Division 22: Mental Health Commission, $715 743 000 —

Ms L.L. Baker, Chair.

Mr R.H. Cook, Minister for Mental Health.

Mr T.M. Marney, Mental Health Commissioner.

Mr L. Bechelli, Acting Director, Corporate Services.

Mr M. Moltoni, Director, Performance, Monitoring and Evaluation.

Mr N.J Fergus, Chief of Staff, Minister for Mental Health.

[Witnesses introduced.]

The CHAIR: Welcome to the first session of Estimates Committee A of the Legislative Assembly. This estimates committee will be reported by Hansard. The daily proof *Hansard* will be available the following day. It is the intention of the Chair to ensure that as many questions as possible are asked and answered and that both questions and answers are short and to the point. The estimates committee's consideration of the estimates will be restricted to discussion of those items for which a vote of money is proposed in the consolidated account. Questions must be clearly related to a page number, item, program or amount in the current division. Members should give these details in preface to their question. If a division or service is the responsibility of more than one minister, a minister shall be examined only in relation to their portfolio responsibilities.

The minister may agree to provide supplementary information to the committee rather than asking that the question be put on notice for the next sitting week. I ask the minister to clearly indicate what supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the principal clerk by Friday, 1 June 2018. I caution members that if the minister asks that a matter be put on notice, it is up to the member to lodge the question on notice through the online questions system.

I give the call to the member for Churchlands.

Mr S.K. L'ESTRANGE: I refer to health services on page 272 of budget paper No 2, volume 1, and the statement that the government is committed to delivering quality health care to Western Australians, including inpatient care. How many adolescents are currently placed in adult wards in all hospitals across the state?

Mr R.H. COOK: I thank the member for the question. Because the question goes to the detail of mental health services, I ask the commissioner to respond.

Mr T.M. Marney: As at today, I am not aware of any people under 18 years of age placed in adult wards, but I would have to confirm that via supplementary information to be 100 per cent sure. I will have to check with all health service providers and I will do so immediately after this hearing and provide supplementary information if that is satisfactory.

[*Supplementary Information No A8*.]

Mr S.K. L'ESTRANGE: Over the past 18 months, how many adolescents have been in adult facilities for each week for all hospitals?

Mr T.M. Marney: Again, I will have to provide that as supplementary information. It would be quite a data collection exercise to provide that information for each week. If there is a more suitable presentation of that data, is the member willing to have that flexibility? I understand that the gist of the question is how many people under 18 years old are being held in adult wards. As far as possible we seek to avoid that across the system of course, but there are some circumstances in which it is clinically appropriate and it is the least worst option for young people to be on adult wards. As the member may be aware, we have invested quite substantially over recent years in a youth stream across our health service providers. We currently have a set of youth beds—I think it is 14 beds—at Fiona Stanley Hospital. We have Youth Hospital in the Home beds in the North Metropolitan Health Service and after the opening of the Perth Children's Hospital we will be opening a youth unit in the East Metropolitan Health Service. The issue the member has raised has certainly been of concern to us. We have put considerable effort into planning and phasing the introduction of youth services across all health service providers in order to address that issue and to ensure that as much as possible young people are kept in an environment that is suitable to their maturity and that the cohort they are with is complementary to their recovery.

Mr R.H. COOK: I add that once the Perth Children's Hospital is open, there will be extra capacity to take younger patients into the system. Obviously, they will be under 16 years of age, but that will hopefully provide extra capacity in adolescent units such as Bentley. I would just like to clarify that two lots of information have been requested. The first lot is more detailed and I would respectfully say that it should be requested through a question on notice.

Mr S.K. L'ESTRANGE: Yes.

Mr R.H. COOK: I am worried that if we commit to providing it as supplementary information, we will not be able to provide a weekly breakdown, because it is quite a detailed piece of work.

Mr S.K. L'ESTRANGE: Would it be easier to find if it were monthly?

Mr T.M. Marney: Monthly should be doable, and I can assure the member that we will try to capture every young person who has been held in an adult ward.

Mr S.K. L'ESTRANGE: It is just to allow us to gauge what the situation is in the health system.

Mr R.H. COOK: It is a good question. I might come back to the member with some supplementary information, and provide a more detailed answer later on.

Mr S.K. L'ESTRANGE: I appreciate that.

The CHAIR: After that very long description, could somebody please say in 20 words or fewer what is being looked for?

Mr S.K. L'ESTRANGE: Maybe I could clarify. I am seeking over the past 18 months how many adolescents have been in adult facilities for all hospitals. If that could be broken down by month, it would be great.

[*Supplementary Information No A9*.]

Mr S.K. L'ESTRANGE: The commissioner mentioned that there are 14 mental health adolescent beds at Fiona Stanley Hospital. Are they in use?

Mr R.H. COOK: My understanding is that they are. I will just ask Tim to provide some further detail.

Mr T.M. Marney: Yes, the beds are fully operational and occupancy for those beds tends to run at around 90 per cent to 95 per cent, so they are well utilised by the youth cohort.

Mr R.H. COOK: My understanding is that the beds there are split into two units or wings of that ward. I know in the early days only one of those was utilised, but my understanding is that they now both are. I know because I asked that question when I was the shadow Minister for Mental Health.

Mr S.K. L'ESTRANGE: Are there adolescent mental health beds in use at Royal Perth Hospital?

Mr R.H. COOK: That is very good question.

Mr T.M. Marney: No, not at this point. After the opening of the Perth Children's Hospital, a youth unit will be opening at what is now the Bentley Adolescent Unit. That will be called the east metropolitan youth unit and that will consist of 12 beds. That will be an addition of 12 beds to the system, with an additional net increase of one bed for children and adolescents at Perth Children's Hospital.

Mr S.K. L'ESTRANGE: When will the Bentley facility open?

Mr T.M. Marney: As soon as practical after the opening of Perth Children's Hospital.

[9.10 am]

Mr S.K. L'ESTRANGE: Is the commissioner saying that mental health beds exist for adolescents at Royal Perth Hospital but they are not in use?

Mr T.M. Marney: There are no youth beds at Royal Perth; there are only adult beds.

Mr S.K. L'ESTRANGE: What is the shortage of dedicated adolescent mental health services in Western Australia?

Mr T.M. Marney: Can I seek clarification on the age cohort? Is it 16 to 17-year-olds to 24-year-olds, or under-16s?

Mr S.K. L'ESTRANGE: Maybe the commissioner could answer for both categories.

Mr T.M. Marney: For up to 16-year-olds, with the opening of Perth Children's Hospital the 20 dedicated mental health beds will see the current modelled demand for that age cohort met in full. Indeed, I think the 2020 modelled demand will be met in the current year. The member may recall that the 10-year plan models the demand for services as at 2017, 2020 and 2025. When Perth Children's Hospital opens, the demand for under-16-year-olds will be fully met up to 2020. In terms of the youth cohort, my understanding is that once the east metropolitan youth unit opens we will again meet the projected demand up until 2020. There are further developments as part of the budget with respect to the mental health unit expansion at Joondalup Health Campus. As part of that expansion we will explore the mix of services required. It is most likely that part of that expansion will involve youth service, which will then take us forward to meet the demand between 2020 and 2025.

One consideration we gave during the purchase of that mix of services was to ensure that we did not create a gap in continuity of service for young people from Perth Children's Hospital to youth wards in the rest of the system. At the moment the cut-off age between the child and adolescent and adult and youth system is a hard single-point cut-off. We will purchase going forward a blended cut-off between Perth Children's Hospital and the youth units so that where applicable a 16-year-old, when clinically appropriate, can be treated at Perth Children's Hospital.

Similarly, when clinically appropriate a 16-year-old may be treated in a youth unit. The aim is that at that particular age some 16-year-olds are very mature. They may have had experience with mental health services previously and, therefore, may be suited to a youth unit that has others in that unit up to the age of 24. Conversely, some 16-year-olds are not mature. Their state of distress and their experience with mental health services may be such that they are better treated among a younger cohort of people; therefore, Perth Children's Hospital is a more appropriate setting for them clinically. That is a shift in the current system that we believe will better meet the needs of the consumers.

Mr Z.R.F. KIRKUP: I refer to page 272 of budget paper No 2. Is there a breakdown of the number of mental health beds for adolescents at Peel Health Campus, and are there future plans to increase that capacity or simply add any to the hospital?

Mr R.H. COOK: As the member would be aware, one of the commitments we made in the election was for the Peel youth and health hub, which will have some counselling and mental health outpatient services. The idea of that is to create an off-campus site where young people can get counselling, particularly around mental health issues related to sexuality, low-level drug use and things of that nature. That $5.2 million commitment will be funded through GP down south, which has been commissioned to put that together. We are waiting on its current milestones in the construction of that facility.

Mr Z.R.F. KIRKUP: The panels are up.

Mr R.H. COOK: Yes. I do not have those notes with me—they are under the Health portfolio—but specifically in relation to Peel, the youth mental health service will get a big boost. The Mental Health Commissioner has some extra information to provide.

Mr T.M. Marney: Further to the minister's response, as part of the GP down south initiative there is also a three-tier suicide prevention initiative targeted particularly at youth. We know there have been some issues in the Peel area with suicide. That is a welcome initiative that has been rolled out and is underway. In terms of support for youth mental health treatment in Peel more broadly, we have commissioned a community treatment service out of a south metro health service provider which is an outreach community treatment service specifically for youth, so supporting the youth inpatient service is a community treatment–based youth service as well. I am sure the member understands that the treatment of that age cohort is quite a specialist area, so having lots of youth units is really not feasible, but aggregating them together and then providing outreach and clinical liaison and support is the approach that we have taken to ensure that there is support to those small units from a youth specialist perspective.

Ms M.J. DAVIES: Page 280 refers to royalties for regions under "Income Statement". Can the minister provide a breakdown of what programs or initiatives are being funded through the regional community services fund for the Mental Health Commission; and, by extension, have any of the projects funded this year or into the forward estimates come out of the Mental Health Commission's budget and into royalties for regions this year?

Mr R.H. COOK: I am happy to make some general comments. We are funding some services, particularly election commitments, from royalties for regions. One that particularly comes to mind is the 30 drug and alcohol rehabilitation beds that we are running in the south west, which is a three-year program. I am not aware of any transference from the Mental Health Commission budget to the RforR budget, although on that particular one because it was a specific three-year program, we have —

Ms M.J. DAVIES: That is a new project?

Mr R.H. COOK: That is correct. That is a new project and is one of the election commitments we made. I will ask the commissioner to make any further comments in relation to that.

Mr T.M. Marney: As the minister mentioned, the south west residential rehabilitation service is RforR funded. There has been a change in the nature of those funds as part of this budget process in order to bring the service forward two years. That is the only shift in funding that has occurred with that one. It was approved as part of the previous budget. The other services funded as part of RforR are the Karratha step-up, step-down service, the Bunbury step-up, step-down service, the Kimberley alcohol and other drug planning—a $200 000 allocation to do a needs assessment across the Kimberley for AOD services—the Ice Breaker program in Albany, the GP down south, which is the three-tier suicide prevention program, Kalgoorlie step-up, step-down, and Geraldton step-up, step-down. Kalgoorlie and Geraldton are new additions to the last year of the forward estimates. I would have to check on whether any of the other step-up, step-down programs were previously funded through the consolidated fund. My recollection is that they were not, but I am happy to check that and confirm by supplementary.

The CHAIR: Minister, would you like to repeat the supplementary information that you will provide?

Mr R.H. COOK: My understanding is that would be total services provided from RforR funding, and any RforR funding that was previously sourced from the consolidated account.

[*Supplementary Information No A10.*]

[9.20 am]

Mr Z.R.F. KIRKUP: I refer to the dot point on page 273 of budget paper No 2 that reads —

> $9.3 million in service delivery from 2018–19 to 2021–22 for the establishment of 33 additional AOD low medical withdrawal and residential rehabilitation beds in the South West.

Can the minister provide any evidence to the house of how these beds will be more beneficial than the $16 million specialist drug rehabilitation centre for the south west that was provided for in the last budget?

Mr R.H. COOK: That is a really good question. As the member would be aware, one of our election commitments was for a dedicated alcohol and other drug rehabilitation clinic, or building, for want of a better word. I acknowledge Hon Adele Farina and the member for Bunbury for championing that project. The reality of government is very different from the aspirations of opposition. I will be honest: the step-up, step-down facilities that we are trying to develop in Bunbury, Kalgoorlie, Karratha and other places are hard beasts to land. We have to find the land, get a commitment that the land can be acquired and go through a consultation process. Often that consultation process has a few bumps and scrapes along the way because of community attitudes, and ultimately it is a very long process. It was put to us, in the context of the south west, that a much better and more nimble way to do this was to engage existing community or non-government organisation capacity in the south west. The member may be aware of a couple of organisations that have some cracking facilities in the south west.

We are trying to be a little bit more flexible in our thoughts around this issue. Rather than try to build a standalone facility, we sought to engage beds that would perhaps be spread out a bit more equitably across the south west. That enabled us to bring these beds on two years earlier than we had otherwise planned. It is a good outcome because it means that people can be serviced or treated much earlier than we had otherwise anticipated. As the member would know, a lot of the issues around drug addiction in the south west are now related to methamphetamine abuse, so this is a good policy outcome from that perspective. Previously, we were looking to a build that would take us to somewhere between 2020–21 and 2021–22 before we could actually provide those services. Now we are anticipating bringing those services on stream in early 2019, to my understanding. That means that we can get on and get those services delivered to the community.

As part of the 2017–18 budget, royalties for regions funding of $17.9 million was allocated over three years for residential rehabilitation and treatment services. This comprised $16.1 million in capital funding in 2018–19 and 2019–20, and recurrent funding of $1.8 million in 2020–21. Now, bringing that on earlier will involve bringing that operational funding forward, and—I am not sure whether the word is transference—relieving the capital budget in relation to that. Now, $9.3 million in operational funding has been allocated in the 2018–19 budget to contract for services in the south west, which is an increase of $7.4 million in operational funding across the forward estimates because we are bringing them on earlier. It will allow for 33 beds for residential rehabilitation and low medical withdrawal to commence in January 2019. As I said, this is two years ahead of the original schedule. I will ask the commissioner whether he has anything to add to that.

Mr T.M. Marney: That was a very comprehensive summary. The only figure that was missing was $8.7 million saved in net debt from royalties for regions, so bringing the beds forward was actually in part about making the royalties for regions money go further. When we commenced this project, standing back from the figures—we all rattle off figures pretty quickly—$16.1 million to build 33 beds equates to around $480 000 per 50-square-metre unit. From a value for money perspective, it just was not really stacking up. We took an alternative approach, which was to go to our existing service providers and/or potential new service providers and ask them what might be feasible. That has produced a result that, as has been highlighted, brings forward the services for individuals in the south west much earlier. It will also enable us to respond to individual cohorts in the south west in a more suitable way. Community accessibility will be enhanced as well as accessibility for, hopefully, different cohorts such as youth and Aboriginal people.

Mr R.H. COOK: Just to add to that, other information I can provide is that in October 2017 we went out for a registration of interest, and that process is now ongoing to, as I said, commence the services in January 2019.

Mr S.K. L'ESTRANGE: I refer to the service summary table on page 274 of budget paper No 2, and the 14.7 per cent budget reduction for prevention in 2018–19, when compared with what was allocated in the 2017–18 budget, and also the 43.3 per cent reduction in 2019–20, when compared with the 2017–18 budget. Can the minister provide detailed figures on the specific prevention initiatives that have been stopped by program, funding source, funding amount and funding time frame?

Mr R.H. COOK: Was that page 274?

Mr S.K. L'ESTRANGE: Yes. We are looking at a 14.7 per cent reduction between the 2017–18 and 2018–19 budgets, and we are looking at a 43.3 per cent prevention budget reduction from 2017–18 out to 2019–20. We

want to know what the detailed figures are on specific prevention initiatives that have been stopped by program, funding source, funding amount and funding time frame.

Mr R.H. COOK: I thank the member for the question. The budget decrease of $2.3 million between the 2018–19 budget estimate and the 2017–18 estimated actual is primarily the result of negotiations for the continuation of some external grant agreements that are yet to be finalised. In relation to the longer-term projections for the forward estimates, I will ask the commissioner, or other relevant staff, to make comment.

Mr T.M. Marney: As has just been highlighted, the main reason for the drop-off in 2018–19 is externally funded programs that the commission runs on behalf of other agencies, including the commonwealth—programs such as Strong Spirit, Strong Minds, which is a $1.13 million per annum program aimed at alcohol and other drug education and support for Aboriginal people in particular; and the parents and young people and alcohol campaign, which is just under $700 000 per annum. Those programs are funded by, respectively, the commonwealth and Healthway. A number of other initiatives are funded by organisations such as the Department of Health and the Royal Australian and New Zealand College of Psychiatrists. Those funding grant agreements expire at 30 June 2018. As at the budget cut-off point, we did not have renegotiated agreements with those organisations for the continuation of those programs. Hence, both the revenue and expenditure are not reflected in the budget papers. However, I can inform the member that since then all but one of those programs have been either verbally or formally confirmed as being renewed. The actual prevention figure in 2018–19, as at the midyear review, will be increased. The only program we are aware of that we will not be continuing is the safer settings program, which is about checking with festival organisers around the appropriateness of their environments from a drug and alcohol perspective. That was a commonwealth-funded program that will not be renewed.

The major reason for the decline in prevention activity funding in the forward estimates beyond 2018–19 is the expiry of the current suicide prevention strategy. Funding for the current suicide prevention strategy will end as at 30 June 2019. We are in the process of evaluating the current strategy to inform consideration of renewal of the strategy and amendments to the strategy going forward from 2019. From memory, that strategy was funded to the tune of $26 million over four years, so that money causes the drop-off in 2019–20.

[9.30 am]

Mr S.K. L'ESTRANGE: So is that the main reason for the 43.3 per cent reduction between the 2017–18 figure and the 2019–20 figure? Is that significant reduction because of that program?

Mr T.M. Marney: Correct.

Mr S.K. L'ESTRANGE: Can we anticipate that the figure for the 2019–20 out year in next year's budget will be rectified when a new program is in place to replace the program that is ending?

Mr R.H. COOK: The commissioner.

Mr T.M. Marney: Yes. We have an agreed process in place to undertake a rigorous evaluation of the existing strategy so that if stuff is not working, we can determine what we need to do to improve it, and we have a process laid out to present to Treasury as part of the midyear review and budget process next year.

Ms M.J. DAVIES: I refer to the step-up, step-down facilities outlined on page 273 of the budget papers. On the basis of need, where does the minister consider the priority is for the further rollout of step-up, step-down facilities in regional Western Australia? How would that need be measured in terms of the criteria and the demand for services?

Mr R.H. COOK: Thanks for the question. I think the step-up, step-down policy is a particularly exciting part of the mental health landscape at the moment. It is all part of the evolution of our understanding around mental health services and what is needed to make sure that people are locked into a recovery pathway. Smaller community-based mental health facilities around the state are obviously an important part of that process. The member will be aware that currently we have step-up, step-down facilities planned for Albany, Bunbury, Kalgoorlie, Karratha, Geraldton and Broome, and each of those facilities is currently being progressed but, as I said to the member for Dawesville, in some cases in a particularly tortuously slow manner.

The Albany step-up, step-down facility is a real success story in the sense that we are repurposing a current facility. The old hospice buildings next to Albany Health Campus have been repurposed for a dedicated step-up, step-down community mental health facility, and I am very much looking forward to opening that later in the year. The Bunbury facility is progressing, although we have had some issues with commissioning the services in Bunbury simply because it is proposed to be built in a new area, so we are waiting for the utilities to be available. The Kalgoorlie facility is progressing in the usual manner. The Broome facility is going well. I think we have now identified a more appropriate site for that facility. Previously, we were looking at developing it at Robinson Street. The Shire of Broome was initially supportive of it going in that area, but after we started to progress the development, it had a rethink, so we have now found a more appropriate place to position it. I do not know where those negotiations are at. It may be subject to more confidential arrangements, so I will leave it to the commissioner

to provide more information on that. We made an election commitment for 10 Geraldton beds, and they are in the early stages of development. The Karratha facility was subject to further negotiation with the City of Karratha after the community consultation process hit some bumps. I think we have now identified a more appropriate site for that particular facility. That is a big body of work at the moment to get all those sites up and running. I know the Mental Health Commission is working tirelessly to progress them as best it can, and it is working with local government authorities and other government departments that are potentially the current owners of those sites and, obviously, in the community consultation process. I will ask the commissioner to make some comments on where we might head to next.

Mr T.M. Marney: Part of the member's question was about how that need is established.

Ms M.J. DAVIES: That is right. On the basis of need, where is the priority for further rollout considered to be and how is that need determined? What criteria and measurements are used to determine the demand?

Mr T.M. Marney: Establishing the need is articulated in the 10-year plan. It is based on all of our needs analysis. No matter what service we commission, it is based on the application of the national modelling tool for mental health and the modelling tool for alcohol and other drug services, which is an epidemiologically based tool that maps the prevalence rates of mental health issues and AOD issues in the community across existing geographical areas based on population and determines what that population optimally requires in both the level of services and the mix of acuity of services. On that basis, the current program for the step-up, step-down services rollout, which is quite substantial, meets the full projected need through to 2025 based on that very rigorous modelling and the population cohorts. That is the technical background, I guess, to the needs analysis.

At a service level and on the ground, the need goes hand in hand with wherever there is substantial mental health treatment on the ground at the moment, because these services are there to support people in the community and to complement existing mental health services. In the case of Albany, which has a dedicated mental health inpatient unit, the step-up, step-down service is a highly valued complement to that service. Similarly, when there are high levels of mental health activity in general hospitals, the presence of a step-up, step-down service in the community is highly beneficial—for instance, in the case of Karratha, which does not have an inpatient mental health unit. We expect the next phase would probably be Port Hedland, which does not at this point have a step-up, step-down service planned, but there is significant mental health activity in the Port Hedland general hospital setting. Certainly, as we do the updates to the 10-year plan, that will draw out where the next tranche of step-up, step-down facilities is required. My recollection of the 2017 version of the plan is that these were the priority facilities identified based on need. We are currently in the process of doing an update to the modelling, and that may show changes in activity and population. We have seen a significant shift in population since the data point for the first version of the plan. The population data point for that plan was around 2014, so there has been a lot of change since then. The next update of the plan will bring that population change to inform the needs analysis and may throw up a different distribution, but that is what we are going through at the moment.

Ms M.J. DAVIES: In an area like the central wheatbelt, which has a pretty small population that is spread out, does the modelling preclude it? Does that get taken into consideration, because it does not seem to be a significant focus in that area? From my perspective, anecdotally there is a demand. If it is spread out in the way that service planning is done for child care and aged care, we seem to fall through the gaps because we do not have the population base or a regional centre or the services are not there. How does that get taken into account, or does it?

[9.40 am]

Mr R.H. COOK: I will ask the commissioner to make comment.

Mr T.M. Marney: Regional dispersion does have an impact because if there is not the concentration of population, then, in the stricter sense, the modelling tools do not quite pick that up adequately, which is why we overlay where the activity is happening as well to do a reality check on the technical modelling to assess where the mental health activity is being delivered and where support is needed. We pick that up by supplementing the modelling with that kind of reality check. The next iteration of the modelling will probably not pick that up in a technical sense. Introducing all these services is going to be quite a positive shock to the system. Seeing how the system flows subsequent to the introduction of these services is going to be really important to then assess, to maximise the marginal benefit of our next dollar of investment, where is the next priority. It will mean that these services need to be up and running to be able to assess how the system is flowing. We have other elements of flow in the system that we need to work on as well. Step-up, step-down facilities are just a small part of our supported accommodation solutions. We have almost 1 800 accommodation places in other forms of supported accommodation. We also need to look more intensively at how we flow people across those and they are more dispersed because they are not concentrated numbers of beds. They are spread throughout the community. That is probably what we would be looking at for the central wheatbelt.

Mr Z.R.F. KIRKUP: I refer to the service summary on page 274. The first line item relates to prevention. I understand that the "Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025" set a target of prevention for the commission at around two per cent. I note that over the forward estimates, the money set aside as a percentage of the budget goes from about 1.9 per cent down to 1.2 per cent of the budget. These figures are obviously below the initial stepped up plan that I think would end up with five per cent of funding in 2025 going towards prevention. I am keen to understand why there is a disparity of about 3.8-plus per cent of the budget, which is a significant amount given how much money the Mental Health Commission has. Why is there that disparity and what more detailed figures or plans does the minister have to get back to that, if it is still an aspiration?

Mr R.H. COOK: The development of a prevention strategy was identified in the strategic framework for 2018–2025. The first draft of that prevention strategy has been developed and I think it is currently subject to consultation with the community. Coming out of that, we could certainly expect to see a more concerted effort around the preventive approach. I will ask the commissioner to make some comment on the numbers and where that sits in the Mental Health Commission's overall budget.

Mr T.M. Marney: The main reason for the drop-off and not meeting that two per cent target is the matter discussed earlier around the external grants revenue and the suicide prevention strategy coming to an end at the end of 2018–19. That is what brings those numbers down from that two per cent target. We have made progress in the prevention space in a number of areas. In particular, through the amalgamation of the old Drug and Alcohol Office with the Mental Health Commission, we have brought the prevention capability of the Drug and Alcohol Office, which was quite substantial and longstanding, to bear on suicide prevention and stigma reduction. Members may have seen the "Think Mental Health" campaign, particularly on social media, which was a first for Western Australia and is something that we will be looking to build on. But it is a first, so we need to evaluate that and check whether it is working, whether we are reducing the stigma and more people are seeking help, or whether the space is too crowded. The evaluation of that, in part, will determine where we go forward in prevention. In addition, as mentioned by the Deputy Premier, the prevention strategy was a recommendation of the 10-year plan. That prevention strategy is nearing completion and should be released in its final form in the second half of this year. That will set the broader framework for the development of our various prevention activities, which will enable us to go in a systematic and robust way towards, first, the two per cent target, and then the five per cent target.

Mr S.K. L'ESTRANGE: I refer to the service summary table on page 274 and the line item for community support. The "Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025" identified a need to increase community support from 842 000 support hours to 5.28 million support hours by 2025. This target is supported by the Sustainable Health Review, which identified the need for access to community-based support and earlier intervention. Is the government committed to increasing community support hours in keeping with the plan's target support hours, with adjusted modelling being undertaken for the two-year plan update?

Mr R.H. COOK: It is an extremely good question and I invite the commissioner to make some comment.

Mr T.M. Marney: It is a very good question and, yes, community support has tapered off in the current financial year and across the forward estimates. The reason is that the member will see an offsetting increase in community bed–based services. Two components are driving that but it is purely a compositional shift and how we categorise our different services. Under the independent community living strategy, that is classified as community support. During the current financial year, we have had two developments. One was the establishment of the Albany step-up, step-down service and the second was the relocation of a number of residents from a private psychiatric hostel, which closed on 30 December. In order to fund both those increases in service, we reallocated finances from the independent community living strategy, which was classified as community support, into those new services, which are classified as community bed–based services. In the case of the residents of the psychiatric hostel, funding that was provided for their support was also previously classified as community support. The hostel closed on the basis, in part, of withdrawal of funds by the Mental Health Commission due to the failure of that hostel to meet minimum quality standards for mental health service. We took people from a situation in which they were not getting the quality of service that they should and we re-accommodated them in supported accommodation, which is in the category of community bed–based service. They are now getting a far more suitable and higher quality level of service. I have to say that it is also a higher cost. The upshot of that compositional shift is that the lives of a number of individuals who were residing in a psychiatric hostel have been greatly improved. That is something that, to be honest as a public servant, I am extremely proud of.

Mr R.H. COOK: If I might follow up on that, the situation around Franciscan House was one that I think both the Department of Health and the Mental Health Commission should be highly commended for. Essentially, there was a requirement for Franciscan House to update its facilities. They said it would be too hard, so they withdrew from service. Both the Department of Health and the Mental Health Commission had to manage this cohort of residents, who essentially would have been turfed out on 31 December last year. It was a very difficult situation

and one that they coped with very well. Ultimately, if Franciscan House had closed down and we did not have alternatives for the residents, they would have been tipped into the hospital system. Obviously, that would not have been good for the residents and certainly would not have been good for the health system. Mr Marney and the East Metropolitan Health Service moved heaven and earth to find these residents community-based services. Many of them they were very long-term residents, so it was a confronting decision for some of them to make. That was done with extreme sensitivity and, as Mr Marney just observed, it has produced some exceptional quality-of-life outcomes. It gives rise, though, in the context of the operations of private psychiatric hostels, to questions about what else is out there and what more needs to be done to improve the lives of these hostel residents. Significant work needs to be done to understand the quality of care at the moment and whether that need meets modern expectations. The member would understand that people are allocated to private psychiatric hostels right around the state and that some of the contracts are very long term that were perhaps struck at a time when our expectations about how these services worked were not as high as they are now. Without inviting too much chaos, in the medium term we need to take a view about the way these services are provided and whether we need to seek community-based solutions for a bigger cohort of residents.

[9.50 am]

Mr S.K. L'ESTRANGE: The minister mentioned that part of the way of addressing the problem is to move people out of hostels that might not be at an acceptable standard to the commission and into community bed–based services. I note that in the same table on page 274 funding of community bed–based services drops by 7.3 per cent from 2017–18 to 2018–19. Given this shift from hostels to bed-based services, why is the funding for community bed–based services dropping by 7.3 per cent?

Mr R.H. COOK: That is a really good question and I invite Mr Marney to answer.

Mr T.M. Marney: The bounce around in funding relates to the timing of the step-up, step-down funding flows. They are a quite significant component. We do not have a full year of funding for Albany in 2018–19, although it is close to a full year, but then as the subsequent years kick in that figure goes up. It is also associated with the existing time frames captured in the budget of step-up, step-down, which will be varied as part of the midyear review given the timing of where we are at on the various projects. Those flows will shift around a bit over the next 12 months as we land the actual build times for each of the step-up, step-down facilities, which are classified as community bed based.

Mr S.K. L'ESTRANGE: Can we anticipate seeing the budget amounts for community bed–based services actually increase in the next three years, not decrease as is currently the case?

Mr R.H. COOK: As the member would observe, the 2017–18 budget amount was about $61.4 million, but the estimated actual is only $59 million. That reflects the reality of whether the beds are commissioned and functioning within the timing that we would otherwise anticipate. I invite the commissioner to comment further, but certainly it is about how quickly we can bring these step-up, step-down facilities onstream.

Mr T.M. Marney: As mentioned, the cash flow of the current services is such that there will need to be carryover from the current financial year, and even previous years, through to subsequent years. As a result the base expenditure that the member is comparing the out years to is inflated and the out years are artificially deflated as a result. As I said, once we land the commitment on construction timing, we will with a greater sense of certainty be able to project through to when the operation will commence. That will enable us to re-cashflow all that expenditure, and at that point it will make sense.

Mr S.K. L'ESTRANGE: Still linked to the community hours targets set in the plan—as I say, from $842 000 to $5.28 million—can the minister provide an outline of the government's time frame for achieving these targets?

Mr T.M. Marney: The hours of community support are articulated at what is the optimal level of service for the community. I am not aware of any government service that reaches its optimal level of service, but certainly that is the aspirational target. Those figures will be updated as part of the update of the plan currently being undertaken at the moment. I can give an early indication that the population growth estimates since the plan was first done have been scaled back quite substantially—that is associated with the overall trends of the state's economy. The figures that will be published as part of the update of the 10-year plan—the two-year update of the 10-year plan—will show those figures coming back. Essentially we will seek to work towards enhancing those community support hours. The modelling gives us an indication not necessarily of the target level that needs be to achieved, but the rebalancing in the system that needs to be achieved. It shows that we are meeting about 80 per cent of inpatient demand, but meeting only about 20 per cent of community support requirements. To have an optimal continuum of service for the community, we need that balance between community support, community bed-based and prevention, as the member has highlighted. That means that in the commission's planning and purchasing activity, we will be seeking to rebalance the system at every opportunity. That is what we will continue to do throughout the life of the plan so as long as it tells us that is what we need to do.

Mr S.K. L'ESTRANGE: Following on from this line of questioning in and around the funding, when that two-year update is put out, will it include which funding is coming from the National Disability Insurance Scheme and which funding is coming from the state government?

Mr R.H. COOK: He has mentioned NDIS—I refuse to answer any questions around NDIS because it just hurts my head!

I invite the commissioner to comment.

Mr T.M. Marney: I am going with him!

At this point in time, due to uncertainties about NDIS coverage we have not assumed anything. We continue to work very closely with other agencies in the area of the NDIS, both with the commonwealth and the Department of Communities, to understand how the needs of people with psychosocial disability will be met under the NDIS. As much as possible we will seek to facilitate people who need to gain access to the NDIS. Going back to the earlier questions around psychiatric hostels, we are currently investing in accelerating the needs assessment for individuals who currently reside in psychiatric hostels to see how they might best fit into the NDIS and to undertake some of their preliminary planning so that when the NDIS hits their geographical area they are ready to go. It will be only through that process that we discover what the revenue contribution for the NDIS will be, and indeed what the service support contribution from the NDIS will be. As the member is probably aware, the 10-year plan does not differentiate between funding sources or service providers from any level of government, so it is something we will monitor closely. But certainly we are seeking to position consumers and carers that we are responsible for as best we can to be able to access funding, planning and services under the NDIS as it rolls into their geographical areas.

Mr R.H. COOK: I suspect that the issue around psychosocial support under the NDIS will result in a huge area of dispute and negotiation with the federal government. It is one that I am particularly anxious about. We will talk shortly about the Health budget, and certainly the NDIS represents a significant threat to budget management in Health. But around mental health, at this stage psychosocial support is almost a blank canvas, and the noises we are hearing from the feds at the moment are not encouraging. It is something we will have to spend a lot of time on. The commissioner would like to add something.

Mr T.M. Marney: To give reassurance to all, other jurisdictions have actually given their mental health expenditure across to the NDIS with, unfortunately, loose strings attached. In Western Australia we have not given any money over to the NDIS. We have held on to all our expenditure on individuals who may transition to the NDIS, and we will continue to support them to the level at which they are currently supported until such time as the NDIS takes over that level of support. We are certainly putting our consumers, carers and families at the forefront of the decision-making around this. We are not letting anything go to NDIS until we are confident that those consumers and carers will at least get a level of service and support that is commensurate with what they are getting now.

The appropriation was recommended.

Meeting suspended from 10.00 to 10.06 am