is going on and reconcile that back to the plan. Otherwise, we run the risk of proving the infinite monkey theorem that you can write stuff for ever and ever and eventually you will get it right. We are trying to reset those structures. As part of that process, we have had some classification shifts in community support. Probably a better representation to get that year-to-year consistency is to look at the funding that is going to non-government organisations, which is predominantly for community support. In 2016–17, in mental health, non-government organisation funding increases by 1.4 per cent. Similarly, in alcohol and other drugs, funding to non-government organisations increases by 7.3 per cent. There is growth in those community support programs. What is offsetting that to an extent is that some of our unallocated community support funding has been harvested from grants and subsidies as part of the agency expenditure review process that the commission complied with. But predominantly those moneys were unallocated, so it is not taking services off anyone and, certainly, we have sought throughout the entire process to ensure that consumers, carers and their families would not be getting less support as a result of the agency expenditure review. Indeed, I think we are fortunate, particularly relative to most other agencies, in

terms of the increase in funding that we received as a result of government's decision to substantially increase the community supports and treatments around methamphetamine addiction. I am very confident that our community support outcomes will continue to grow as a result of these budget settings.

Hon LYNN MacLAREN: Is there any other detail that you can point me to in the budget that would give me a bit more information about what exactly that drop entails or how it is picked up elsewhere? For example, I see that community treatment funding has gone up, and when you say that funding to non-government services has gone up by 1.4 per cent, that could be for support or treatment, because non-government services offer community support and community treatment programs. That 1.4 per cent could be reflected in community treatment and not in community support. Is there some other listing that would enable me to understand where that community support funding drop of $6 million has gone?

[3.00 pm]

Mr Marney: Most of the drop in community support is actually attributable to commonwealth-funded schemes. The one I mentioned previously, which is the acute community intervention for child and adolescent mental health, was a drop of $4.1 million from the current year. That commonwealth funding drops away. The second element is commonwealth support for the individualised community living strategy, which is community support, which is $2.8 million. Those are the two major sources of movement in that community support figure that you highlighted.

Hon LYNN MacLAREN: Does the state pick up that deficit elsewhere if the commonwealth is no longer funding it? Is this one of those things that the commonwealth may at some future date provide funding for?

Mr Marney: We are very hopeful that once a new Australian government is voted into place that we will have successful negotiations in continuing both those funding streams. However, should that not be successful, we have contingencies in place within the commission to at least sustain the ICLS service as long as possible as well as the acute community intervention service. How long we can do that, it will test and strain our resources, but certainly we will be seeking as much as possible to ensure that the consumers, carers and families that benefit from those services are not adversely impacted by an adverse commonwealth funding decision. In that space we are also working very closely with the new arrangements in the WA Primary Health Alliance to ensure that their discretionary funding, which is essentially where the commonwealth's service provision decision-making is being devolved to—that we are talking very closely with them about opportunities for them to build better integration between primary services and community support services, because in many respects primary health is community support, to ensure that there are very clear pathways, linkage and integration and, as is already the case, where there are very sound opportunities for co-funding and co-commissioning of services. The commission and the Primary Health Alliance already co-commission some services. ICLS and ACI are opportunities for the future in that space as well.

Hon LYNN MacLAREN: Okay, I will watch that space; thanks.

The CHAIR: In terms of the national partnerships and commonwealth funding, is it that we are negotiating the final quantum and the governments have given an indication that they will refund the programs or are we actually negotiating for them to be refunded?

Mr Marney: My understanding is that we are negotiating for a continuation of funding which otherwise would cease.

The CHAIR: But have they given a general indication that their intention is to refund the programs or are you still to convince them they should refund the programs? There is a debate about whether

we are talking about what the quantum of funding will be or whether we are still at the point of negotiating whether there will be any funding.

Mr Marney: It is the latter.

The CHAIR: So there is no commitment to any funding at this stage.

Mr Marney: Correct.

Hon DONNA FARAGHER: I suppose we need to take into account that work was underway and then the election was called.

The CHAIR: Yes, but the government called the election!

Hon DONNA FARAGHER: I appreciate that, but I am just saying that that is the challenge that we are in at the moment.

The CHAIR: The current partnerships run out at the end of this financial year and the federal budget has been brought down. Was money allocated in the federal budget for these programs to continue?

Mr Marney: No, there was not.

The CHAIR: So, they would have to find it from other places to continue it. Realistically, it is likely that we are going to have a fight on our hands to keep that funding.

Mr Marney: I think we have always got a fight on our hands to keep any funding, but all of that is mixed up in the changed funding model and purchasing model of the commonwealth government, which, as much as possible—and, frankly, as both of sides of this place have argued for many, many years—decision-making has devolved to the local level. We are seeing that as a substantial opportunity to work closely with service providers to integrate service. As I mentioned previously, the commission has anticipated that there might be this glitch and we have certainly provided for that in our budget allocations for the coming year.

Hon PETER KATSAMBANIS: I refer to page 855 of the budget papers, "Services and Key Efficiency Indicators" and the heading "Prevention". We are spending around $20 million a year on that. Are you able to identify how much of that is what you would call media spend—however you want to phrase it—purchase of media advertising or whatever?

Hon DONNA FARAGHER: We will have to take that on notice.

[*Supplementary Information No B2.*]

Hon PETER KATSAMBANIS: Perhaps as part of that, can you breakdown by type of media—television, radio, print and online?

Hon DONNA FARAGHER: Yes.

The CHAIR: That is all a part of B2.

Hon PETER KATSAMBANIS: I notice that one of the efficiency indicators is "Cost per Person of Alcohol and Other Drug Campaign Target Groups Who are Aware of, and Correctly Recall, the Main Campaign Messages". The cost per person has gone from a budgeted figure of 45c in 2015-16 to an estimated actual of 81c. That effectively means that we are either spending almost double to get to the same amount of people or we are reaching half the number of people we thought we would with this advertising. I realise that there is a note of explanation in the budget papers, but what has led to that outcome?

Hon DONNA FARAGHER: As I understand, it relates to an increased campaign spend, but I will refer to the commissioner.

Mr Marney: Just to provide more detail, I think what that actually does reflect is a doubling in the effort of prevention initiatives and in part relates to reaching more targeted groups of people

through more intensive spend in particular areas, whether that be through purchase social media or radio advertising campaigns and so on. It is actually a conscious decision which is consistent with the 10-year plan to increase our percentage expenditure on prevention initiatives and campaigns. Encouragingly, the campaigns that have been running that we are putting further effort into have shown through their evaluations to be changing the behaviours of people. We have seen that most significantly in the attitudes of young people towards alcohol and reduction in the risky drinking behaviour of young people. The campaigns have been shown to work, hence we have increased our effort in that space, but also narrowing to more precise target groups. The methamphetamine campaign that was launched about nine months ago, I think it was, is very specific in its target group and uses social media mechanisms to very precisely focus in on at-risk groups. That is clearly going to be spending the same amount if not more money on a smaller group of people, hence that indicator shows an increased cost per person in target group.

Hon PETER KATSAMBANIS: That is what I want to clarify. There has not been a real increase in spending over that period or any significant increase in spending over that period. You are spending the money you have got to try and target harder-to-get-to groups—is that the takeaway message?

Mr Marney: Yes, that is correct. We are more intensively targeting the high-risk cohorts rather than just throwing a poncho over the whole population and assuming that everyone is the same. We are really focusing in on those high-risk groups. Today's technology allows us to do that much, much more precisely, particularly with our purchase social media spend. We are able to, for example, identify those who are at events just through their normal use of Facebook and so on and have our media feeds on Facebook very much target around particular events, whether it be music events and the like. So, obviously, the target population becomes more and more precise; therefore, the cost per head of target population goes up.

[3.10 pm]

Hon PETER KATSAMBANIS: In that case, when can we expect to see the cost per person actually come down, or is this going to be a situation where we are always chasing that hard-to-get-at group and it becomes costlier and costlier?

Mr Marney: I would not expect to see that cost per person come down significantly in the near future. I think as technology allows us to target more and more of those people at risk, quite frankly, we will not be wasting our money on prevention effort for those who are never risk anyway. So in that respect the cost per target population going up is actually a really good thing, because it is actually targeting those who are at risk, not giving prevention messages and support to those who are unlikely to be exposed to risky substance abuse or alcohol use in any case.

Hon PETER KATSAMBANIS: As long as the message is getting through, obviously, but I will leave that one to the experts to determine.

In relation to the comment that you made about some patterns in young people that may indicate lower use of alcohol, have you done any work around how much of that is a reduction in total consumption of alcohol and other drugs combined, or whether some of that is to do with substitution from alcohol to other drugs, including illicit drugs?

Mr Marney: That is a good question, but a really, really difficult one to answer, and I would have to take that on notice and see whether or not there is any reliable research in that space. Certainly, the survey information that we do have around young people's attitudes towards alcohol would suggest that it is not substitution but that they are more aware of the risks of alcohol consumption at a younger age; therefore, less and less are using alcohol, and that is mirrored also in the survey results from parents and their attitude towards or understanding of the risks of supplying alcohol to young people. So those two factors tell us that it is not substitution; there has been

actually a shift in community attitudes both among parents and among young people towards alcohol consumption at a young age.

Hon PETER KATSAMBANIS: I hope that is the case, but there is significant evidence that has been produced and communicated in the media that the use of illicit drugs has increased significantly, particularly amongst younger people. I am not necessarily sure that there is any direct evidence to link one or the other, but at a time when there is significant evidence to suggest that usage of illicit drugs, particularly in Western Australia, is increasing and alcohol is decreasing, would there be any value in looking at whether this is a pattern of substitution?

Mr Marney: I think there is always value in looking at evidence, and I think we need to be wary not to assume that that which is published in the media is actually evidence. If you look at Western Australia's long-term use of stimulants such as methamphetamines, the proportion of the population using those stimulants has actually declined over the past 10 years. That is not what gets told in the newspaper. What we do know, though, is that of that lower proportion of the population using stimulant-type drugs, they are using them more frequently and they are using a greater strength version of stimulant, commonly referred to as ice. Again, I do not think the substitution is there. If the substitution was borne out by that evidence, we would have seen a much stronger increase, or, in fact, we would have seen an increase in the proportion of the population using methamphetamine, but in actual fact it has declined. I am happy to take that question on notice and provide you with what evidence we do have, but, again, I would warn you against taking headlines from *The West Australian* as points of evidence, with due respect; sorry, I was not trying to be smart.

Hon PETER KATSAMBANIS: No, and I was not referring to headlines in *The West Australian* either. There are plenty of bodies of evidence coming around that you see discussing all these issues, and some of it is contradictory; I accept that.

[*Supplementary Information No B3.*]

Hon HELEN MORTON: Minister, I am interested in the effectiveness of the special purpose accounts that have been established for the area health services, and there is a second question that will come out of this. I refer to both the inpatient admission work as well as the community-based work that is undertaken by an area health service. Is that mental health funding ring-fenced in such a way that it cannot be used for services other than mental health services at each community health service?

Hon DONNA FARAGHER: Yes, it is ring-fenced, but the Mental Health Commissioner will provide a little more detail for you.

Mr Marney: Thank you for the question; I think it is a very important one in understanding what is one of the fundamental roles of the Mental Health Commission in ensuring that the resources that it provides to any mental health service provider are used for the purpose of treating mental health issues. The specific purpose accounts are set up under the auspices of the Financial Management Act. Under that act, an account may be established through which funds are provided, but can only be expended on a specific purpose, and that specific purpose must be stated and approved by the Treasurer. In the case of the specific purpose accounts that now sit within the Department of Health, the Mental Health Commission purchases all of its publicly provided mental health services through those accounts, so that includes inpatient services. All inpatient services moneys flow into those accounts and can only be expended on mental health services. All community treatment services purchases must flow through that account as well. Off the top of my head, we are talking about $700 million worth of purchasing. Similarly, all of our targeted purchasing such as the recently announced eating disorders outreach and consultation service such as the youth community treatment service in Fiona Stanley, youth community treatment from WA Country Health Service—all of those targeted purchasing expenditures flow through the specific purpose account. There is a grey area and that is consultation and liaison services. Some consultation and liaison mental health

services are funded by the commission within public health; others are funded by Health, so it is a fine line as to whether or not it is classified as core mental health expenditure. That is an area that I expect we will tidy up over time, but for those consultation liaison services that we explicitly purchase as part of our agreements and under the new health services act as part of our bilateral agreements with each area health service, all money must flow from the special purpose account to mental health services. The importance of that is that the special purpose accounts under the Financial Management Act can be audited to establish whether or not every cent in that account that was expended was expended on the specific purpose that was specified. That is incredibly important to ensure that—not that it would ever happen—money that is provided for the commission for mental health services does not become a balancing item in the broader health system for an area health service to balance its books.

The CHAIR: But it has happened in the past, of course—not with these accounts.

Mr Marney: I will take that as a rhetorical question.

Hon HELEN MORTON: Certainly, before SPAs were set up. But I did hear Patrick McGorry on the radio complaining about that issue, not recognising that in WA, SPAs are established. Inside that, the second point of the question was—I cannot actually remember what it was called, but the WA subsidy I used to refer to as the inefficient service subsidy, for the cost of delivering a service by Health in Western Australia compared with the national efficient price—is that decreasing? Is the subsidy that is having to be provided to meet the national efficient price decreasing?

[3.20 pm]

The CHAIR: Feel free, but I know that we only have 10 minutes left.

Mr Marney: This is a 12-minute answer!

Hon STEPHEN DAWSON: Take it on notice!

Mr Marney: The minister is referring to a component that was referred to as a community service subsidy in the budget papers, which, essentially, was the funding differential between the national efficient price and the state price for a weighted activity unit. The subsidy is no longer in place, as I understand it, but instead the government takes a decision as to what the state price will be, and funds up to that state price without separately articulating the differential between the state price and the national efficient price. Having said that, our growth in state price, I understand, continues to converge to the national efficient price over the forward estimates.

Hon RICK MAZZA: On page 852, under "Suicide Prevention", in the first dot point you have got 374 people who took their lives in 2014. Do you keep demographic groups of those people that do take their lives, specifically, say, farmers or other demographic groups?

Hon DONNA FARAGHER: I will ask the commissioner to respond.

Mr Marney: Thank you for the question. Action area 6 under the Suicide Prevention 2020 strategy is targeted at collecting multi-variant data around individual incidents of suicide, so that we can actually trace back through, I think, around 150 different variables associated with those individuals that die by suicide. That is a fairly substantial project which involves rebuilding a database that was in place through the Telethon Kids Institute in conjunction with the coroner's office. That work will come to fruition in the middle of next year, when we will be able to actually search for some of those common deterministic factors, or population groupings—cohorts—whether that be by occupation, whether it be by farmers, FIFO workers or by geographic location, by age. It is a substantial investment of time and of money to establish that database, but I think it will be worth every cent and give us the sort of intelligence in a much more timely way to be able to understand some of the emerging and actual causal factors behind individual suicides, and ensure that we have targeted measures in place for what are then discovered as high-risk groups at that point in time, which is, I think, action area 3 of the suicide prevention strategy. Those elements need to work hand

in hand and, certainly, that is the thinking behind the strategy and also the current work of the Ministerial Council for Suicide Prevention in oversight of the implementation of that strategy.

Hon RICK MAZZA: So that program will be able to go back retrospectively, if you wanted to go back to different years, once it is in place. Is that correct?

Mr Marney: The first stage of the project is to actually rebuild the historical data and then continue to collect it on an ongoing basis.

Hon RICK MAZZA: Earlier, in response to Hon Peter Katsambanis's question, you said that the amount of advertising per person got up to 81c, because you are more targeted in being able to get that message out there. It would follow to me that if you understood which groups were most at risk, you could target that much better as well. I noted that Griffith University in Queensland has also done some of that work, but what they found there was that they were a bit too specific on the term "farmer", for argument's sake, and were not picking up farmers' wives, retired farmers or farmhands, so maybe that is something within what you are doing that you can pick up on. Also, what initiatives do you have in place, or do you plan to have in place, for rural and regional Western Australia as part of your suicide prevention programs?

Mr Marney: We have a range of small grants initiatives that are currently being finalised at the moment. They are grants of up to $20 000 over a period of 12 months or so for community groups to run training and awareness exercises and specific suicide prevention training and awareness. Those grants are currently being rolled out across the state. I think there was an announcement last week in the Kimberley with respect to a range of those grants and recipients, a number of which were organisations run by Aboriginal people for the benefit of Aboriginal people and communities. We also have as part of the strategy the rollout of regional coordinators, whose task it is to embed themselves in the communities in regional areas, and indeed in the metropolitan area, and get an understanding from the community as to what mix of services would best meet their needs from a suicide prevention perspective. It can vary dramatically from community to community. Some need a fairly broadbrush approach in terms of suicide awareness and training and support; others are more targeted interventions that are required. But if we do not have coordinators based in the regional areas actually understanding the community's needs and listening to the community, then again it is throwing a poncho over the whole lot and hoping for the best, which is not evidence based and has been shown not to be the most effective approach. Again, the same as the prevention work, one of the benefits of bringing together the Drug and Alcohol Office and the Mental Health Commission is that all those prevention experts are now in the one spot working together. With my earlier comments around the learnings and benefits from that, this is an area which is benefiting greatly from the amalgamation. Indeed, in rolling out the regional coordinators, we are relying heavily on the existing alcohol and other drug regional networks to assist with that process.

Hon STEPHEN DAWSON: I refer to page 857, community bed–based services. Can I ask about the goldfields subacute centre and the step-up, step-down facility? The former minister, Hon Helen Morton, told the *Kalgoorlie Miner* in 2015 that planning for the site was well underway, and a site was being negotiated, with construction planned to start by the end of this year. That was 2015. She went on to say that the state government was committed to providing a subacute and step-up, step-down facility for the goldfields region to be fully operational in 2016–17. I ask, first of all: has land been purchased or leased for the purpose of the subacute facility, and what steps led to the goldfields subacute centre being scrapped, after we were told that negotiation was being done on a land deal only 12 months ago?

The CHAIR: Who would like to answer that?

Hon DONNA FARAGHER: I will refer to the commissioner.

Mr Marney: I prefer the chair's question, about who would like to answer that!

The member is correct in the statements in terms of the time lines of announcements. The Kalgoorlie subacute facility was first announced in May 2012 as part of the 2012–13 budget. The first allocation of state budget funding was in the 2012–13 budget for operational funding and that allocation was $1.2 million in 2014–15 and $1.3 million in 2015–16. As highlighted, the program currently has funding across the forward estimates of zero. Land was identified for the facility. It was land that was stock held by the Department of Housing, so it was identified and, if you like, notionally allocated by Housing for that purpose, so it was not a purchase of an additional piece of land as such; it was within Housing's existing land stock. As part of the recent budget process, one of the peculiarities, I would have to say, of the funding that was in place for this facility was that there was operational funding but there was not funding for capital. The commission sought to identify capital savings to be able to construct the facility and put a proposal to this year's budget process around that. Unfortunately, that was unsuccessful and the project, as highlighted, is no longer funded in the forward estimates.

[3.30 pm]

Hon STEPHEN DAWSON: Commissioner, can you confirm that this type of service is needed in the goldfields and it still remains a priority, even though there is no money in the budget for it?

Mr Marney: As the member is aware, a lot of planning has been undertaken in identifying community need for services and then fitting the optimal mix of services to meet the community's needs as part of the 10-year mental health drug and alcohol service plan. As part of that plan, the subacute facility or step-up, step-down facility in the goldfields is identified as one of the shorter term actions in that plan.

Hon LYNN MacLAREN: This question is also to do with the response to suicide and self-harm in schools program. There has been a current spate of suicides in the Mandurah region. Can you describe the response to that? What is the rollout? Obviously, you cannot predict when these pockets are going to flare up, so how is it that you manage the lumpiness of needing to respond urgently to this? It is a cascading sort of incident. Where is that in the budget? Is that program able to be flexible enough to respond to these spikes?

Mr Marney: Through the chair, the response that the member is referring to is the school response program under the suicide prevention strategy. From memory, that is about $9.5 million out of the $26 million of funding for that strategy, so it is by far the biggest component of our suicide prevention strategy. It involves a tripartite response from the network of school psychologists within the Department of Education, the child and adolescent mental health services within the area health services, and also our non-government service provider in this space, Youth Focus. What happens is that whenever there is an incidence of the suicide of—it is always very unfortunate whenever that occurs—a school-aged person that a school becomes aware of, then the school psychologist network is alerted to that. They then assess the situation and ensure that there is appropriate response from the child and adolescent mental health services if required. I have to emphasise that because in some cases the worst thing you can do is trudge into a school with a bunch of counsellors and start to ask everyone what is going on. It needs to be done appropriately and sensitively. It is very much at the guidance of the school psychologist network to assess what the level of need is. Then Youth Focus is brought in as well to provide additional counselling support, but also broader suicide prevention and awareness assistance. During that process, there is also very close monitoring of social media to see whether or not there is any emerging contagion or discussion around suicide ideation and also very close monitoring of links of the young person to other schools—schools that they may have been at recently or schools that they have close relatives in as well.

In the case of the very sad increase in the rate of suicide in the Mandurah area among young people, there was also a very close watching of the resource allocation between the child and adolescent mental health services provided out of Peel Health Campus, Rockingham and other sites to assess

whether or not there needed to be redistribution of resources down into that area to respond more rapidly.

We also rely, though, on primary health services as well. Again, that is something that we are looking to closely integrate with the WA Primary Health Alliance to ensure that there is appropriate support at a primary health level, particularly through general practitioners.

Hon LYNN MacLAREN: In this recent incident, are there sufficient resources currently active? What is happening down there currently? Does it mean that there is then a gap in Rockingham, for example, or is there some way to respond when there are these—what did you call them—contagions?

Hon DONNA FARAGHER: I think the commissioner has already responded in part to that.

Hon LYNN MacLAREN: In general terms.

The CHAIR: If there is something brief to add, otherwise we do need to bring it to a close.

Mr Marney: I think the short answer is that it is always a question of relative priorities in ensuring that those areas that are at greatest risk have appropriate resources allocated to them. That often means shifting away from lower priorities elsewhere, but the whole point of the response program is to assess those relative priorities and ensure that the resources are placed where they are needed most at that point in time.

The CHAIR: I think I will need to draw it to a close there.

On behalf of the committee, I thank you for your attendance today. The committee will forward any additional questions it has to you in writing after Monday, 20 June, together with the transcript of evidence, which includes the questions you have taken on notice highlighted on the transcript. Responses to these questions will be requested within 10 working days of receipt of the questions. Should you be unable to meet this 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 be met. If members have any unasked questions, I ask them to submit these to the committee clerk at the close of the hearing. Once again, I thank you for your attendance today.

Hearing concluded at 3.37 pm

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