STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2015–16 BUDGET ESTIMATES HEARINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 24 JUNE 2015

SESSION FOUR
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 7.00 pm

Hon HELEN MORTON
Minister for Mental Health, examined:

Mr TIM MARNEY
Mental Health Commissioner, examined:

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

Dr ELIZABETH MOORE
Executive Director, Mental Health, South Metropolitan Health Service, examined:

Mr KENNETH SMITH
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: 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 and 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 the 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 the Parliament to scrutinise the budget papers on behalf of the people of Western Australia and the committee values your assistance with this.

[Witnesses introduced.]

The CHAIR: Unless anyone wishes to make an opening statement, I will go to questions. I will start with Hon Stephen Dawson.

Hon STEPHEN DAWSON: I want to ask a series of questions about the Stokes review. I refer to page 394 of the *Budget Statements*, "Significant Issues Impacting the Agency". The second dot point talks about the Stokes review recommendations. The progress status dashboard on the Mental Health Commission's website provides an update of the details of the recommendations. The website states that 34 of the recommendations have been completed. I am keen to get a sense of what the cost has been to implement these 34 recommendations. I am also keen to find out about the 91 recommendations that are progressing or on track, if the department has costed those

recommendations and if you can give me a sense of what the figure is. I might just start off with that.

Hon HELEN MORTON: As you would know, some of the recommendations were able to be achieved without cost. Some of them have been integrated into just the general way of operating. A lot of them related to the work that has been undertaken by the establishment of the new Mental Health Act and the implementation of that. Of course, those things are not necessarily costed as part of this project; rather, they are costed as part of the implementation of the Mental Health Act. So the extent to which that can be separated out as costs that relate specifically to the Stokes review implementation, I would just ask the commissioner to make a few comments.

Mr Marney: As the minister indicated, a lot of these Stokes review recommendations were about how services are provided and I guess the models and underlying culture of service provision as well, rather than explicitly addition of new, if you like, activity in the system. In that context, the cost of the implementation of the Stokes review in its broader sense is covered by the government's funding for overall cost increase for the existing activity. For the current 2015–16 year, that cost increase is three per cent for existing activities, so it is captured within that overall envelope. There are a few of the initiatives that are discrete, if you like, and will have a cost associated with them. If it is acceptable, we would be happy to examine that on the basis of a request for supplementary information, where possible, but the bulk of the cost is really embedded within the system and the processes within the system. If you look at recommendations around follow-up post discharge and recommendations around addressing the physical health of those with mental illness, the aspect of physical health is dealt with, for example, by an operational directive from the acting director general of health. It is just a requirement within the model of service rather than an additional services or an additional cost.

Hon HELEN MORTON: I will also add that some of the recommendations—actually quite a few of them—were actions that had already commenced and were in operation—things like the subacute facilities and the patient transfer service. A whole range of those recommendations were things that were already incorporated into existing budgets. I actually think it is going to be quite difficult to cost out the full implementation of the Stokes review recommendations because they are embedded in so many aspects of general service.

Hon STEPHEN DAWSON: I appreciate that now, minister.

The CHAIR: There was an offer for supplementary information. Does the member want that? I think you are aware of what you are offering, Mr Marney, so I will make that D1.

[*Supplementary Information No D1.*]

Hon STEPHEN DAWSON: Thank you. In light of the commissioner's comments about that, I am very happy to take that on face value. In terms of the 91 recommendations that are progressing still or are on track, is there a matrix or a time line in the months and years ahead for when these will be finished and finalised?

Hon HELEN MORTON: Every one of the recommendations from the Stokes review has been charted in terms of its implementation. Many of them have now been incorporated into the implementation of the Mental Health Act, for example. Some of them have been incorporated into the new mental health services plan. In fact the plan itself was the major recommendation. To make sure that no recommendation has been lost in that process, there is a process of tracking how each of those initiatives are being implemented: either completed, transitioned to another implementation process but still within the tame frame that would be expected of it, or in progress at the moment.

Hon STEPHEN DAWSON: I do not recall whether that document, that chart that you spoke about, minister, is actually available on the progress status dashboard. If it is not, can you provide a copy of that chart that sets out what is ahead? If you are able to provide that by supplementary. I would be very grateful.

Hon HELEN MORTON: That is not a problem.

[*Supplementary Information No D2.*]

Hon STEPHEN DAWSON: Minister, one of the recommendations or in fact as part of the review, Professor Stokes investigated 255 suicides and determined that 15 per cent of men and 20 per cent of women who took their own life in WA died within 24 hours of being discharged from a mental health facility, and that one third took their own life within a month. Is the minister able to provide or advise on the latest health statistics for Western Australians discharged from mental health hospitals on the day and month following this? Have you tracked this again and are there updated figure you can provide?

Hon HELEN MORTON: I have not got it. It is something that we would have to follow up. It would take a little bit of time. Obviously, we get critical incidents reported through to the Chief Psychiatrist on that information and, obviously, I meet with him regularly and those things are brought to my attention, but I have not got that here.

[7.10 pm]

Hon STEPHEN DAWSON: Perhaps by way of supplementary, if we can pick a time, say, in the last two years, if that is possible.

Hon HELEN MORTON: So what you want to know is how many people have died from suicide, within what time frame after leaving hospital?

Hon STEPHEN DAWSON: Between a day and a month after.

Hon HELEN MORTON: From a day to a month after leaving hospital, in the last two years.

Hon STEPHEN DAWSON: After they have been discharged, yes, please.

[*Supplementary Information No D3.*]

Hon STEPHEN DAWSON: Minister, another of the Stokes review recommendations or issues found that the state has proportionately fewer child and adolescent beds and forensic beds and non-acute beds compared to other states. It also found that there were no specialised mental health inpatient beds for children and adolescents in rural areas. Based on the latest population figures, where does WA currently sit in relation to other states in the number of child and adolescent beds and forensic beds and non-acute beds? I am aware that some have opened recently in some of the new facilities, but I am keen to get a sense of where we sit on the national scale.

Hon HELEN MORTON: Obviously, that is incorporated into the mental health services planning, so using the national framework we have been able to track that. I will ask the commissioner to make some comments about that.

Mr Marney: Thank you. One of the things that we need to take into consideration in providing that information is the establishment of the new youth stream, which differentiates us from some of the other jurisdictions in how we deal with child and adolescent. That has seen six youth beds opened at the new unit at Fiona Stanley Hospital, with another 14 beds to come, as well as a new youth community treatment stream. So, while beds relative to other jurisdictions are an important comparison, given the different models of service that we are now commissioning, it is probably not the best comparison to make. But certainly the mental health and alcohol and other drug services plan has underpinning it a very comprehensive framework for modelling population need, and it does so by age-weighted population. So the estimates that you see in the plan for the time horizons 2017, 2020 and 2025 are based on that age-weighted population and the epidemiology, as well as then mapping to that the optimal service mix as determined by the national framework and the World Health Organization. So rather than rely on inter-jurisdictional comparisons, we are seeking to essentially implement world's best practice.

Hon STEPHEN DAWSON: Thank you. I appreciate that. I would be keen to see if we could get by way of supplementary those extra figures of that comparison between the states, if that is possible.

[*Supplementary Information No D4.*]

Hon STEPHEN DAWSON: Again, on the Stokes review, the latest quarterly chairman's report that I have seen, which is from February—obviously, the minister will have more up-to-date information—states that all IPG member agencies were asked to provide an update on the actions taken by the agency to address the reforms proposed by the Stokes review. It goes on to state —

> All agencies other than the Department of Corrective Services, Department of Premier and Cabinet, Aboriginal Health Council, Carers WA, CoMHWA, Arafmi, WAAMH and Office of Multicultural Interests provided appropriate responses.

Are you in a position now to tell me if all those agencies have now provided responses; and, if not, which agencies have not yet provided responses, and what is Mental Health Commission doing to ensure that responses are provided?

Hon HELEN MORTON: I am not in a position to give you that assurance; however, there is another quarterly review to be provided in the next month. That work, the updates and the quarterly responses or whatever it is, I cannot remember the words you used —

Hon STEPHEN DAWSON: The quarterly report.

Hon HELEN MORTON: The response that we are looking for from those different agencies probably is because there was not a further update from their point of view at that stage. However, that does not mean that there would not be a further update in the next quarterly report.

Hon STEPHEN DAWSON: Minister, I saw it as a criticism when I read the chairman's quarterly report, so I appreciate you said that there is a new quarterly report due out soon. However, I have heard from you previously that reports are on the way, including the suicide prevention strategy, and it has taken months. If you do not mind, if Hansard does not have it, I am happy to provide the list of agencies and perhaps by way of supplementary you could check if those agencies have now submitted the information that they are required to submit.

Hon HELEN MORTON: Sure.

The CHAIR: Is that further supplementary then?

Hon STEPHEN DAWSON: Yes, please.

[*Supplementary Information No D5.*]

Hon STEPHEN DAWSON: I have one final question on this. Obviously the quote in the Stokes review also mentioned forensic mental health beds. I want to ask the minister if the Barnett government is considering the co-location of a new forensic facility with a prison. Also has the Mental Health Commissioner met with the corrective services commissioner on this issue? If yes, the government is considering this co-location of a forensic facility on a prison site, what sites are being considered?

Hon HELEN MORTON: I will just give some general comment first and then the commissioner can speak for his own self in terms of conversations that he has had. There are two lots of issues around forensic mental health services. There are people who are in prison who need to be in prison who have been convicted of a serious criminal offence, but would either have a mental illness or could acquire a mental illness while they are in prison and they need to get treatment. So there needs to be some quite specific mental health service in a prison that will allow prisoners to not have to be taken out of a prison environment to access that service. It also means that when people are stabilised and they go back to prison—which happens at the moment—and they could benefit from a community treatment order or an involuntary ongoing treatment, that they need to have

a service dedicated to a prison environment whereby they can receive that ongoing community treatment order or involuntary level of treatment. That is difficult at the moment on the basis of the way services are provided from off-site. There is a requirement to have a prison service, a mental health service, within a prison environment.

There are also a number of people who are captured by forensic mental health services who are not prisoners—they have not been convicted—and as a result they currently receive their treatment outside of a prison environment, obviously at the Frankland Centre. So there are two areas, and of course there is a range of other community-based forensic mental health services that are provided in the community for people who have ongoing services and are either detained in one or other of the places that I have mentioned previously. So there is a statewide forensic mental health service that has really got a variety of needs; a community-based service that reaches out into the community; a service for people who are not associated with prison; and services for people who are associated with a prison. Conversations have been taking place how best to provide that service in Western Australia, and I believe that discussions have taken place. I am happy for the Mental Health Commissioner to talk about that.

Mr Marney: As you would appreciate, the forensic mental health services come under the umbrella of Corrective Services and the Department of Health, so the conversations we are having around this actually involve all three parties, particularly the North Metropolitan Health Service. As the minister indicated, there is actually a need for accommodating two cohorts of forensic patient. The planning that we are undertaking is consistent with the consultation outcomes from the 20 forums and numerous submissions around the 10-year mental health, alcohol and other drug services plan, which emphasises the need to respect the rights of those who are not convicted of a crime to be treated appropriately and separately to those that have.

[7.20 pm]

That is the work that we are doing now in terms of working with corrective services and health as part of a planning committee that we now have in place. I have had numerous discussions with both the acting director general of health and the Commissioner of Corrective Services, and we are scheduled to meet again this Friday to get a status update on that planning work, but bearing in mind that the objective is to address the needs of those two cohorts of forensic patient in an appropriate way and in a way that respects their rights and also has regard to community safety and security, but also address those needs in an efficient model of service as well. There is an issue of economies of scale of service and location. All those matters are to be resolved.

Hon STEPHEN DAWSON: Excuse me, commissioner, I am conscious of the time. Have sites been identified for a possible new facility? Is it anticipated that you might have a facility that has convicted prisoners in one side and people who have not been convicted of any crime, just people with mental illness, on the other side? Will there be a co-located facility?

Hon HELEN MORTON: I will just make a comment here. Considerations have gone ahead on all of that. At some point in time it has been talked about as being co-located on a prison site, knowing full well that there needs to be some service within a prison establishment itself. Then there is the issue about women and men, and whether to have it spread between, say, the women's prison and a men's prison. Then there is the issue around children or juveniles and how that fits with the juvenile corrective services. Then there is the issue about whether you continue to extend the services currently at the Frankland Centre. I would say that we have not landed on anything in terms of precisely what model that will be, what site it will be, but all of those things that I have mentioned are things that have been considered.

The CHAIR: I think the member asked about whether a decision had been made about possible locations.

Hon HELEN MORTON: I have said that no decisions have been made.

Hon RICK MAZZA: I refer to page 394, under suicide prevention. I note there that the ABS statistics show that suicide, between the ages of 15 and 44, is double that of the road toll. More concerning is also the fact that there was an article on ABC Rural last week regarding a partnership between CBH group and the Black Dog Institute that are going to invest $450 000 into the mental health program. Part of the article stated —

> "It was striking for me to learn that Australian men in regional areas are two-and-a-half times more likely to die by suicide than their urban counterparts …

There is obviously a very big problem in country Western Australia. I just wondered, under your suicide prevention strategy, what things were in place for rural Western Australia.

Hon HELEN MORTON: I hope that we have two hours left to talk, because there is a lot to talk about.

The CHAIR: No, we would like concise answers, minister.

Hon HELEN MORTON: There is so much to talk about in this area but, once again, I will just make a few general comments, and the commissioner might like to add to that. The suicide prevention strategy, as you know, has now been published, and it has received double the amount of funding that we have previously spent on suicide prevention. It builds on the way in which we have undertaken general awareness and community awareness raising around suicide and suicide prevention before. It builds on the community action plans. Many of those are in the country, having communities involved and partnering with the Mental Health Commission in continuing to raise people's awareness about how they can intervene and assist and support somebody to get professional assistance if they need it. It picks up on the areas of those people who are most in need, identifies and has specific strategies for those people who are at high risk and in that of course there are rural communities, men of different age groups, Aboriginal people et cetera. There are front-line service providers. Once again, they are spread right across the country. There is a whole section in there about providing additional services to the schooling programs that are already in place around suicide co-responsive schools et cetera. There is the data collection. I have missed out one of the six areas; I have forgotten it off the top of my head very quickly. I would say that we have identified that people in country areas have a higher rate of suicide. Our suicide prevention strategy is very much focused on high-risk groups, which picks that up. In that process, work is being undertaken right now in terms of implementing the strategy. There is a separate implementation plan for Aboriginal people and one for implementing the strategy in general. That is the work that is being undertaken right now by the Mental Health Commission.

Hon RICK MAZZA: It is obviously a big problem if a private organisation like CBH has got involved and is going to invest $450 000 in the program. It is obviously a big problem out that way. Is the Mental Health Commission going to get involved in this particular joint venture that Black Dog and CBH have formed and would they be donating money to them possibly to help assist with that?

Hon HELEN MORTON: We do put a fair bit of money into a variety of areas of work that would be picked up by some of that. I will allow the commissioner to make some comments about that specifically.

Mr Marney: The new suicide prevention strategy does allow for partnering with other agencies and other service providers to implement targeted suicide prevention activities as you have highlighted. Suicides, particularly among men in rural areas there is a higher prevalence than the general population. One of the key principles behind the new suicide prevention strategy is to target high-risk groups. That is certainly an area that we will be looking at in the implementation plans going forward.

One of the other key action areas of the new suicide prevention strategy is to focus on workplaces and to use, if you like, both the opportunity and the responsibility of workplaces and employers'

responsibilities to provide healthy and safe workplaces to address suicide prevention. I think the example that you have raised highlights that suicide prevention is actually everyone's responsibility; it is not just the Mental Health Commission's responsibility. To truly have an impact on the prevalence of suicide in our community, it is going to take a lot of effort from many different parties. That includes the state, the Mental Health Commission, it includes addressing the Stokes review recommendations, it involves commonwealth programs and the likes of beyondblue, which has a substantial workplace program as well. One of the things we are looking at as part of the implementation of the suicide prevention strategy is to provide incentive for employers, not just punitive measures if they do not comply with occupational health and safety laws but to actually provide incentives for them to become accredited or recognised as mentally healthy workplaces and exemplary mentally healthy workplaces. That is the sort of area that we will work with employers and the likes of CBH in partnership to assist in the implementation of actions and, importantly, to recognise those where they are effective.

[7.30 pm]

Hon RICK MAZZA: Does the Mental Health Commission partner with the Department of Health on the MITH program?

Hon HELEN MORTON: In the what?

Hon RICK MAZZA: The MITH program—the Mental Health in the Home program?

Hon HELEN MORTON: We actually think of it as the HITH program—the Hospital in the Home program.

Hon RICK MAZZA: There is a HITH program but there is also a MITH program.

Hon HELEN MORTON: Is that right?

Hon RICK MAZZA: Yes.

The CHAIR: The "myth" program is something to do with the Premier's department rather than the health department!

Hon RICK MAZZA: It is on page 134; I hope it is not a myth!

Hon HELEN MORTON: I am sure it is not.

The Hospital in the Home service for mental health is a really important aspect of new work that is occurring in Western Australia. When I say "new work", we have had a few isolated programs operating in WA for a longish period of time but nowhere near the extent to which it is provided in other jurisdictions in Western Australia. It has proven to be unbelievably good, especially for children —

The CHAIR: I think the member was trying to inquire whether you are partnering. Did you have a further question that you wanted to ask?

Hon RICK MAZZA: I have some further questions, but I am interested in what the minister has got to say about the issue.

Hon HELEN MORTON: In terms of children, the introduction of the ACIT team, the acute community intervention team, and the ART, the acute response team, has seen a huge reduction in the number of children being admitted to Princess Margaret Hospital's mental health unit or attending their emergency department for self-harm, for example, because these services are able to provide that level of intensity for people in the community. At the same time the CAPA program, the choice and partnership approach, which is again providing a greater level of immediate service to people in the community, has had a significant impact on children as well. In the adult area, that has been found in the establishment of new services and closing beds at Graylands, and providing the services as Hospital in the Home services. The first ever of the older-age Hospital in the Home service is being provided at Joondalup, and some others.

Hon RICK MAZZA: Minister, I know that others want to ask some questions. I have a list of a few questions on this issue. Can I take those on notice? From an estimates point of view, I just want to know the average daily cost per day was for patients on the MITH program and how many days there is in the program in the last 12 months —

Hon HELEN MORTON: On average before people are discharged, do you mean? They have like a normal admission, if you know what I mean, only it is not in a hospital; it is in the home and in the community.

Hon RICK MAZZA: And as I understand it there are trained nurses.

Hon HELEN MORTON: Absolutely!

Hon RICK MAZZA: And there is a doctor, I think.

Hon HELEN MORTON: And they have psychiatrists and they have consultant registrars. They have the full team that would be providing those services to them if they were in a hospital, only they are providing those services in the community.

Hon RICK MAZZA: If you could give me how many "in the home" days there is for the MITH program in the last 12 months, that would be good.

Hon HELEN MORTON: Okay.

Hon RICK MAZZA: One last thing: and the ratio of those days between metropolitan and regional areas.

Hon HELEN MORTON: I do not think there are any services operating in the regions; it is all metropolitan based at the moment.

Hon RICK MAZZA: So this MITH program is simply metropolitan at this stage?

Hon HELEN MORTON: It is. The HITH program—Hospital in the Home—for mental health patients is all metropolitan based at the moment.

[*Supplementary Information No D6.*]

Hon SALLY TALBOT: I have a couple of preliminary questions and then I will get to my substantive point. Can you go to page 393? Under "Spending Changes" is "Fresh Start Recovery Program".

Hon HELEN MORTON: Yes.

Hon SALLY TALBOT: I notice that there is money for three years. Can you tell us what that is about?

Hon HELEN MORTON: I will ask Neil Guard to speak about that in more detail because he seriously has been significantly involved in the negotiations with Fresh Start. We provide funding to Fresh Start for some general services that they provide for people with drug and alcohol problems. But over and above that, we also provided some funding that was specific towards assisting in the process of getting the drug naltrexone approved by the Therapeutic Goods Administration. This is now getting to the stage where Fresh Start will be able to proceed with that in its own right, so that the need for the government to continue to support Fresh Start to the extent that we have been to get that work approved by the Therapeutic Goods Administration is declining, and that is what you see. The only thing you see in that line is the declining amount of financial support for them for that part of it. But in terms of the rest of the services, Mr Guard.

Mr Guard: As the minister says, this is additional grant funding over and above the core funding for the Fresh Start Recovery program to help them through to the period when they expect to be able to lodge the application for registration of the naltrexone implant with the Therapeutic Goods Administration. There is a bit of work that is still required to do over the next couple of years, including a small pharmacokinetic trial and some stability testing and collation of that application.

But based on an independent review in 2014, the latest expectation is they should be ready to lodge that application in early 2017. So this is tiding them through.

Hon SALLY TALBOT: So this is actually paying for their research work that is needed to substantiate their application?

Mr Guard: No. They are paying for the remaining research work around doing that.

Hon SALLY TALBOT: So what is this money actually being used for?

Mr Guard: This is supporting them to ensure sustainability of the other work that they are doing within the program, primarily around counselling and other support services while that other work is being progressed by the organisation.

Hon SALLY TALBOT: I refer to the following page and the significant issues and the second dot point under "Mental Health Activity in the Public Hospital Systems". Can you tell us why that comment about the alignment with the national framework is a significant issue impacting the agency?

Hon HELEN MORTON: Which one in particular?

Hon SALLY TALBOT: It states —

> WA Health is the provider of mental health public hospital services in Western Australia and operates within an … (ABF) —

Hon HELEN MORTON: An activity-based framework. I will ask Tim Marney to speak on that.

Mr Marney: Part of the national health reform agreement that was struck a number of years ago actually requires the health system in its entirety to shift to an activity-based funding model. Mental health is a part of that process, as far as mental health services are delivered by the Department of Health through the area health services. The activity-based funding framework closely aligns with the national framework to ensure that we are purchasing activity from the public health system in a manner that is consistent with the classification measurement pricing of activity in other jurisdictions so that we can use other jurisdictions as a benchmark to compare the efficiency of our services, and we can use the work of the Independent Hospital Pricing Authority to provide guidance to us as to the appropriate benchmark in terms of cost structure for the provision of what are referred to as weighted activity units, which is the classification system under the national framework that we rely upon, and also in not just the mental health system but the general health system, to model the need for services in the community and through various regional locations and area health services and to then allocate funding to best align with that modelled service need. It is actually quite a complex framework but very comprehensive in being able to identify the services that are required, in what locations and at what levels and also to give us a fair guide as to the efficient price of those services. That really underpins the work of the Mental Health Commission and underpins the resource allocation framework from the Department of Health for general health services as well.

Hon SALLY TALBOT: What is the nature of the impact? Is it because you need different IT systems? Does it involve capacity development amongst your staff? What is the nature of the financial impact, one would assume, if it is there in the budget papers?

[7.40 pm]

Hon HELEN MORTON: The reason that this is under that section "Significant Issues Impacting the Agency" is because at the moment the way services are delivered in Western Australia and the price for which those services are delivered is higher than the national efficient price, and so there is a subsidy that has been paid but has a sliding scale of reducing over a number of years.

Hon SALLY TALBOT: A subsidy paid by whom?

Hon HELEN MORTON: By the state, for that weighted activity that is being incorporated into the contracts. As the subsidy that the state pays for the weighted activity reduces over a period of time, the expectation is that the agencies that are providing the services—mostly it is the health department—will be able to provide those services to match the efficient price for doing that. But the significant issues impacting are that as that subsidy reduces, the agencies need to be able to provide those services more efficiently.

Hon SALLY TALBOT: Is it actually a cost-cutting program?

Hon HELEN MORTON: It has nothing to do with cost cutting at all.

Hon SALLY TALBOT: Why were the prices so discrepant?

Hon HELEN MORTON: It is because what is deemed to be the efficient price—that is, undertaken by the national average of providing that particular weighted activity—is being provided in Western Australia at a higher cost.

Hon SALLY TALBOT: Why?

Hon HELEN MORTON: For a variety of reasons. As you know, we have the highest number of acute beds per head of population; we have the highest number of staff; and we have the most resources per specialist mental health service per head of population anywhere in the nation. We are providing many of our services in an acute setting, which is a higher base setting than could be provided in a lower cost setting in a community-based setting. So there are those sorts of things.

Hon SALLY TALBOT: I talk about cost cutting because you address that presumably not by reducing the cost of acute care, but by switching care out of acute into community settings.

Hon HELEN MORTON: What was the point of that, sorry? You are right, that is what we need to be looking at: providing more services. But we have other —

Hon SALLY TALBOT: Have you got a list of those factors, because you just named three or four of them. I am wondering if this is obviously —

Hon HELEN MORTON: I do not have a list of those factors. These are things that we —

Hon SALLY TALBOT: Can you ask the commissioner whether there is a list?

Hon HELEN MORTON: I know that there is not a list of the factors, but these are the things we know are making our services more costly. And included in that are things like the level of regional disbursement of services that are delivered in Western Australia compared to something in Victoria, for example, or in New South Wales.

Hon SALLY TALBOT: Is this incorporated into the 10-year plan or is it a separate document, a separate process? This process of aligning with the NHRA framework, is that a process that is going on in parallel to other planning studies?

Hon HELEN MORTON: That is correct. The Mental Health Commissioner might like to make some more comment about that.

The CHAIR: Knowing the commissioner, I would be surprised if it he does not have a dashboard of drivers of costs within the organisation by now!

Hon SALLY TALBOT: That is what I am looking for!

Hon HELEN MORTON: There is no dashboard that I have seen.

The CHAIR: I am sure he will have one!

Hon HELEN MORTON: We are certainly aware of it though.

Mr Marney: It is fair to say that the pricier mental health activity is not black and white, in fact, it is more sort of yellow and black, if anything. This is an area which is under development. The national framework, it is fair to say, is in its infancy, particularly with respect to mental health.

When we talk about a national efficient price or a national average price for a weighted activity unit, we are actually talking about the pricing for total health services including mental health. The Independent Hospital Pricing Authority has actually got a substantial process underway at the moment at the national level to better understand the actual pricing of mental health activity as opposed to general health activity. That is the process that we are part of; that is what is a significant issue for the organisation because we need to get the outcomes of that process as robust as possible to ensure that going forward we can better understand the difference between what is an efficient price for a mental health weighted activity unit and what our actual price is, and then understand the cost drivers that cause the divergence between the two.

As the minister mentioned and if you go to the various publication of the Grants Commission around the state's cost relativities it will highlight indigeneity, a high proportion of Indigenous population relative to national average; it will highlight regional and remote dispersion of services; it will also highlight a higher than average FTE wage cost, which is in recognition of the significant wage pressures in the state historically and also in attracting regional professionals and employees to the services; and it will be driven also by variations in acuity and epidemiology and our age-weighted population, which is very different, for example, to say Tasmania or Queensland. All those factors go into driving a differential cost relative to the national average.

Hon SALLY TALBOT: The minister has just said that there is no list, but is there any document that you would be able to provide for us that shows where we have to make those adjustments to bring the state to a place where it meets the requirements of the NHRA?

Mr Marney: In stark factual terms we are actually meeting the requirements at the moment. The question is how far we drive towards national efficient price, and that is a matter for the state to determine based on analysis of what those cost drivers are.

Hon SALLY TALBOT: Is that a policy question or a management question?

Hon HELEN MORTON: The question of how much we substitute?

The CHAIR: Or how much we seek to drive towards the national average price.

Hon HELEN MORTON: At the end of the day, if the state wanted to continue to so-called "top up" the amount of funding so that we can continue to provide services at the cost that we are currently continuing to provide them, the state can continue to do that if we want to do that. If we want to reduce the cost of service delivery so that it closer matches the national efficient price, we can make a decision to do that. So that is the decision that we will take on an annual basis when we negotiate things like budgets and go through EERC.

Hon SALLY TALBOT: So we are talking about two prices here. We are talking about a nationally efficient price and we are talking about a WA price.

Hon HELEN MORTON: That is correct.

Hon SALLY TALBOT: Is there a table that show us what the difference is between those two figures for various services?

The CHAIR: Whilst you are getting that, can I just ask the commissioner, as I just want to clarify. So the national efficient price is not just a single national price? I think you were saying earlier that through the Commonwealth Grants Commission though they should be making allowances for all those other factors that when they do their assessment of WA needs be providing us with sufficient funding to meet those additional costs over the national efficient price. If that is the case, do we ever break it out of what the Commonwealth Grants Commission calculates would be the WA price? Which may help the member.

Hon SALLY TALBOT: Thank you, Mr Chair, very eloquently summarised.

The CHAIR: Does anyone ever then pull it out and ask: in calculating in the mental health area, over and above the national efficient price is the cost of the delivering mental health services in WA at that national standard? I will leave the minister to answer and then maybe the commissioner.

Hon HELEN MORTON: I would just say that it is per weighted activity unit. In language, when I hear some of these people talking they call it "WAUs". A single WAU in Western Australia will cost $5 454 and by virtue of it being a weighted activity it does not matter which service you are providing, it is relative to whatever the weighted activity is. Whether it is more complex or whether it is less complex, there is a single weighted activity unit, and one unit is worth $5 454. The national efficient price for that unit is $5 122, and the state contribution to that at the moment is $332. Some people have been unfairly referring to that $332 as an "inefficiency" price, but I do not think that takes into —

[7.50 pm]

The CHAIR: They would have to be down at Treasury saying those sorts of horrible things!

Hon HELEN MORTON: That does not take into account those issues that have been raised around regional dispersion of —

Hon SALLY TALBOT: Have you said no to the question that I asked and then the Chair paraphrased?

Hon HELEN MORTON: There is no chart of anything.

The CHAIR: Does anyone pull out of —

Hon HELEN MORTON: If you fully understand the idea of a weighted activity unit —

Hon SALLY TALBOT: I am pretty sure I am there.

Hon HELEN MORTON: — then every service that is funded in this way relates to that one unit.

Hon SALLY TALBOT: Yes, but then it becomes a question of how many units a particular service is using.

The CHAIR: But the other question is —

Hon HELEN MORTON: Across the whole state.

The CHAIR: But, minister, the other question, which is the one I was asking, is when the Commonwealth Grants Commission decides on the allocation to WA, what do they determine would be the WAU or the cost above the national efficient price for providing services in WA? That is why I am still not sure that we have ever pulled that figure out of those Commonwealth Grants Commission calculations. Is that something that happens, and do we have it?

Hon HELEN MORTON: The commissioner is really wanting to answer that.

The CHAIR: I am happy for the commissioner to answer it.

Mr Marney: I think the minister may have misled the house on that occasion!

The CHAIR: Are you sure it is just on that occasion?

Mr Marney: I do not want to creep back into previous territory, but, Chair, the process you have articulated is actually the opposite of what happens. In the state formulating its submission to the Grants Commission, it provides evidence on the basis of actual costs of services. So the Department of Health will feed into Treasury and the Grants Commission submission, and that then goes off to the Grants Commission and goes into their black box, which we all are mystified by, and comes out as weightings or loadings on the cost structure of the state service provision. So it does not come out as, if you like, an identifiable price differential index; it comes out as a consolidated weighting so it is very difficult to disaggregate that weighting into a price dollar differential. But the process is that the state tries to articulate as best it can the impact of those peculiar drivers like indigeneity,

regional and remote location, service delivery challenges and so on. In terms of getting to the degree of sophistication of actually breaking down what is the cost of regional and remote, what is the cost of a higher rate of indigeneity it is fair to say that the framework is not at a level of sophistication yet to be able to do that; we have a long way to go. We do not yet have a stand-alone price for mental health weighted activity units, so that gives you a sense that —

Hon SALLY TALBOT: That is interesting. Do you expect to have that at some stage?

Mr Marney: I think I mentioned in a previous answer that we are working with the Independent Hospital Pricing Authority that is undertaking investigation and review to establish a dedicated quantification, through weighted activity units, of mental health weighted activity units, and establishing the national average price for that. At this point the time line for that work is to be complete in about 18 months' time.

Hon SALLY TALBOT: Eighteen months from now?

Mr Marney: That is when we will get to a point of sophistication when we can then try to reconcile back to our existing cost structures and understand where some of those differentials are. But as the minister highlighted before, those differentials are broad and varied and include policy decisions as well. So, the state can take a decision. It is part of government's role to take a decision to provide a better quality or model of service than the national average. Dissecting that from differentials in underlying cost drivers is extremely difficult, and I think even the best econometrician would struggle to get it down to the sort of degree of precisions that you are looking for. But what we can understand at the end of that process is, broadly, what some of the key drivers are and how far we are out.

Hon SALLY TALBOT: What happens when you get to those overlapping areas as, for example, with the NDIS? What happens with the mental health weighted activity units?

Hon HELEN MORTON: It does not overlap because, once again, the NDIS does not provide any treatment services, only support services to people. The treatment services that somebody with a mental illness needs, even if they are getting support through the NDIS for their home living, but they have an escalation of an illness where they need treatment, they will get that treatment according to the clinical treatment services in a hospital, if they need to go to hospital, or in the community if they do not, but it does not impact on the NDIS.

Hon SALLY TALBOT: So, people with a psychosocial disability literally remain covered by two umbrellas?

Hon HELEN MORTON: It is the same as somebody with a disability who gets pneumonia. If they get pneumonia, they have to go to hospital for treatment of their pneumonia, but their disability is still with them.

Hon SALLY TALBOT: It is interesting. It is actually not the same, but I understand what you mean.

Hon HELEN MORTON: If somebody with a psychosocial disability has an exacerbation of an illness that requires medical intervention and treatment, they will go and get that treatment and then come back.

Hon SALLY TALBOT: Even if it is a psychosocial illness?

Hon HELEN MORTON: Even if it is a psychiatric illness.

Hon SALLY TALBOT: I have one more question that segues into the 12-month lead-up time for the implementation of the new act. You have given yourselves a 12-month implementation period. Is that on track and what is going to happen in November? Is the world going to change?

Hon HELEN MORTON: It is on track. I am not saying that it is easy; people are not having an easy time with it on track.

Hon SALLY TALBOT: In what sense, minister?

Hon HELEN MORTON: There is pressure on people to go through an educative program around the implications of the act. Work is happening right now on a system of information exchange from the Mental Health Tribunal and the advocacy service to the Mental Health Commission, and about how automated we can make the treatment services rather than using paper-based approaches. The clinicians have had some involvement in getting the practice guidelines out through the Chief Psychiatrist.

Hon SALLY TALBOT: Is there anything that you can share with us in the way of practice guidelines?

Hon HELEN MORTON: All the practice guidelines have been completed.

Hon SALLY TALBOT: Have they been published?

Hon HELEN MORTON: The clinical guidelines will be out on 31 July.

Hon SALLY TALBOT: All the clinical guidelines will be out on 31 July. Will they be on the website?

Hon HELEN MORTON: The Chief Psychiatrist will have those on the website, yes.

Hon SALLY TALBOT: Are there any areas of concern or that will require an extension?

Hon HELEN MORTON: I am really hoping not to have an extension, but at the same time I am not going to be silly about that. If there was a critical element of work that was not completed, I would look for a way to enhance the work that is needed to get that completed. We sought an understanding of whether we could get support if we could implement the act in different stages—that is, different components at different stages if some of the work was not completed.

Hon SALLY TALBOT: What was the answer?

Hon HELEN MORTON: The answer was that it is desirable that it go ahead as one complete act and that we also believe that we will get it done on 30 November.

Hon SALLY TALBOT: Do you have an implementation board?

Hon HELEN MORTON: Yes, we do have an implementation board.

Hon SALLY TALBOT: Is it going to be wound up in November

Hon HELEN MORTON: No. There will be some post-implementation work that needs to happen. The board is chaired by a very astute man by the name of Eric Ripper.

Hon SALLY TALBOT: I have heard of him. Do they stay as a monitoring body after November?

[8.00 pm]

Hon HELEN MORTON: We have not actually talked about how long they will stay on after that. I have not talked to him about that.

Hon SALLY TALBOT: So you have not made a decision about whether they will be disbanded.

Hon HELEN MORTON: No, but there has been some discussion between Mr Ripper and myself. I have regular meetings with him in my office about the need for some ongoing work after 30 November, but it has not been determined how long or specifically how that would take place.

Hon SALLY TALBOT: I cannot avoid catching the Chair's eye for much longer!

Hon HELEN MORTON: Just a minute, there is one more thing I want to add.

The CHAIR: I was going to say that putting Mr Ripper and Mr Marney together is getting an excellent team that will give you great credibility, minister!

Hon HELEN MORTON: I think that we will ask Mr Marney to just make one further comment on that.

Mr Marney: Part of the process of implementing the act is to actually design what would be the ongoing compliance and monitoring regime post implementation. As the minister highlighted, the current implementation working group or reference group will be in place post the commencement of the act to check whether or not it has gone the way it should, and also to advise on what that regime should be going forward, but I can give you full assurance that there will be no, if you like, dropping of the ball in that process. Given the significance of the act and going back to previous members' comments around the recommendations of the Stokes review, the act and the successful implementation of the act is actually crucial in achieving a whole range of those recommendations. It is crucial to the involvement of consumers, carers and families in the entire system, and there are other crucial elements in terms of workforce as well and the role of psychiatrists and the forms which need to be updated as well. All parties are heavily involved in those processes at the moment, which we thank them for, but we need to make sure we get the implementation right, and bearing in mind that we will be asking particularly the clinical workforce to undergo substantial training in the new act at a time when we already know they are under pressure, so I guess I take this opportunity to thank them for their efforts in this process as well.

Hon NICK GOIRAN: I would just like to ask a few questions around the Suicide Prevention 2020 strategy. I thank the minister for a letter that I received, and I presume all members received in recent times, providing a copy of the strategy. In the second paragraph of that letter the minister advises that in Western Australia, on average, one person dies each day by suicide. You then outline what you refer to as a bold and ambitious target to reduce Western Australia's suicide rate by 50 per cent over the next 10 years. I am wondering if you could inform the committee as to whether there are any forces—what I am going to refer to as forces—that are working against the commission's suicide prevention strategy.

Hon HELEN MORTON: Sorry, you are asking me who is working against it?

Hon NICK GOIRAN: Yes. Does the commission consider that there are any forces in Western Australia that are working against your suicide prevention strategy?

Hon HELEN MORTON: Right.

Hon NICK GOIRAN: Or everyone in Western Australia is on the same page and we are all moving forward together.

Hon HELEN MORTON: I do not know about anybody who is specifically working against it, is my issue. I mean I think there are issues like lack of awareness. There are issues like people being not necessarily understanding what everyday people in a community can do to assist that. There are obviously issues like risky alcohol consumption and drug and alcohol problems, and the increasing use of those.

Hon ADELE FARINA: Do not forget Treasury!

Hon HELEN MORTON: Treasury is not working against it!

Hon ADELE FARINA: It never provides enough money!

Hon HELEN MORTON: Obviously, we have doubled the funding. Double the funding and double the effort is the catch cry for these next four years. Maybe the commissioner has had time to think about anything that is working against it.

Mr Marney: There is no active, if you like, opposition to the suicide prevention strategy. There is certainly a difference of opinion as to priorities. I think in the case of suicide prevention, this is a very complex issue and it is not surprising that there are different priorities across different perspectives. But I think it is useful to recognise, as was pointed out in the suicide prevention strategy, that for individuals who die by suicide, 90 per cent have either a pre-existing diagnosed or

undiagnosed mental illness, so the work that is going into the rest of the system, into even implementation of the new Mental Health Act, for example, is all about addressing suicide from one angle or another. I do not think that there is anyone actively undermining the efforts, but we certainly need support and effort from all aspects of the community, workplaces and the health system to help prevent suicide.

Hon NICK GOIRAN: Indeed. I recall the commissioner mentioning earlier that it is not just the Mental Health Commission's job; it is the job for all of us. Minister, I came across a document in recent times—I think it may have been a talk or something of that nature—by the Mental Health Commissioner in which he referred to rational suicide as an oxymoron. I am just wondering whether either the minister or the commissioner might consider that those who are promoting this idea of rational suicide, whether they are necessarily doing so out of their own good intent and own good motivations, are actually undermining and working against the government's strategy.

Hon HELEN MORTON: I have a feeling that I have a bit of an inkling of where the member is coming from now. Yes, obviously those who promote euthanasia are people who do not always understand. I have heard discussions, for example, on the radio about a mum who was asking why—if euthanasia was an acceptable form of ending one's life, she did not want to see her daughter miss out on that opportunity. Her daughter, as young as she was, had a mental illness and that daughter wanted the opportunity to end her life as well. The commentator spoke a little more to the mother about that. The daughter was away on holiday at that time in another country, yet it was being suggested that she have the right to end her life through euthanasia. I would say that most people who have a mental illness have the opportunity to receive treatment. The suicidal ideation that many people with a mental illness feel from time to time is also treatable. Nevertheless, as I have also been on radio and said from time to time, despite the very best treatment that can be provided—the world's best treatment—and despite the very best known technology and information around treatment for mental illnesses and medication et cetera, and the greatest support that a family can give to somebody, sometimes we cannot save those people. I would like to see if Elizabeth Moore would like to make any further comments around the idea of the ability to treat somebody with suicidal ideation, as a psychiatrist.

Dr Moore: The notion of rational suicide was one by Arthur Koestler. The literature shows that most people under that banner have some treatable illness. Therefore, from a clinician's point of view, as the minister has said, we would want to do our best efforts to diagnose and manage those people because the outcome is so much better.

Hon NICK GOIRAN: Minister, in the "Suicide Prevention 2020: Together we can save lives" document, page 22, is the listing "Other challenges". One of those challenges listed is media reporting, including social media. The document concludes with the following, and I quote —

> Examples of inappropriate media coverage of suicide include showing photographs or information about the method used; gratuitous coverage of celebrity suicides; or normalising suicide in any way.

My question is: given that the Mental Health Commissioner has referred to rational suicide as an oxymoron, are those efforts by those pressing for rational suicide what you consider to be normalising suicide?

[8.10 pm]

Hon HELEN MORTON: I will just say that there are guidelines that have been put out from organisations like Sane Australia, for example, on how reporting should take place around suicide. But in terms of whether the commissioner has made the comments and the context in which he has made the comments, I think he should speak for himself.

Mr Marney: The comments around rational suicide were in the context of the euthanasia debate. I would echo the comments made already in terms of a treatable illness, and that is that someone

who is in a state of distress who has a significant mental illness is not in a place to rationalise those sorts of decisions. That is the context of my comments.

In terms of the comments around media in the suicide prevention strategy, those comments are directed two ways: firstly, to seek to improve the responsible nature of media coverage of suicide, and that really goes to the sometimes duplicitous nature of media reporting around suicide whereby if an individual in the community that is important to a lot of people happens to take their own life, then that is considered taboo to discuss in the media. However, if a prominent celebrity takes their own life, then it is open slather and away you go. That, I think, is what we were trying to refer to as there needs to be a greater degree of responsibility and consistency, but not to not report. The important aspect here is that it is actually made clear and transparent to the community the incidence of suicide in the community, and the fact that it is double the road toll, and the fact that for every person who dies by suicide it is estimated another 20 attempt to take their life. What we are trying to say is media reporting of death by suicide can be done in a more responsible way and in accordance with the guidelines of the likes of Sane and Mindframe. The historical fear, if you like, of media reporting around suicide is no longer valid because social media has got it well and truly covered. Really, we need to actually adopt a far more contemporary approach to the disclosure of the incidence of suicide and recognise that we actually need to manage what is going to be very substantial and sometimes graphic reporting in social media. So, that is the challenge.

Hon NICK GOIRAN: I realise that the Mental Health Commission has to work with a finite set of resources and has to, like any other agency, prioritise its resources, but does it have any capacity to monitor the reporting by media of some of these instances; and on monitoring it, then responding, if you like, challenging the media so that maybe some of those journalists and media outlets might learn for next time?

Mr Marney: I appreciate your recognition of our finite resources, but this is an area that is extremely important. We monitor the reporting of suicide actively on a daily, hourly basis and where there is a sense that the reporting might go down a path that we think is inappropriate, I can assure you we are in touch with the appropriate media outlets immediately. If we miss something before it is reported and it is actually reported inappropriately, again I can assure you we are onto it straightaway. That is a priority. We take that issue extremely seriously.

The CHAIR: I might add from the chair that one of the most chilling facts I have ever had as a member of this committee was when the coroner came before us and pointed out the spike after a particular celebrity committed suicide in Perth. I have never forgotten that. We have only 45 minutes left, so I would ask members to try to be concise with their questions, and we will try to get through them all, because there are still a number of members who want to ask questions, and also if the answers can be as concise as possible. I give the call to Hon Adele Farina.

Hon ADELE FARINA: Thank you, Chairman. Is there any funding in the 2015–16 budget for a drug and alcohol rehabilitation facility in Bunbury; and, if not, when can we expect to get such a facility?

Hon HELEN MORTON: It is not listed in this existing budget. The mental health services plan indicates a requirement for that by 2017—to commence development of it by 2017. The process by which that will be achieved is through the completion of the mental health and drug and alcohol services plan, taking that through to cabinet, getting cabinet endorsement for it, commencing the business case for it, and getting that funded. I am hopeful that we will get the mental health services and drug and alcohol plan endorsed by cabinet by the middle of this year and that we will commence on the priority areas, of which this is one, and it will be developed up for the coming budget.

Hon ADELE FARINA: Is it the intention that that will be a public facility?

Hon HELEN MORTON: Yes it is, absolutely. But you do understand that most of our drug and alcohol rehabilitation programs are public facilities but provided by not-for-profit organisations. We do not actually provide any of those services ourselves, other than a withdrawal program in East Perth. The government does not provide any of those services itself. It is all contracted services.

Hon ADELE FARINA: How much funding will the Mental Health Commission provide to south west CAMHS in 2015–16?

Hon HELEN MORTON: I anticipated this question!

Hon ADELE FARINA: I anticipated that the budget has been finalised!

The CHAIR: I hope you bumped up the funding for them and north metro at the same time!

Hon HELEN MORTON: Hang on. We are just talking about CAMHS in the south west at this stage. Unfortunately, it will not be finalised until Friday afternoon, so I cannot answer the question at this stage.

Hon ADELE FARINA: It is interesting the way these things are always finalised after estimates!

The CHAIR: If it is finalised by Friday, are you happy it take it on notice for the member? That is within the 10 days. You will have it all well and truly done and dusted.

Hon HELEN MORTON: Of course, our allocation is with WA Country Health Service, it requires them to have their information finalised also around their allocation to individual health services. So I cannot guarantee it will be ready within the 10 days; but, if it is, you will definitely get it.

The CHAIR: If it is available, if you can provide as much information as you can.

[*Supplementary Information No D7.*]

Hon ADELE FARINA: How much block funding has been allocated for tier 2 services in the lower south west in the budget?

Hon HELEN MORTON: I think you are referring to disability services—tier 2?

Hon ADELE FARINA: Do not say that, minister, because when I asked the question in disability services, you told me I needed to ask it during mental health. So do not tell me now that I needed to ask it in disability services, because we have had that discussion.

Hon HELEN MORTON: You are asking about tier 2 services. I will put it a different way. As I understand it now, because you are referring to a previous question, you are asking how many support programs are being provided in the south west for people with a mental illness—ongoing psychosocial support.

Hon ADELE FARINA: Yes, but tier 2 services, because obviously people who are eligible under the NDIS —

Hon HELEN MORTON: But there are other tier 2 services that are provided through disability services that are not necessarily funded by the Mental Health Commission.

Hon ADELE FARINA: I am focusing on people with a mental health problems.

Hon HELEN MORTON: The Mental Health Commission has a range of support services for people with a mental illness in the south west. I now that we have provided those for you before.

[8.20 pm]

Hon ADELE FARINA: I want to know how much block funding will be made available in the lower south west to deliver tier 2 mental health services.

Hon HELEN MORTON: But they are by individual service provider—I do not have that at my fingertips right now, but all I am saying is that I know we have provided that information to you before, saying that those services are continuing for at least two years; they are itemised by service provider. I can repeat and provide that information from the Mental Health Commission again,

unless the Mental Health Commission has it here today. I doubt it. I am happy to provide it to you again, but I know I have provided it to you at least once if not twice.

Hon ADELE FARINA: We have a new budget being handed down and I want to make sure that no money goes missing during the course of this budget.

Hon HELEN MORTON: They were ongoing contracts of which no funding has been reduced and no funding has been increased. They were ongoing contracts for two years until the end of June 2016.

The CHAIR: Minister, if you are happy to take it on notice and then the member can be confident —

Hon HELEN MORTON: I am happy to provide it again. We have provided it and I am very happy to provide it again.

[*Supplementary Information No D8.*]

Hon ADELE FARINA: In relation to the vacant clinical psychologist position at south west CAMHS, what alternative methods are you exploring to have that position filled?

Hon HELEN MORTON: That obviously is a service that is provided by Health through the WA Country Health Service. I know that once again this is information that has been requested and provided.

Hon ADELE FARINA: No, it has not been provided, minister.

Hon HELEN MORTON: In terms of—

Hon ADELE FARINA: Your last answer to me in terms of my parliamentary question was that you were exploring alternative methods.

Hon HELEN MORTON: It was vacant and alternative options, yes.

Hon ADELE FARINA: So today I am asking you what alternative methods you are you exploring. If you need to take that on notice —

Hon HELEN MORTON: I have to go back to Health and get that information —

The CHAIR: One at a time, please.

Hon HELEN MORTON: — and find out what are the alternative methods they are currently employing. I do not know what that is off the top of my head.

Hon ADELE FARINA: Take it on notice.

[*Supplementary Information No D9.*]

Hon PETER KATSAMBANIS: I refer page 394 of the budget paper, a series of significant issues impacting the agency. They are all significant.

Hon HELEN MORTON: That is why they are there.

Hon PETER KATSAMBANIS: Exactly, and all just as significant as each other in this area. I refer to the area under "Suicide Prevention". It talks about suicide being the leading cause of death for Australians aged between 15 and 44, which in itself is striking and is double the road toll in Western Australia. Anecdotally and from what we heard before dinner from the Department for Child Protection and Family Support, it seems that younger and younger people are tending towards self-harm, suicidal thoughts and occasionally achieving suicide when they attempt it. What has the Mental Health Commission, firstly, picked up about these events happening to younger and younger people? Secondly, what specific strategies are in place that deal with youth self-harm, youth mental health and preventing youth suicide?

Hon HELEN MORTON: Apart from some specific strategies around providing suicide prevention through schools, and the work of Youth Focus, for example, across the state, the work that has been

picked up in particular commonwealth-funded services in primary care, like headspace for example—these are all youth focussed, youth specific and child and adolescent specific services, like the acute community intervention team and the acute response team services. The fact that we have had such a reduction in the number of kids turning up at Princess Margaret Hospital in one year for self-harm gives us an indication that we are starting to make a mark in that area.

Hon PETER KATSAMBANIS: Sorry about that minister. That happens all the time in this seat when we are not standing in the chamber. Not to worry. I am still listening.

Hon HELEN MORTON: I know.

Hon PETER KATSAMBANIS: It is just that the Hansard reporters are between us and we cannot make eye contact.

Hon HELEN MORTON: I think that the increase in the number of beds at Princess Margaret Hospital for admissions; the CAPA—the choice and partnership—approach to providing services to people who have been referred means that the waiting time for people is significantly reduced so that people are not being left on their own basically. There is a significant amount of funding that is now going through to schools in educating, using the opportunity of the school environment basically to capture kids and provide suicide prevention knowledge and information there as well. I will just ask the commissioner if he has got anything else.

Mr Marney: In part, the issue you have raised goes back to the Ombudsman's findings of 2012, where the Ombudsman's office investigated 36 suicides among 13 to 17-year-olds in Western Australia. The Ombudsman's recommendations have been fully accepted by the Mental Health Commission and are being implemented by the Mental Health Commission, in part addressed by the suicide prevention strategy. The previous suicide prevention strategy actually targeted young people, with just under half a million dollars allocated to specific community action plans, and they were particularly targeting young people, including those who are Aboriginal, homeless or living in regional and remote areas; so again taking a high-risk group, if you like, targeted approach. In addition to that, in 2014–15 the Mental Health Commission has currently in place and will continue through to the end of this year, support to the Department of Health's child and adolescent mental health services of just over $1 million to support 7.2 specialist clinicians in various metropolitan and Peel community CAMHS teams, particularly focusing on those high-risk, at-risk children. We also funded Youth Focus and the Department of Education to ensure that there was school-based mental health training in place and also statewide prevention and postvention support across schools. We now have a process in place, through the various initiatives of the government suicide prevention strategy whereby if there is an incident of significant self-harm or if there is indeed an unfortunate death by suicide of a student in any of the schools across the state, that there is a notification process, and that is shared so that there can be immediate response provided to the school and its students and any other schools that may have interaction and with parents, to ensure that the impact of that suicide is minimised, if you like. The issue of suicides presenting amongst younger and younger children, I will refer that to Dr Liz Moore to answer that.

Dr Moore: I think the points that I wanted to make were that the health department finds the collaboration with headspace extremely important in community capacity building, because headspace is a collaborative process and it works with council as well as non-government agencies. That is a really important strategy for targeting wellbeing and promoting wellbeing, and also reaching out to the youth in the community. In terms of at-risk groups, I think the work of YouthReach South and its compatriot in the north is really important because it targets homeless youth; and homeless youth are more at risk of mental illness and more at risk of suicide, so those are really important target areas.

[8.30 pm]

Hon PETER KATSAMBANIS: Just on that, I do not think any of us here are clinicians.

Hon HELEN MORTON: Yes, we are.

Hon PETER KATSAMBANIS: Okay; Dr Moore is. Perhaps you might be one of the people who might be able to assist us in this. Often we provide a lot of materials to schools, teachers and parents but what we do know is that kids often confide in other kids. What sort of mechanisms and training have we put in place to allow those kids who have been confided in to feel safe and empowered to either quietly or efficiently or whatever report their concerns in an environment in which they would feel protected from their peer groups, so they are not seen as snitches, and at the same time provides for the earliest possible identification, intervention and prevention? Do we have any specific programs that tell kids the equivalent of the R U OK? campaign that is more prevalent?

Hon HELEN MORTON: There are. I will ask the Mental Health Commissioner to talk about those two programs.

Mr Marney: The Mental Health Commission makes a substantial contribution annually to beyondblue. Beyondblue has two programs that it is rolling out nationwide, including through Western Australia. One is called KidsMatter. That is for primary school aged kids. The other is called MindMatters, which is for high school age. Both of those programs are about training teachers, parents and kids and the students to be aware of signs of deteriorating mental health, to be aware of the early signals of distress and, indeed, to recognise at-risk peers—at-risk kids. It is very much aimed at equipping everyone in the school setting, including all students, with the ability to be able to identify, if you like, spot the risk and address the hazard by referring appropriately, firstly, around facilitating the conversation with the individual who is considered at risk, which is not always easy, or, if they do not feel comfortable with that, it is about ensuring that the appropriate persons are alerted who can take timely action to ensure the safety of the student involved. Those two programs are particularly important. The Mental Health Commission also has relationships with organisations like ReachOut.com, which is very much focused at youth wellbeing. It is not just mental health; it is holistic. But it has very similar resources that equip students with the ability to have an eye to and an awareness of risk factors and really equips them to look after each other.

Hon HELEN MORTON: Can I add that just recently I attended one of the suicide prevention training programs for coaches at Netball WA. Through that long weekend, they were accessing 500 people in this training program. I sat in on one of them only. In that session, once again, it was Youth Focus providing the training to coaches and other personnel associated with netball. They were providing them with training on how to deal with that very issue. One of the kids who was there at that particular day asked the question, "If they told me not to tell anyone, how can I then go ahead and tell the mother as well?" The response was pretty much along the lines, "Yes, you have been told something and have said not to tell anyone but would you rather only tell them once they are dead?" It was sort of like, "You have a choice about breaking that person's confidence and telling somebody and perhaps saving their life or maintaining that confidence and perhaps that person dying." When the kids are shown that they need to weigh up those sorts of things, I think most kids would actually recognise that breaking their confidence to save a young person's life is probably a reasonable action for them to take.

Hon PETER KATSAMBANIS: Obviously I think saving young people's lives, or any person's life, is really important and that is why I am going to ask this next question. I do not know what the answer is, that is why I am asking it; it will sound a bit Orwellian. We all know that all people really, but young people in particular, interact a lot through the internet and through social media. I know that if I google the forthcoming release of the Iron Maiden album, which I am interested in, for the next three or four weeks everything I open up on the internet will include ads for similar new albums from Judas Priest or Def Leppard, or whoever is bringing out an album. We know that is how these advertising algorithms work. Have we at all pursued the concept of utilising modern technology to perhaps passively put out the Lifeline message or the "seek help" message through

social media as people perhaps are seeking information about less good, and more bad, things, to put it that way?

Hon HELEN MORTON: The Mental Health Commissioner has something to say about this.

Hon PETER KATSAMBANIS: I am sorry for my taste in music. I think it is good taste; many people think it is bad taste. I know the commissioner is probably closer to my side of the fence on that.

The CHAIR: I am about to shut down the hearing if it gets any worse than this!

Mr Marney: That is really the space that ReachOut.com is the national expert in, in terms of not only online resources but online promotion as well. It is also the space that beyondblue is in because most of its campaigns are driven by social media. There is also substantial research going into the usage of social media and how patterns of usage vary with an individual's wellbeing. It is early, but there is certainly a lot of investigation into both the opportunities but also identifying risks in terms of those patterns of social media activity. It is certainly increasingly an area that the likes of beyondblue and ReachOut.com monitor in terms of their interactive pages. There is active monitoring in that space and there is definite targeted messaging as well to ensure that they are getting the reinforcement and using the technology to advantage in that way. Certainly ReachOut.com, which we have a close relationship with, is the nation leader in that space with youth.

Hon PETER KATSAMBANIS: Thank you. I am happy to yield now to other members. I have other questions but I am sure other members have, too.

Hon ADELE FARINA: If my recollection serves me right, the Ombudsman's report identified that a number of students who have died by suicide had had a lot of time off school, so there was a high truancy rate with those particular students. Given the cut in funding to the education budget and the fact that schools are directing less and less effort into dealing with truancy because they simply do not have the resources to do it, how has that changed the way you go about trying to deal with this problem? Obviously it is great once kids get to school but I am talking about the ones who are the target area and are not actually getting to school regularly.

Hon HELEN MORTON: I will just add that there is no cut in funding to schools, so the issue that you are referring to is probably—if kids are absent from school, how are we picking that up through the school?

Hon ADELE FARINA: In answer to the questions that have been asked, all I have heard about are programs that are being run in schools. The Ombudsman's report identified the high truancy of these students. They are not actually in school a lot of the time. How are we reaching out to the at-risk group?

Hon HELEN MORTON: The commissioner wants to make a comment.

[8.40 pm]

Mr Marney: I think the recommendations of the Ombudsman's report were even more complicated than that in that they identified that not only were a number of these students who passed away not attending school, but also they had interaction with Child Protection and Family Support, with the justice system, with corrections and so on. We are actually working with a lot of those agencies. I think it might be recommendation 22 from the Ombudsman's report that recommends that the Mental Health Commission provide leadership across those agencies to a process that identifies particularly those children who are at higher risk, who are having interaction with Child Protection and Family Support and who are having interaction with the justice system and to identify them and ensure that there is appropriate support and services provided to them at an early stage. It is a different body of work. You are right; the, if you like, population-based programs that are rolling

out in schools do not capture everyone. I think that is really what the Ombudsman's recommendations highlighted, so we have a different set of processes to address that.

Hon STEPHEN DAWSON: I refer to page 394 and the suicide prevention strategy. We know from announcements that $26 million will be spent over the four years. I think in your media statements you have previously said that half the total funding will be for targeted interventions for high-risk groups. I am keen to get a sense as to how much will be spent particularly on tackling the problem of suicides amongst the FIFO populations and also will be spent on tackling suicide amongst the Aboriginal population. Do you have those figures?

Hon HELEN MORTON: Because those implementation plans are still being finalised, the allocations have not been allocated to that level of specificity at this stage. You are looking for the amount that might go towards FIFO and the amount that might go towards Aboriginal people, and we do not have that.

Hon STEPHEN DAWSON: When do you propose or when do you think these figures might be available?

Hon HELEN MORTON: I believe that the implementation will be ready by August–September—that sort of time frame. But the whole area around the extent to which we have put funding into the specific area of FIFO is now going to be informed by the government's response to the recent FIFO report that has been tabled in Parliament. So we would just have to make sure that we dovetail in with the government's response to that.

Hon STEPHEN DAWSON: If, say, $13 million is being spent on these priority areas, do you think now, as a result of the committee's report into suicides amongst the FIFO population, that that cohort might get an extra amount or more of the pie?

Hon HELEN MORTON: I really honestly cannot say at this stage, because the government has not made a determination about the extent to which it wants to take up the recommendations that have been made around that. That is work that is being coordinated by Premier and Cabinet at the moment and it crosses Mental Health, Mines and Petroleum, Attorney General—it crosses a whole raft of areas. Some of the recommendations that are in there are things that we had already identified that we were going to be doing anyway. I guess we will just have to let that process take its course to get the government response in place before we can allocate the funding.

Hon STEPHEN DAWSON: Minister, I turn to page 400 under "Community Support". We know that there are 144 individualised community living strategies currently funded. Are you able to provide me with the figure as to how many patients are on a waiting list to access one of those individualised community living packages?

Hon HELEN MORTON: I have never seen a waitlist for this service. It is actually managed in a slightly different way when one of those positions becomes available, because there is a set number of packages in that area, and until we increase the number of packages, those packages are set. As one of those packages becomes available, we go out to find a person who would most apparently suits the requirement to come into that community living strategy.

Hon STEPHEN DAWSON: So there is no announcement or advertisement to say that this is available?

Hon HELEN MORTON: No, that is right. It is a bit like saying we are going to build, say, community options homes or places and once people are in them, when one becomes available, we then let people know one is available and we look for the most appropriate person to fill that position.

Hon STEPHEN DAWSON: What is the process you undertake? You said you look for somebody to see who is most appropriate. What agencies do you contact? How do you make the final decision; how do you get to it?

Dr Moore: The process is that once a place called for, health services will fill in an application form, because the packages are of different levels, so you are looking for a person of the level of the package. There is then a panel called and the panel makes a decision from all the applications for the most suitable person.

Hon STEPHEN DAWSON: Who is that panel made up of? Is it made up of Mental Health Commission staff; does it have outside people or NGOs?

Dr Moore: Yes, certainly from the area health services. There is a panel at the area health service level made up of clinicians and the area manager who vet the suitability of candidates. Then it goes the ICLS panel, which is made up of members of the area health service and the Mental Health Commission, who then determine who is the best person.

Hon STEPHEN DAWSON: How long does somebody get access to one of these packages? Are they one of the 144 "forever amen" until they the pass away or when they recover and do not need anymore? Is there a time frame attached to it; and how do we get a vacancy?

Dr Moore: Usually the vacancy is from somebody either moving into different accommodation obviously recovering or they are not suitable for the accommodation and have needed a further level of care. I cannot give percentages of either, but that is the way that the vacancies come up.

Hon STEPHEN DAWSON: Can I ask by way of supplementary information whether you are able to provide a list, not of the people, but of the 144 and how long somebody has been accessing one of them, if that is possible?

Hon HELEN MORTON: Sorry, you want that information for each of the 144 people?

Hon STEPHEN DAWSON: If that is possible. Obviously, I do not want names or identifying factors, but I want to get a sense of how long somebody has had one of these.

Hon HELEN MORTON: The duration of each of the packages that are currently in play?

Hon STEPHEN DAWSON: If possible.

Mr Marney: Can I seek a point of clarification? If we give you the duration of everyone that is currently in, it will not tell you what I think you want to know, which is those people who have moved out for one reason or another. I think we need to give the duration of all persons who are currently or who have been in ICLS since it commenced.

Hon STEPHEN DAWSON: That would be perfect. You are very helpful, minister, and your team are very helpful.

Hon HELEN MORTON: As I said, here to please!

[*Supplementary Information No D10.*]

Hon STEPHEN DAWSON: On page 393, "Spending changes", the first page of your budget, regarding the one per cent general government efficiency dividend, I have previously asked questions about 2014–15, but there is an amount $6.4 million next year; then there is $6.77 million and $5.538 million in 2018–19. Can you advise me what is the plan for the Mental Health Commission to find those savings?

[8.50 pm]

Hon HELEN MORTON: The Mental Health Commissioner will talk to this.

Mr Marney: The amount is the Mental Health Commission's allocation, which in total, I think, in 2014–15 is $6.4 million. Of that, $4.5 million passes through to the Department of Health as part of our purchasing. So, it then goes into that whole conversation we had earlier around pricing and how we reduce the price down towards the national efficient price over time. That $6.4 million was with respect to 2015–16. The other mental health activities—so other cost base, if you like, of the Mental Health Commission—has a saving target of just over $1 million, and alcohol and other drug is

about $800 000. Essentially, those efficiencies across the commission and the Drug and Alcohol Office are being achieved through really having a hard look at the value-for-money outcomes from some of our expenditures, particularly grant expenditures, and testing very hard the veracity of those and, where appropriate, either reducing or ceasing the lower priority grant expenditures.

Hon STEPHEN DAWSON: Minister or commissioner, are you in a position to guarantee that no further job losses will result from these efficiencies either next year or in the out years?

The CHAIR: If you have a succinct answer to that, I might move on.

Hon HELEN MORTON: Are you looking for a yes or no?

The CHAIR: Yes.

Hon HELEN MORTON: I cannot guarantee that.

Hon LIZ BEHJAT: Minister, I refer you to page 394, "Significant Issues Impacting the Agency". Moving away from suicide prevention on that page, although it has been a very interesting session in relation to that and also how there has been quite a focus on youth this evening, I am referring to perhaps the plan—the principal recommendation of the Stokes review and the plan. I am assuming that it is still at the consultation phase, and my understanding is that it will be finalised very shortly.

Hon HELEN MORTON: The consultation is completed. What is happening at the moment is the compilation and the rewrite of sections of the plan on the basis of feedback that has been received.

Hon LIZ BEHJAT: I do not think it will change the questions that I am going ask, which are contained in the draft plan. As you would expect, Mental Health estimates would not be complete without me asking questions about mental health in the CALD community, which is an area that I have a huge interest in. Seeing as tonight we have had a bit of a focus on youth—because there is so much I could canvass in this area, talking about youth—I notice on the website in relation to the Transcultural Mental Health Centre, there is an occasional electronic publication *Transcultural Dialogue*. I have not seen an edition since May 2014, so whether that is continued or perhaps OMI may have picked that up, I do not know, but it is a very good publication on that website. One of the interesting things it talks about is the need for engagement of people from CALD backgrounds, and youth in particular, into another one of my pet hates, which is violent video games. In the area there, we know where there have been issues with youth engaging in violent video games, but it is exacerbated when those youth come from a CALD background, because the parents themselves have no knowledge of the video background—again, it goes to social media and all those sorts of things.

There are a number of references made in the plan to the need for transcultural mental health services, but I am just wondering, in the time we have left, whether you might outline some of those more specific things that you could look at, especially with youth and the need for diversion programs. Very topically at the moment, I think there would be issues surrounding terrorism and youth engaging, or attempting to engage, in activities overseas, and all these coming into a mental health state of being for these people. This is something that I think is going to be really big in the future, and whether we have actually turned our minds to it.

Hon HELEN MORTON: I mean, obviously it is very interesting, the whole area. People who come from a refugee background or people who have experienced some of the traumas associated with those sorts of mechanisms by which they have arrived in Australia and the trauma they have experienced in that process are obviously more vulnerable to mental health problems than the general population. That is an area of considerable problem.

Dr Moore: There is a program called Assets, which actually targets people from a refugee background who have a history of trauma. It is a very good program for doing that. But in Health we also believe, with our culturally diverse community, that we need to actually make all our clinicians culturally competent. There is a number of programs not only in the Aboriginal space, but

also training programs particularly through south metro that are targeting cultural awareness and the cultural competency of our clinicians so that we can treat people in their own space. In terms of CALD youth: I am sorry, I am not able to comment.

Hon HELEN MORTON: One of the areas that has also been picked up in this area is around the Links program, which is the court diversion program. As you know, the mental health court service has both a mental health adult court and a children's court as well, and so the children who are being found to have been picked up by the juvenile justice system et cetera can go through that court and actually be provided with services. We do find that a number of young people from the CALD background, for reasons that are not hard to imagine, have found themselves in that program as well. So they are children who are now getting appropriate services through a clinical approach and a health approach, rather than going through a justice approach to dealing with some of the issues they are facing.

Mr Marney: As you may be aware, there was an extension of funding for the START court and Links court that the minister just mentioned on the basis of the performance of those courts in diverting and assessing and treating individuals through the period of their experience with the justice system. Between 18 March 2013 and 28 February 2015 the START court listed 623 individuals to appear, and carried out 373 clinical assessments. So you can see that it is quite a significant throughput through that system. In the child and adolescent version of that, the Links court received 451 referrals and performed 369 clinical assessments, so about the same number of assessments in that period as well. The preliminary evaluation contained very positive findings about both the adult program and the children's program, but there still needs to be ongoing evaluation. Obviously, the impact of this process takes some time to reveal itself because we are talking about, particularly in the case of children, their developmental trajectory, and really we are trying to change that trajectory so measuring that is going to take some time. As a result, further funding of $4.7 million in 2015-16 will extend those programs by a further 12 months to enable that data collection to be carried out. But if you ever get the opportunity to visit one of those courts, you will witness for yourself that it makes a profound difference to the individuals who are entering the justice system in a distressed state.

[9.00 pm]

Hon LIZ BEHJAT: There is a lot more we could talk about in this area. I am keen to discuss further with the minister about CALD youth and certainly some engagement in activities other than going overseas and fighting.

The CHAIR: I will finish on one issue that was raised earlier—that is, whether there is a pattern of more young people committing suicide or not and the incidence. The minister talked about lower presentations at Princess Margaret, for self-harm I would imagine. I am happy to take on notice the statistics on the long-term historical measure on population size whether we are seeing an increase or a decrease and what is the trend, particularly for young people. I understand there is a difference between self-harm and suicide.

Hon HELEN MORTON: We can certainly provide information on self-harm.

The CHAIR: I am more interested in actual suicides.

Hon HELEN MORTON: The only information we get is what the coroner provides. That is broken down by people over the age of 25 and under 25, so that information does not necessarily capture very young people.

The CHAIR: I am interested in whatever you can provide, because a lot of assumptions are made about whether it is going up or down and linkages to self-harm and the reduction in self-harm. I will make that D11.

Hon HELEN MORTON: The commissioner might be able to answer that for you.

Mr Marney: There is discussion around whether the prevalence of suicide is increasing. We cannot answer that at the moment. Anecdotally, it would appear to be the case, but we also do not know whether that is because of a change of reporting of that.

The CHAIR: And demographics too, because there is a lot more people in this age category than ever before and it may not be the case on a per hundred thousand basis; it may not have increased.

Mr Marney: Going back to a previous question, the same applies to suicides among FIFO workers. We cannot validate the number of FIFO workers who have taken their own lives. As part of the new suicide prevention strategy, one of the six areas of action is to establish a comprehensive database that will be owned by the coroner but that would enable us to go back and reconstruct the database to answer these questions, both in terms of individual's occupation, age cohorts and so on; and, also, going forward, to have the timely information to be able to respond where there is a change in those patterns. At the moment we really rely on ABS data with a two- year lag. We need to be dealing with data with a two-day lag.

The CHAIR: In other words, there is no point putting it on notice. I understand what you are saying.

Mr Marney: We just do not have the data.

The CHAIR: We will delete D11, but I appreciate your answer. With that I finish the hearing.

The committee will forward any additional questions it has to you in writing in the next couple of days through the minister, together with the transcript of evidence, which includes questions you have taken on notice. 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 hearing. On behalf of the committee, I thank you for your attendance today.

Hearing concluded at 9.03 pm