STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2015–16 ANNUAL REPORT HEARINGS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
THURSDAY, 3 NOVEMBER 2016

SESSION TWO
MENTAL HEALTH COMMISSION

Members

Hon Rick Mazza (Chair)
Hon Peter Katsambanis (Deputy Chair)
Hon Alanna Clohesy
Hon Helen Morton
Hon Sally Talbot

Hearing commenced at 10.45 am

Hon NICK GOIRAN
Parliamentary Secretary to the Minister for Mental Health, examined:

Mr TIMOTHY MARNEY
Mental Health Commissioner, examined:

Mr DAVID AXWORTHY
Acting Assistant Commissioner, Planning, Policy and Strategy, examined:

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

Ms MARIE FALCONER
Chief Finance Officer, examined:

The CHAIR: On behalf of the Legislative Council Standing Committee on Estimates and Financial Operations, I 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: 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. It is also being broadcast live on the Parliament's website. The hearing is being held in public although there is discretion available to the committee to hear evidence in private. 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. Agencies and departments have an important role and duty in assisting the Parliament to review agency outcomes, and the committee values your assistance with this.

Hon STEPHEN DAWSON: I will start at page 28 and the Mental Health Act 2014; I will just ask a couple of questions in relation to that. Parliamentary Secretary or Commissioner, I could not find it; do we list somewhere in the annual report the numbers of people who have been detained under the new Mental Health Act involuntarily since it has come into practice?

Mr Marney: Sorry, no, we do not.

Hon STEPHEN DAWSON: I am glad; I could not find it.

Mr Marney: That is more an operational matter for health services themselves and probably a question that is better directed to the Chief Psychiatrist, who oversees from a broad governance, safety and quality perspective.

Hon STEPHEN DAWSON: So if I asked you to provide by way of supplementary information to the committee the numbers of people who have been detained under the act in this financial year and since, is that something you could provide?

Mr Marney: Maybe if we could slightly amend the wording to "committed to involuntary treatment under the act", rather than "detained". I am more than happy to take that as a supplementary.

Hon STEPHEN DAWSON: I am happy to change that.

[*Supplementary Information B1.*]

Hon STEPHEN DAWSON: I heard yesterday that Port Hedland Hospital in particular has been keeping a number of involuntary patients in the Hedland ED for long periods of time over the past few months. Are you aware of that? Is that something that would come to your attention?

Mr Marney: Not specifically with respect to Port Hedland. We do get a daily bed report on the number of individuals awaiting either voluntary admission or involuntary admission. We have not seen a blip in Port Hedland as such. There has been a little bit of a blip with respective occupancy at Broome, and that may be impacting on Port Hedland. Occupancy at Broome Hospital inpatient unit is running extremely high—running sort of 98 per cent to 100 per cent consistently for a number of months. There are a couple of patients in Broome who have been there for quite some time and there is difficulty finding the appropriate step down for them for release. That is causing some difficulties in flow, which no doubt is impacting on Port Hedland.

Hon STEPHEN DAWSON: Could you, if you do not mind, undertake to investigate Port Hedland in particular?

Mr Marney: Sure.

Hon STEPHEN DAWSON: As I said, it came to my attention yesterday. I received information that people have been kept there in the ED for long periods of time, as in days, and weeks in one case, so could you clarify that and provide information back to committee by way of supplementary?

Mr Marney: I am happy to take that as supplementary.

[*Supplementary Information B2.*]

Hon STEPHEN DAWSON: If I can move to page 20 and the Western Australian mental health, alcohol and other drugs services plan. Parliamentary Secretary or Commissioner, can I ask whether the commission can provide a status report to the committee on which elements of the plan have been state funded and at what cost?

Mr Marney: If I can again suggest an amendment to the question, it would be "What elements of the plan are currently being implemented?" because they are not all subject to additional funding. There are a range of elements of the plan that are being implemented currently, some of which are being done through existing resources. Police co-response, for example, is existing resources of the commission and the WA police service. The new eating disorder outreach service is within existing funding. Step up, step down in Broome, Bunbury and Karratha are funded. The new youth community assessment team at south metro health service is from within our existing purchasing. The methamphetamine strategy, again, is a funded element but also draws together existing services that we already provide.

[10.50 am]

Hon STEPHEN DAWSON: I am happy with your suggested amendment. Can you provide to the committee, by way of supplementary, the status report on the elements that are—what was the word you used?

Mr Marney: Currently being implemented.

Hon STEPHEN DAWSON: Currently being implemented—and if you can identify what is being done out of existing resources, whether there has been new funding attached and, for each of the elements that are currently being implemented, what the cost attached to it is?

[*Supplementary Information No B3.*]

Hon STEPHEN DAWSON: I turn to page 21; that is the methamphetamine-related harm or the meth strategy paragraph. I understand an announcement was made this week in relation to where those new beds will be placed. How was the decision made where they will be located?

Hon NICK GOIRAN: It is right; there was an announcement this week. In terms of the way in which the decision was made, I will refer that to the commissioner.

Mr Marney: In part, it was based on our original tender which expressed a desire for a distribution of both metropolitan and regional beds. The decision around where the beds were located was driven in part by that guidance that we provided up-front in the tender process, but also in part determined by where the bed capacity was available. We tried to match where we knew the high demand was, based on our modelling under the 10-year plan, against what would be available and could be up and running in a very short time frame to respond to community need. As a result, there are 24 beds across the metropolitan area and, not surprisingly, there is already a concentration of beds across the metropolitan area. The greater emphasis then was on 28 residential rehabilitation beds across regional areas, particularly the south west which has an absence of beds and has been identified in the 10-year plan as a short-term priority, and also in the midwest, which has a small footprint of a residential withdrawal service at the moment, but adding to that a residential rehabilitation service that provides a continuum in that location from withdrawal through to residential rehab, and then also in the goldfields. There are other areas across the state regionally where there is already a footprint of residential rehab beds, so we did not look to supplement where there is already demand being met there. It was really to try to fill the major gaps and do so in a way that could get those services up and running in a reasonably short time frame.

Hon STEPHEN DAWSON: Was any direction given either by a minister or by the Premier's department as to where some of these beds should be located?

Mr Marney: Absolutely not.

Hon STEPHEN DAWSON: That is okay; I will leave that.

Mr Marney: And you know I would not accept that direction anyway because we have to go through a pure and clean tender process, as always.

Hon STEPHEN DAWSON: It will be in next year's annual report; I did not want to have to wait until then to see it.

Commissioner, you would be aware that another parliamentary committee of the Legislative Council has looked into the issue of the need for beds in Esperance. Why do we not see any new beds in Esperance? I know the community down there are crying out for it and certainly all the correspondence I have received, the minister and the parliamentary committee have received—it is on the net, so I am not sharing any parliamentary committee information—why has Esperance not been given a bed?

Mr Marney: There are some beds in Esperance through service provider Teen Challenge. We did not, from memory, receive any bids. We did not receive any bids for beds from Esperance, so there was no provider basically willing to provide residential rehab in that area. Having said that, I should make two points: firstly, in speaking with individuals in residential rehab facilities across the state, often a lot of them will tell us that they actually prefer to go out of their region to enter residential rehab to, in some respects, break some of their social connections to drug use and harmful alcohol use. That is something we also took into consideration; that a lot of people liked to go to different regions and, for Aboriginal people, while for the most part we adopt a philosophy that keeping people on country is a good thing, for some to go to a residential rehab facility on country means everyone knows. It also means sometimes that they are being treated by other Aboriginal people—which is appropriate—but it may not be that they are from a skin group or family group that they necessarily do not get along with. To treat people in their own region has always been our default, but certainly I have learned in the last nine months that we need to be a lot more flexible around that.

Hon STEPHEN DAWSON: I agree with the flexibility. For some people, I think the opposite is true too.

Mr Marney: Absolutely.

Hon STEPHEN DAWSON: Being able to be treated close to home and to have a support network potentially around you who can visit you helps on their recovery journey.

Mr Marney: Absolutely.

Hon STEPHEN DAWSON: You can either answer this now or by way of supplementary: the initiatives that have been announced under the meth strategy so far, can you give us a list of those and the funding attached to each one of those?

Mr Marney: Yes. I believe they were detailed in the budget papers. They are not in the annual report because those announcements have been in the current financial year. I am more than happy to provide a full listing of what has been announced and the funding attached to it.

Hon STEPHEN DAWSON: To date?

Mr Marney: Yes.

[*Supplementary Information No B4.*]

Hon STEPHEN DAWSON: I will go next to the "Key Effectiveness Indicator" on page 106. I particularly want to ask about the readmission to acute mental health inpatient facilities within 28 days of discharge. As the document says, this result is higher than the year before and is above the nationally set target of less than or equal to 12 per cent. We are 5.6 per cent higher than the national target. Why is it the case that our readmission rates are so high and what is the agency doing to ensure that that figure decreases?

[11.00 am]

Mr Marney: Yes, there are a couple of reasons. Part of it relates to changes in model of care, which we are still kind of digesting and seeing how that impacts on the readmission rate—in particular, the addition to the system of mental health observation areas, which are very short term stay and assessment, which seek to stabilise people and get them back to community and avoid an admission. While they try to avoid an admission, sometimes that is nevertheless necessary post that discharge from the observation area. The observation area in itself is an admission, so therefore if someone goes into the observation area, is discharged from there and then has to return a day or a week later, that is classified as a readmission. Similarly, hospital in the home—if someone is discharged from an inpatient facility to hospital in the home, then that is classified as a readmission when, in actual fact, it is just a change in the admission. We have a few data classification issues to work through around that. That process is currently being worked through through the new Independent Hospital Pricing Authority classification process, which we are heavily involved in at the moment. But, essentially, the models of service have evolved ahead of the classification and data collection systems, so we are getting some quirks in, particularly, the readmission rate, but also, similarly, in the seven-day follow-up post discharge. Again, a lot of the follow-ups are occurring but are not classified under the current system. We meet with the health service providers on a quarterly basis and interrogate those KPIs and have uncovered a lot of those underlying data issues, which we are working through, both with Health through the central data systems in Royal Street, with the health service providers, and also at a national level through the new classification system.

Hon STEPHEN DAWSON: Given this problem was identified in the annual report from June, are we going to see proper figures in next year's annual report for the whole year, or are we going to have a similar issue of a kind of amalgam of older, kind of rubbery figures and then the new figures from the new process?

Mr Marney: I have to say the figures are not "rubbery"; they are just not quite reflective of the models of service. What we will see is that we will try to improve the accuracy in terms of the

intent of what they are trying to measure, and where possible we will back-cast those so that you can compare them, because I hate giving you figures that are non-comparable; it is meaningless.

Hon STEPHEN DAWSON: So when will this process be finalised? When will your negotiations or your conversations with the Independent Hospital Pricing Authority take place so the problem can be fixed?

Mr Marney: The Independent Hospital Pricing Authority is looking to implement at least a trialled application of the new framework from 2017–18. We think, given some of the complexities in that, that that at this point is optimistic, but we continue to work with them as hard as we can to try to iron out some of these idiosyncrasies. But it is not just them; we have to improve our data collection and consistency of data collection across the system because those two metrics are absolutely critically important. I will ask Michael Moltoni to add to that.

Mr Moltoni: Thank you. The other thing to consider with this indicator is that it works on a lag because of the linkage process, so the actual cases themselves have to be coded as well, so the data in the annual report is kind of six months behind, so it uses the calendar year process. There has been a lot of work in WA to actually improve the linkage process. We have one of the best linkage systems in Australia, and that in some ways disadvantages WA because we are really good at picking up whether it is a readmission or not. There are a few things like that which, at a national level, are being looked at and addressed, which we are working through, but it is a combination of that and working with the service providers to make sure that any of these technical elements that sit underneath it do not falsely represent a higher readmission rate. We are regularly working back with the health services to try to pick out those different elements and try to address each issue as they come up.

Mr Marney: We do monitor those stats on a quarterly basis and if there is any change, given that the methodology is not changing—the flaws are the flaws and they are constant, but if there is any change in those metrics, I can assure you we interrogate services to understand what is going on because we are absolutely committed to achieving the best outcome for consumers possible.

The CHAIR: Hon Helen Morton.

Mr Marney: I will pass, thanks!

Hon HELEN MORTON: You will not when you hear this one!

Hon STEPHEN DAWSON: It is not a dorothy, is it?

Hon HELEN MORTON: It is not a dorothy at all!

We had the Insurance Commission of WA in here yesterday and we were asking them about their claims—how they varied by different types. Their highest cost claims are mental stress claims, and they gave us the reason for that as mostly being due to the length of time it takes for people to be off work and for that claim then to be made. I suspect it is also because, in the first instance, people are not taking seriously the problems associated with work stress. I am just wondering what the Mental Health Commission is doing about that. I suggested to Rod Whithear that he make contact with you and perhaps work together on it, but it is a significant issue in terms of the claims structure for the Insurance Commission of WA.

Mr Marney: Thank you. It is a significant issue as an employer because you do not want people going through that stressful process; it is not good for anyone. It is not good for the individual, it is not good for the employer either, and I can assure you it is not good for the employee's mental health. The processes, I think, tend to be protracted for a number of reasons partly because, as you would know, the clinical treatment for mental ill-health is not straightforward and often it takes a long time to establish whether or not someone has a prospect of recovering to a functional level of returning to work, so that length of time taken therefore increases the cost of any claim. The Mental Health Commission, through its suicide prevention activity, has actually developed a

set of mentally healthy workplace standards, which we are currently in conversation about with WorkCover and RiskCover; we will extend those conversations to ICWA as well, but we are also in conversations with industry—the Chamber of Commerce and the Chamber of Minerals and Energy and so on—so that we can have some sort of framework for employers to ensure that, firstly, they understand whether or not their workplace is mentally healthy, and then, secondly, what they can do to improve it. Most workplaces have basic mechanisms in place in terms of employee assistance programs, but they tend to be called upon when it is too late and when individuals' health has deteriorated to the extent that they are already heading down that path of time off work due to stress and then, following that, claims. I would say it is not only the biggest cost in terms of insurance commission claims and RiskCover claims, but also one of the biggest costs in terms of loss of productivity in organisations, and productivity not only from the individual, but also dealing with, sometimes, the management issues and grievances that arise as a result of someone's deteriorating mental health. It is a very significant issue that the commission is seeking to address through establishing standards and, if you like, a ranking system for mentally healthy workplaces.

Hon NICK GOIRAN: I might just add for the member that one of the other issues that arises is that it is lot easier for an insurance company to be able to dispute a stress-related claim than it is for a physical injury. If a person has a fracture in their back, it is much more difficult for them to find a specialist who is going to have a contrary view, but for the worker who claims a stress-related injury, it is often fairly straightforward for an employer or an insurer to be able to find a psychologist or psychiatrist who will say, "No, this is not a stress-related injury. It's not related to work; it may be related to some other thing that's happened in their past." That is part of the reason why these claims end up taking so long and becoming very costly.

[11.10 am]

The CHAIR: Just on that topic, one of the agencies that we had in yesterday—I cannot recall exactly which one it was—had an item in their report where their lost hours and lost days through sickness and accident had more than doubled. When I asked the question about what that related to, they said that it was mainly stress leave. Does the commission find that it is getting more and more activity from departments as far as stress leave is concerned?

Mr Marney: We have had a particularly challenging year—a year of substantial change in the organisation, with the merger of the Drug and Alcohol Office. That has brought change in people's roles, change in who they report to and change in accountability. In many respects the Drug and Alcohol Office was a little bit removed from central government and the normal governance and accountability structures, by virtue of having its own board sitting over it and so on. Bringing people together to work with different people in a different place under different accountability arrangements has resulted in, certainly, a noticeable increase in the level of anxiety within the organisation and, indeed in a number of cases, some elevated stress and absence due to stress. That is really unfortunate. We are doing everything we can to try to assist those individuals and manage those issues. I think our case has been peculiar though because we have had so many changes underway at once. I would have to refer you to RiskCover in terms of if there are any trends across the public sector in terms of those claims, because they are the ones that would have that information.

The CHAIR: Thanks for that.

Hon SALLY TALBOT: Parliamentary secretary, I will start with page 26, which is about the mental health beds in hospitals; hospital-based services. I wondered whether you could talk about the number of bed closures that are currently in existence, particularly at Bentley, Rockingham, PMH and Selby Lodge.

Hon NICK GOIRAN: Yes. You wanted to know the number of them?

Hon SALLY TALBOT: Yes, please.

Hon NICK GOIRAN: You said Bentley: what was the other one?

Hon SALLY TALBOT: Bentley, Rockingham, PMH and Selby Lodge.

Hon NICK GOIRAN: I will ask the commissioner, who has that information.

Mr Marney: I will go off the top of my head, but Michael Moltoni will correct me if I am wrong. We currently have four older adult beds closed in Rockingham due to a lack of demand for those beds at the moment.

Hon SALLY TALBOT: Older adult, did you say?

Mr Marney: Older adult, yes, in the inpatient unit. We have eight child and adolescent beds closed at Princess Margaret Hospital at the moment, which is due to clinical reasons. Those clinical reasons are related to having adequate staff to run an independent mental health ward.

Hon SALLY TALBOT: Is it the whole ward that is closed?

Mr Marney: The whole ward is closed. Treatment for the individuals who normally would have been on that ward is being provided in a general ward setting. They are still receiving treatment but it is an in-reach service into a general ward setting with general nursing, as opposed to specialist mental health nursing. That is the main difference. We are working with child and adolescent mental health services at the moment to, frankly, validate that and ensure that those young people who do need treatment are getting the treatment that they need. We are assured at this point that that is the case. It is just being met through them being located on a general ward, as opposed to a specific mental health ward.

Hon SALLY TALBOT: Is that due to an unavailability of specialist staff? Are those children still receiving the specialist care on the general wards?

Mr Marney: Yes, because the staffing levels required to provide that care on a general ward, where there is other staffing as well, is quite different to running an eight-bed ward, which is not really, quite frankly, an efficient number of beds to run. An eight-bed ward requires —

Hon SALLY TALBOT: So what is wrong? Is there something wrong with the model?

Mr Marney: No, it is really just that the ward is too small. It requires a lot more staff for a small number of beds.

Hon SALLY TALBOT: In your view what would be the optimum efficient size of a specialist mental health ward?

Mr Marney: That is really a clinical question, but just off the top of my head the anecdotal evidence is around sort of 16 to 20 beds.

Hon SALLY TALBOT: Right; which is more than double the size of the existing facility?

Mr Marney: Yes.

Hon SALLY TALBOT: Bentley?

Mr Marney: At Bentley we have four beds closed due to refurbishment, from memory, and a further four beds currently closed short term for clinical reasons. That relates to a patient cohort issue.

Hon SALLY TALBOT: Is this to do with 16 and 17-year-olds?

Mr Marney: No.

Hon SALLY TALBOT: Do you want to tell us what it is about?

Mr Marney: It is in the adult ward. There is one individual there at the moment who is particularly unwell. That manifests in behaviours which make it very difficult to have other people on the ward with him. We are currently working through a process to find a more suitable location, but until we do that it is not safe for anyone else to be on that ward.

Hon SALLY TALBOT: So you had to close four other beds?

Mr Marney: Three other beds.

Hon SALLY TALBOT: Three other beds to cope with this person.

Mr Marney: Unfortunately, that is not unusual. It is usually only for a week or two weeks, but in the interests of patient safety it is actually better to close —

Hon SALLY TALBOT: How long has that situation been going on at Bentley?

Mr Marney: As far as I am aware, it has been a couple of weeks.

Hon SALLY TALBOT: So that is considerably longer than is normal. You are saying it is not an uncommon occurrence?

Mr Marney: No, that is not out of the bounds of a normal stay. The average length of stay is 14 or 15 days, so that is not unusual in that context. We are just trying to find a more suitable treatment option for that individual. It has only been a couple of days, I am informed.

Hon SALLY TALBOT: A couple of days at the moment?

Mr Marney: Yes. That bed report that I gave you just then is based on this morning's bed report. I think we have one more bed closed at Selby, which is the older adult facility. That, again, is due to clinical reasons.

Hon SALLY TALBOT: So is that a patient who needs rehoming?

Mr Marney: Or a patient who, for whatever reason, requires some space around them.

Hon SALLY TALBOT: Okay. Let us, first of all, just talk about the situation at Bentley. So there clearly are not the facilities that are required to deal with a patient like that at Bentley?

Mr Marney: There are not really the facilities required for that extreme of behaviour anywhere.

Hon SALLY TALBOT: Anywhere in the state?

Mr Marney: It is rare. The only clinically safe way of dealing with that is a broader isolation for that individual, until they stabilise to the point that they are able to then be incorporated with other patients.

Hon SALLY TALBOT: Obviously, we all know what the facilities are at Graylands, albeit somewhat outdated. There is nowhere at Graylands that you could take this person?

Mr Marney: That is what we are looking at at the moment, but again it has to be an environment where the risk of harm to others is eliminated, basically, in this case.

Hon SALLY TALBOT: Okay. I wanted to talk about the 16 and 17-year-olds, which is why I thought that you might be segueing into that. What is the plan for the 16 and 17-year-olds? Does Bentley have 12 beds currently? Okay. It is supposed to take patients under 18: is it taking patients up to that age now?

Mr Marney: My understanding is that Bentley adolescent unit is taking 16 and 17-year-olds at the moment. As it is currently under the child and adolescent mental health service, they currently still take 16 and 17-year-olds.

Hon SALLY TALBOT: What I am testing is some advice that they are not, in fact, taking 17-year-olds.

Mr Marney: I would have to check that.

Hon SALLY TALBOT: Could you take that on notice and let us know?

Mr Marney: Yes.

[*Supplementary Information No B5.*]

Mr Marney: I understand that was their position as at September—that that was their intention—but I believe we have pushed that back until such time as there is an adequate resolution as to where those 17-year-olds will go through the system.

Hon SALLY TALBOT: Okay. Was the plan to put the 17-year-olds at Fiona Stanley?

Mr Marney: The plans as to where to treat 16 and 17-year-olds are currently being finalised. Part of the solution is the increased capacity at Fiona Stanley, with the addition of a further six youth treatment beds, bringing the total number to 14.

Hon SALLY TALBOT: So youth treatment would be the 17-year-olds?

Mr Marney: That would include 16, 17 and up to 24.

[11.20 am]

Hon SALLY TALBOT: So, the Perth Children's Hospital: how many beds is that going to have?

Mr Marney: The Perth Children's provides for a total in the infrastructure of 20 beds. How many of those beds are open depends on our activity purchasing and how we distribute that activity across the 16 and 17-year-olds that have to go elsewhere in the system and also the 15 and below back through Perth Children's Hospital. That is the work that is happening at the moment and will be finalised ahead of the opening of Perth Children's Hospital.

Hon SALLY TALBOT: Do you know when that is going to be?

Mr Marney: The opening?

Hon SALLY TALBOT: Yes.

Mr Marney: Nice try.

Hon SALLY TALBOT: At the new Children's Hospital, what is the age limit on those adolescent mental health beds?

Mr Marney: At this point—and this is what we are planning through at the moment—the desired age limit is below 16 years of age.

Hon SALLY TALBOT: Below 16. So that still does not solve the 16, and 17-year-old —

Mr Marney: No. That is what we are working through at the moment. What is intended at this point is that child and adolescent mental health services will continue in a community setting to treat 16 and 17-year-olds where appropriate—bearing in mind that child and adolescent mental health services are quite different to adult services in that about 25 per cent of their expenditure and activity is in-patient; 75 per cent is non-admitted. Obviously, with child and adolescents, you want to try and keep them out of hospital and with family where appropriate and with their natural supports. So, that activity arrangement and treatment arrangement is not changing. It is just that switch in the inpatient activity, which is very much a small part of that 16 and 17-year-old activity; it is only 25 per cent. And the 10-year plan is very clear in terms of the intention to, as much as possible, avoid, where appropriate, inpatient stays, particularly for young people.

Hon SALLY TALBOT: I do accept that, but having said that, the figure for this reporting year, 2015–16, I understand, is 182 children who were treated in an adult facility.

Mr Marney: Yes, which is not ideal, but it is not inconsistent with the Mental Health Act. We, again, monitor that very closely, but we rely on the clinicians to assess the best environment for the individuals, and sometimes an admission to an adult setting is not inappropriate from a number of perspectives. It may be that some 16 and 17-year-olds these days are very much adults in their —

Hon SALLY TALBOT: It does not seem to me to be too controversial to suggest that it is often the only option —

Mr Marney: In some cases.

Hon SALLY TALBOT: — and that there would not be many cases where a child was admitted to an adult facility because it was felt that the adult facility was better.

Mr Marney: It comes down to what clinicians determine is clinically appropriate as well.

Hon SALLY TALBOT: Yes. Do you have any data about the ages of those 182 children or can you take that on notice?

Mr Marney: We could take it on notice. I cannot guarantee that we have got it.

Hon SALLY TALBOT: If you can do it by age and by region, and I am not asking for identifying information, but —

Mr Marney: By region might be difficult, but we can certainly have a go.

[*Supplementary Information No B6.*]

Mr Marney: If we cannot do it in a resource-effective way, we might seek your indulgence.

Hon SALLY TALBOT: Yes, I understand that. Would it be fair to summarise by saying that there is still an unresolved issue with the 17-year-olds?

Mr Marney: Yes. That is fair to say. The intention is to, hopefully, resolve that issue with a meeting that I have with the director general of Health and the health service providers tomorrow, which, hopefully, is a culmination of the project work to plan for that transition.

Hon SALLY TALBOT: Okay. That is good timing for our next three weeks of question time.

Mr Marney: Excellent.

Hon STEPHEN DAWSON: Chair, just before you move on, can I just ask in relation to those four older adult beds at Rockingham, how long have they been vacant and is there any plan to repurpose them and use them for something else?

Mr Marney: I will see if we can figure out how long they have been vacant for. We will be relying on the power of Grayskull for that one. We have been in discussions with south metro mental health. I actually visited that facility a couple of weeks ago. South metro clearly is looking at a reconfiguration of its services across its various facilities post the commissioning of Fiona Stanley Hospital. Looking at what it does in Fremantle, what it has now got at Fiona Stanley Hospital and how that links back to Rockingham. In that context, also, given the commission is purchasing now a youth service, which was not factored into the build however long ago, and we are also now commissioning a youth community assessment team service, south metro is looking at: how does it reconfigure to provide a specific youth stream in a holistic way? In that context, Rockingham is being looked at in terms of, well, if we do not need those older adult beds, is there a youth conversion option for that facility? As I am sure you are aware, it is a very new facility, and contemporary design lends itself to easy reconfigurations. We are in discussions with south metro. That is the sort of thing we will discuss with them over the next six months or so ahead of then establishing our purchasing for 2017–18. But, again, we will go back to the numbers and see what the demand is, what the demographic of the Rockingham area requires specifically so that we optimise the delivery of service as close to people’s homes as possible and in the appropriate form. Those beds have been closed since 14 December last year.

Hon ALANNA CLOHESY: The subacute facilities in Karratha and Bunbury—in the financials there is a note there particularly about carrying over—so, in the notes on page 80 referring to the non-current assets on page 88, there is a note about plant and equipment deferred because of the delay in the subacute facilities in Bunbury and Karratha. How much of that has been carried over, the Bunbury and Karratha money?

Mr Marney: We had originally planned to spend the full $9.9 million. All of that has been carried over.

Hon ALANNA CLOHESY: All of it.

Mr Marney: Yes.

Hon ALANNA CLOHESY: Okay. What are the plans for those now? Are we expecting to expend that within this financial year?

Mr Marney: Yes, we are. So, we were hoping to get the okay to start that expenditure in 2015–16 through some additional process required for royalties for regions in terms of due diligence. That resulted in some additional approval requirements. We now have those approvals. so we are full steam ahead on both those developments. I think the minister and the parliamentary secretary were in Karratha yesterday announcing the location, and an announcement with respect to Bunbury is likely in the very near future. That will enable us to go into full-blown community consultation and commence design works and also to procure a partner to operate the facilities, which we want to do sooner rather than later so that they can influence also the engagement with the community and the design of the facilities to ensure that they are as effective as possible for the model of service that is going to be run.

Hon ALANNA CLOHESY: The consultation plan phases for each, how long do you expect those to be?

Mr Marney: Consultation for both will commence probably in December and run through January. We will have to suspend that during caretaker period and recommence that in April post-election. I would say we would be done by the end of April. At the same time, we will commence preliminary design. We hope to have those facilities up and running in 2018.

[11.30 am]

Hon ALANNA CLOHESY: Out of the $4 million that was allocated for Karratha for 2016–17, how much of that has been expended already?

Mr Marney: None of it.

Hon ALANNA CLOHESY: And similarly with the $4.8 million for Bunbury?

Mr Marney: Correct.

Hon ALANNA CLOHESY: Just going back to that note also, it has been offset by the deferral of the sale of Field Street, Mt Lawley. Can you tell me what is happening with that?

Mr Marney: There is a lot of technical stuff that has to be done, given the ownership of that property was under a piece of legislation that has now changed. That property's ownership had to be transferred across. Basically, we have done all of that title transfer stuff. The property is currently listed in the government's property clearing house for expressions of interest by any other agencies that may be interested in utilising the property. I understand that process is nearing a close at the moment. I believe a couple of organisations did express an interest in utilising that property. I am not sure of the time frames for that process. Should one of those organisations be given the okay to use the property, then it will be transferred very quickly. Should no suitable use by government be identified, then I would expect it would go through the usual land disposal process through LandCorp. But that probably would not occur until, I would say, the middle of next year.

Hon ALANNA CLOHESY: How imminent did you say the decision about the possible use by another agency was?

Mr Marney: I would expect within the next month.

Hon STEPHEN DAWSON: Chair, can I ask in relation to Karratha, I understand that for the venue that has been announced, there is a plan for the facility next door to have a liquor licence, so there will be a licensed premises next door to the facility. Does the commission have any views on the suitability of that? Would the commission go as far as taking a step to appeal against the liquor licence?

Mr Marney: We will have a look at the specifics of the application when it comes through, and also the proximity of the location. If it was directly next door, I would be concerned. If it was a block or a few blocks away, then I would not be concerned, because the intention of the step-up, step-down facilities is that they are actually a normal part of the community; and, like it or not, normally there is a liquor store within a few blocks of where everyone lives. We actually want people to be able to live in that environment in a safe and sustainable way rather than shelter them.

Hon NICK GOIRAN: It might assist the member to recall that I think since 2013, there has been a facility in Joondalup. I do not profess to be an expert on the geography of Joondalup, but I imagine that it is for most residents not too difficult to access a place that has a liquor licence. So in many respects this one would not be any different.

Hon STEPHEN DAWSON: Sure. I was not making any judgement on it. I was just wondering does the commission think about these things.

Mr Marney: It is a balance between having it at the back fence, versus having it approximate and just part of the normal community.

Hon STEPHEN DAWSON: So if it was at the back fence, or opposite, you would seriously consider lodging an appeal?

Mr Marney: Yes; we would certainly look at it.

Hon STEPHEN DAWSON: Can I ask, just briefly, there is a parcel of land on the corner of Keirnan Street and Watkins Road in Mundijong. Can you by way of supplementary check whether that actually belongs to the Mental Health Commission?

Mr Marney: I do not believe it does. I do not believe it is on our asset register.

Hon STEPHEN DAWSON: If you could take it on notice—if it is yours, can you let us know that it is yours?

Mr Marney: If it is ours, there will be a for sale sign on it by Sunday!

[*Supplementary Information No B7.*]

Hon STEPHEN DAWSON: The neighbours might not like it! I turn to page 144 under "Community Bed Based Services". I want to ask a question in relation to rehab beds and funding from the state government to a range of organisations in 2015–16. Can you provide, either here or by way of supplementary, the total number of beds funded for Cyrenian House, Hope Community, Palmerston and Fresh Start, and the value of funding allocated to those agencies too, please?

Mr Marney: I will certainly have to take the value of those beds on notice.

[*Supplementary Information No B8.*]

Hon NICK GOIRAN: Just in terms of the number, do you have the number?

Mr Marney: I can run through Cyrenian. Cyrenian House Rick Hammersley Centre is 40; Cyrenian House Saranna, which is also in Gnangara, is 14; and Rockingham is 28. I think that is all of theirs. Sorry. The other was Palmerston?

Hon STEPHEN DAWSON: Yes.

Mr Marney: Palmerston Farm is 32 and Fresh Start is 30.

Hon STEPHEN DAWSON: And Hope Community?

Mr Marney: Hope Rosanna House is 12. There is also Hope Springs, which is coming on board with 18.

Hon STEPHEN DAWSON: Great. Thank you for those. Can you by way of supplementary provide the value of funding?

Mr Marney: Yes. We will do that.

Hon STEPHEN DAWSON: I am also interested to know how many bed days are anticipated to be delivered in this financial year by each of those four agencies. If you have to provide that by way of supplementary as well, I am happy with that.

Mr Marney: Yes. Unfortunately I cannot provide that because it does not relate to 2015–16.

Hon STEPHEN DAWSON: You are joking! We can go the easy way or the hard way, Commissioner!

Mr Marney: Do you want actual bed days?

Hon STEPHEN DAWSON: Yes.

[*Supplementary Information No B9.*]

Hon STEPHEN DAWSON: The next question relates to concerns that have been raised with me about Grow. Grow is obviously a service provider that is funded by the Mental Health Commission at the moment. Can you advise the committee how much is the annual funding that Grow gets? Are you aware of concerns that have been raised in relation to how Grow in Western Australia has been managed, and what work is being undertaken to deal with those concerns?

Mr Marney: Thank you. I will perhaps have to take as supplementary information the total contract value, unless we can find it prior to that.

[*Supplementary Information No B10.*]

Mr Marney: In terms of the concerns, those concerns have been raised with me. I assume they are the same concerns in terms of acquittal of activity and funds by Grow. Those concerns have been raised with me formally and are currently being investigated by my contract management team in terms of the veracity of those claims and giving Grow a right of reply to those accusations. That process is currently underway.

Hon STEPHEN DAWSON: When do you anticipate that process being finalised?

Mr Marney: I would expect within probably the next four weeks.

Hon STEPHEN DAWSON: That is being undertaken internally by some of your staff, is it?

Mr Marney: By our contract managers. Their job is to ensure the quality and quantity of delivery of service by organisations that we fund. If we have a significant concern, we would bring in an external investigator. So, internally, we will do a preliminary examination of those claims. If there is found to be some validity to those, then we will engage external parties to go further.

Hon STEPHEN DAWSON: Thank you. The next question relates to page 161 and compliance with Electoral Act advertising. There is an amount there for $2 275 737.37 that has been paid to the Brand Agency via Curtin University. Are you able to provide the committee with a breakdown of that payment to the Brand Agency?

Mr Marney: Yes, certainly. That relates predominantly to our campaign content regarding methamphetamine prevention, also Alcohol Think Again, and also our Strong Spirit Strong Mind—elements of that campaign in terms of avoidance of alcohol during pregnancy. It is those sorts of things. We can give you a full breakdown on both what the cost was of content development and also placement.

Hon STEPHEN DAWSON: Great.

The CHAIR: Did you want that on notice, member?

Hon STEPHEN DAWSON: Yes, please.

[*Supplementary Information No B11.*]

[11.40 am]

Mr Marney: It also picks up the campaign around alcohol and young people, which has been spectacular in its results. Before the campaign started, about 10 per cent of young people were non-drinking and recognised that that was bad for them. That figure has now jumped to 30 per cent. It has had a marked impact, including among adults in terms of awareness of the harms of serving alcohol to young children, which kind of ties in with the secondary supply legislation that was passed late last year as well.

Hon STEPHEN DAWSON: Did each of those campaigns go to public tender?

Mr Marney: They did in so much as the arrangement with Curtin University and Brand was tendered about four years ago. The contract award was a contract of three years plus the potential, from memory, for two one-year extensions. We are still under that competitive tendered arrangement within that spend.

Hon STEPHEN DAWSON: What was the overall tender amount for that initial tender?

Mr Marney: I would have to take that on notice.

[*Supplementary Information No B12.*]

Hon STEPHEN DAWSON: I refer to page 132, service two, "Hospital Bed Based Services". It seems to me that Hospital in the Home beds are causing significantly more than anticipated per purchased inpatient bed day. What is behind that, and is this a blip as we start the process or more serious?

Mr Marney: I will get Michael Moltoni to add to my response but it is actually a blip in the Auditor General's treatment requirement of the cost in terms of what is included in the total cost of those beds. That is a matter that we need to work through with the auditors in better understanding their requirements across things for those beds and also ensuring consistency in the costing methodology with inpatient beds. What you are seeing there is a mismatch in costing methodology between the two. I had the exact same question when the draft report came to me because it does not make sense because HITH beds were supposed to be a lot more cost effective as well as better outcomes for individuals. It is really an issue of what has been classified as in scope for cost as opposed to out of. Our version of that number, from a non-audited perspective, is a lot lower so we are going to work through that. I apologise for that confusion but that is what we are required to report from an audit perspective.

Mr Moltoni: At the moment there is a bit of a mismatch between the numerator and the denominator. At the moment it is including the total costs of the system as a whole but because it uses something called ward on discharge at the end, you might have had part of your actual episode within the acute component. You might have been in the hospital itself, you were then discharged to the HITH component and then finally discharged overall from the HITH component. It is only capturing part of the bed days. You are then dividing the total cost by part of the bed days. We are just working through a methodology at the moment to more accurately pick that up, more accurately reflecting what it looks like.

Mr Marney: You are getting that total number of days in terms of cost but only the HITH days in terms of stay. It just mucks it up.

Mr Moltoni: A lot of international research shows that HITH is a lot cheaper overall. You normally get a slightly longer length of stay because your patients are kind of stepping into that component. Certainly international research clearly shows that it is cheaper.

Hon STEPHEN DAWSON: I have just one final question, Chair; I know we are running out of time.

Commissioner, I think in questions that have been answered pre-today, you provided a breakdown of the value of investment for suicide prevention and you listed the programs or services that are

being delivered. By way of supplementary, would you be able to give us a breakdown as to how much has been spent on each of those?

Mr Marney: I am more than happy to provide that.

[*Supplementary Information No B13.*]

Hon HELEN MORTON: I have two very quick ones. First, you mentioned Karratha and Bunbury in the step down facilities but you did not mention Broome. Is that progressing ahead of Bunbury and Karratha?

Mr Marney: That is correct. With Broome, we had all those approvals and release of funds. The land has been identified. We are currently going through the planning approvals process with council. Coincident with that, we are undertaking preliminary architectural design. As recently as yesterday we had further discussions with the local Yaru people and representatives around how to build a model of service that meets the needs of the Yaru people and the Kimberley people more broadly that is culturally appropriate. I am quite excited that we can do something very different in Broome and very much appropriate to the community. I think the community engagement on that facility is going to be very different from the others.

Hon HELEN MORTON: Are you doing anything to resurrect the Kalgoorlie step down facility?

Mr Marney: That is a matter for government decision-making and one which I cannot comment on.

Hon HELEN MORTON: My second question is about the special purpose accounts, which you make comment on, on page 30 under "Improved commissioning practices". Are area health services participating or treating those special purpose accounts in the manner to which they are meant to be?

Mr Marney: In terms of respecting that the funds have to be spent for their intended purpose on mental health services, I believe so. If I have any doubts in that respect, it is one phone call to the Auditor General and that gets examined. I believe they are working effectively. I also believe they are working effectively in terms of the new governance arrangements across the health system. We had a situation in which it took us a little time to finalise the new bilateral agreements for the current financial year. As a result, because of our control of the specific purpose accounts, none of the appropriation appropriated to the Mental Health Commission for purchasing from health service providers actually flowed to them until those agreements were signed. I can confidently say that that got their attention.

The CHAIR: On behalf of the committee, I thank you for your attendance today. The committee will forward the transcript of evidence, which highlights the questions taken on notice, together with any additional questions in writing, after Monday, 7 November 2016. 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 beforehand. The advice is to include specific reasons as to why the due date cannot be met. If members have any unasked questions, I ask them to submit these to the committee clerk at the close of the hearing. Once again, I thank you for your attendance today. I have a reminder to members that the deadline for submitting additional questions is 12.00 pm on Monday, 7 November 2016, as stated in paragraph 8.2 of the policy and procedures.

Hearing concluded at 11.48 am