Division 9: Mental Health Commission, $714 009 000 —

Mr R.S. Love, Chair.

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

Mr T.M. Marney, Mental Health Commissioner.

Mrs M.E. Falconer, Chief Finance Officer.

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

Mr E.A. Locke, Chief of Staff.

[Witnesses introduced.]

The CHAIR: 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 only be examined 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, 29 September 2017. I caution members that if a 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.

Member for Nedlands.

Mr W.R. MARMION: I refer to page 118 of budget paper No 3. The third last bold heading on that page is "Internal Savings—Grants and Services Purchased". I refer to the proposed savings of $5.8 million through the cessation of various grants and contracts with non-government organisations. Which non-government organisations have had their grants or contracts ceased?

Mr R.H. COOK: Thank you very much for the question. Obviously, it is important in the current context of the budget to make sure that the funds applied, as precious as they are, are put to use in absolute certainty. Some of those were considered to be non-core items. In particular, they relate to the St Patrick's Community Support Centre choir and the Spirit of the Streets Choir. It was also agreed with the organisations that a range of services would not be funded. They include the Wiluna patrol and Silver Chain community support. It was decided, upon closer examination, that a range of services were either duplicated or not producing the outcomes we were looking for. I will ask Mr Marney to provide some further details on those.

Mr T.M. Marney: As the minister mentioned, a number of services were not considered to be core business for the Mental Health Commission or were not currently delivering value for money relative to the priorities of the government. Also, some services were experiencing low rates of utilisation. From both looking at the utilisation and discussions with the service providers themselves, in a couple of cases, as the minister mentioned, the service providers sought to no longer provide the service—Silver Chain stands out there and also the Wiluna patrol. One of the objectives of the commission and the 10-year plan is to ensure that gaps and overlaps in mental health and drug and alcohol service provision are minimised to the greatest extent possible so that we are not wasting money, essentially, on repeat services that ultimately render it difficult for people to navigate those service systems. One case in point is the service by the Samaritans, which is primarily a phone conversation connection service, if you like, or an interaction service. It is not a helpline or a counselling service. In looking across the various helplines and counselling services in place, it was considered that that space was adequately covered, particularly through the growth in organisations such as Lifeline, beyondblue and the like. Those services will cease as of 30 June 2018, with the other services that are in place more than able to pick up that need from service consumers. Most of the services do not terminate until 30 June 2018, which will give us time to work with the service providers on, if need be, alternative funding arrangements where that might be appropriate or where there might be a better fit with those services with other organisations, whether that be state-based agencies or through commonwealth funding through the likes of the WA Primary Health Network.

Mr W.R. MARMION: Good answer. Mr Marney has answered some of my supplementary questions in terms of the notification. All agencies that are going to have services cut will be given notification so that they can gear up.

Can the minister provide a list of the organisations and the amount of each grant by way of supplementary information?

Mr R.H. COOK: I am happy for the Mental Health Commissioner to provide that information.

Mr T.M. Marney: I can do that now. The first item is the Samaritans, which I mentioned, with total savings from 2017–18 to 2020–21 of $525 789. St Patrick's is a saving of $116 233, and the Spirit of the Streets Choir is a saving of $116 233 also. The Lamp housing support worker grant is linked to a national partnership agreement around homelessness. The partnership agreement at this point terminates on 30 June 2018. In line with that and without indication of a continuation of that agreement, our funding also terminates now at 30 June 2018. That is an amount of $248 871. Silver Chain ceased its service on 30 June 2017, with it notifying us that it no longer wished to continue providing the service. This service is based in the Pilbara and the saving over that period mentioned previously is $1 011 606. Teen Challenge is an Esperance-based residential drug and alcohol rehabilitation service and the amount is $712 415; Hope Community Services street van, $380 428; the community-controlled health services patrol of Wiluna, $474 557; and the Geraldton Sobering Up Centre, which is also provided by Hope, just over $1.9 million.

[12.10 pm]

Mrs L.M. O'MALLEY: I refer to significant issues impacting the agency on page 142 of budget paper No 2. My question relates to suicide prevention. I note the budget refers to the alarming statistic that suicide remains the leading cause of death for Australians aged between 15 and 44 years. In 2015, 394 people took their own lives in WA. What is this government doing to rectify this alarming statistic? What money is in the budget for suicide prevention programs? Are there groups more susceptible to suicide in our community? If yes, what money is being targeted to these groups?

Mr R.H. COOK: I think that is a great question. Suicide prevention is obviously a key focus for the Mental Health Commission. The statistics for suicide continue to alarm and they are a real, concrete measure in the community of how we are doing in Mental Health. The work we are doing really builds on the work that the Mental Health Commission has undertaken, particularly on the "Suicide Prevention 2020" plan. That focuses on a number of action areas, such as greater public awareness; local support and community prevention across the lifespan; coordinated and targeted services to homeless groups; shared responsibility across government; increased suicide prevention training; and timely data and evidence to improve responses and services. I will make a couple of comments about some of the key groups that we need to focus on.

Obviously, Aboriginal suicide is particularly alarming, especially in the Kimberley. A lot of organisations and governments, both commonwealth and state, are doing work on some of those issues. I am very pleased to say for our part that we have recently appointed a suicide prevention coordinator who is to work with communities to continue to build their capacity to respond. We know that communities that already have had incidents of suicide are more likely to see other incidents occurring, so working with those communities is really important. One of the key aims of the prevention coordinators is to make sure that organisations in the region work well together to bring in as many resources as possible.

I also recently announced a range of funding in the context of the same-sex marriage plebiscite. We already fund organisations that target members of the lesbian, gay, bisexual, transgender, intersex and queer community to the tune of around $500 000. In the context of the plebiscite, we have made other funds available to Living Proud and the Western Australian AIDS Council to boost their capacity to provide counselling services to members of the community who would be particularly vulnerable at this time. I am very pleased to have feedback from those organisations that the money is not only appreciated, but also assisting them to meet some of those increased pressures. I saw some media coverage yesterday of national organisations raising the alarm that they had had an increase in inquiries about mental health services from members of that community.

One of the really challenging aspects of this issue, which I will ask the commissioner to make some comments on shortly, is gathering data for suicide prevention. Because suicide falls under the auspices of the coroner, it is difficult to maintain a level of data that is both timely and responsive to the needs of service organisations. I note that the coroner is undertaking an inquiry in the Kimberley at the moment on the suicide of young people in the community, and the Mental Health Commission made a submission to that inquiry. I will not comment on that, obviously, because that inquiry is ongoing. One observation made in that submission is the importance of data in helping guide us in future work on suicide prevention. With the indulgence of the Chair, I will ask the Mental Health Commissioner to make some further comments.

Mr T.M. Marney: I will address the specific comments about high-risk groups and what has been done in that space. The current suicide prevention strategy has six key action areas and one of those is to address the needs of high-risk groups. They are identified through the data as being LGBTIQ people, Aboriginal people, people who

have attempted suicide previously, children bereaved by the suicide of a parent or close family member and so on. We have gone through the data and identified those people who have a disproportionate and higher, if you like, probability of dying by suicide. That has been done through investment in a new WA coronial suicide information system, which the minister touched on. The information system tracks every death by suicide back to, I think, the late 1980s and classifies and identifies 200 variables that sit behind that individual who died to get an understanding of some of the high-risk factors, as well as the protective factors that we need to augment. A lot of our investment in suicide prevention is about investing in those protective factors.

I will give a couple of examples. We have invested in the Aboriginal family wellbeing pilot project; mental health and wellbeing education for men in regional areas, particularly farming communities; and Mates in Construction, which has a focus on not only the construction industry, but also fly in, fly out workers. There is a new program, in fact a national first, for children and young people bereaved by suicide. We know that they are four times more likely to die by suicide themselves, so investing in them early to help them cope with and address the trauma associated with the suicide of a parent is critically important. In addition to that, we have suicide prevention training for Aboriginal people and we are currently working on a workplace suicide prevention initiative, which is quite substantial. We are also working on a greater emphasis on public awareness and a broader public education campaign as well, which will come to fruition very soon.

All those things are about building resilient communities, making sure that we are targeting those particularly vulnerable people and seeking to engender a broader community conversation about suicide such that it is the responsibility of not only health systems, but also communities and families, which is where the protective factors really come in and, unfortunately, where some of the risk factors emerge. We are about 40 per cent of the way through our expenditure on the suicide prevention strategy that was approved under the previous government and given the lead-up on some of those initiatives, we will see a lot of those programs hitting their main outcome achievements over the next 18 months or so. That is pretty much where we are at. One of the key things we need, though, is access to real-time data, and that is about identifying in real time when any suicide risk or elevated risk in particular communities is emerging and being able to address it immediately so we can prevent any further tragic loss of life.

[12.20 pm]

Ms M.J. DAVIES: It was interesting that there was only one brief mention then of fly in, fly out workers. The minister was very outspoken in the debate back in 2014 about the impact of fly in, fly out method of employment on workers and the likelihood of people engaged in that practice to commit suicide. They have all the indicators and the circumstances that lead to a higher suicide rate. What work is the Mental Health Commission and the minister doing to progress the recommendations of the report that was done by the Education and Health Standing Committee chaired by Graham Jacobs? Has the minister engaged with the Minister for Lands about the Woodside proposal that is before Parliament for a 700-bed FIFO camp in Karratha?

Mr R.H. COOK: It is a very good question and the member is right. We have talked about the issue as recently as this week when we talked about an allocation of some $300 000 to Mates in Construction WA to continue the work it does with a fairly young male-dominated workforce. From that point of view, it has an important role to play. I think that the work of Graham Jacobs and the Education and Health Standing Committee was really important and it has informed a lot of members of Parliament about those issues. The Chamber of Minerals and Energy will put to me that it is not a question of people's work status and whether they are FIFO or permanently based; the chamber says that it is more a question of dealing with a particularly vulnerable cohort of workers. I see the member smiling and I must say that it does not coincide with everyone's intuitive understanding of the issues.

The Mental Health Commission is funding really important work at the University of Western Australia; that is, academic research into workplace mental health issues relating to FIFO. I met with those researchers a couple of months ago. My understanding is that they will bring down their report later this year. That will be an important piece of work because it will inform us and, hopefully, test the theories on both sides of that debate.

I will ask the Mental Health Commissioner to comment shortly on the specific recommendations of the report, but, no, I have not had discussions with the Minister for Planning, but I am, as is the member, concerned about the issue of mental health in our FIFO workforce. That is certainly one of the reasons that we have a strong partnership with Mates in Construction. I am very much looking forward to that research to build our level of understanding of those issues.

Mr T.M. Marney: I have just a couple of quick comments. As the minister mentioned, there are a number of competing views on whether FIFO is a cause or a common factor of suicide. Given that another common factor is the age cohort and younger males being predominantly FIFO workers, suicide is, unfortunately, the leading cause of death for people aged 15 to 44. If that age cohort is dominating the workforce, we are going to have, unfortunately, a disproportionate rate of death by suicide. Also, four out of five suicides are male. Again,

a male-dominated workforce is going to lead to a higher suicide rate. Whether that is related to FIFO is really the topic of the research. The recommendations that came from the parliamentary committee are the primary focus of the Mental Health Commission at the moment. We need to gather some evidence about: What is driving this experience? What are the common factors? Is it the FIFO work arrangements or is it those other underlying factors? As mentioned, there are competing views on what those factors are and what dominates the outcomes that we are seeing. To address that, as the minister mentioned, a substantial piece of research is being undertaken by UWA. Everything we do is based on evidence, so we need an evidence base to which to respond. That evidence base is not there at the moment, which was a key finding of the parliamentary inquiry. The evidence is being overseen by a research committee that involves the industry, unions and family members of those who have died by suicide who were working in FIFO, as well as service providers. The aim is for those competing perspectives to work together to understand the problem, what is causing it and the solutions we can implement.

Mr W.R. MARMION: On the general question raised by the member about suicide, and on the same point, the minister mentioned the suicide prevention coordinators. Specifically, I am after data. The budgets estimates suggest that there will be 10 suicide prevention coordinators across the state. Can the minister tell me where they will be deployed throughout the state, the allocated salary for each coordinators, the total cost of establishing and running each of those services in those locations over the next three years?

Mr R.H. COOK: I will ask Mr Marney to respond to that question.

Mr T.M. Marney: The coordinators are spread across the state from memory. We can provide it as supplementary information given that I do not have at hand the salary figures the member has asked for. From memory, there are two coordinators in the metropolitan area. The rest are spread in each region, such as the great southern, the south west and so on. The only one that is not in place yet is in the Pilbara. We had someone recruited, but, unfortunately, that fell through in late July—but all the other suicide prevention coordinators are in place. Their role specifically is not to provide a service but to ensure that they understand and can articulate the needs of the community in suicide prevention. When needs are identified through that process of building a relationship with the community, the coordinators' role is to make sure that those needs are met and coordinated across existing service providers. I go back to the earlier statement that mental health and drug and alcohol systems are fraught with gaps and overlaps. Part of their job is to make sure that people get the services they need when and where they need them and to build long-term relationships with communities because communities do not naturally come forward and speak about suicide and suicide prevention and what they need. One of the failings we have seen in previous initiatives in the suicide prevention space and, indeed, in some current initiatives of another level of government, is the propensity to so drop in and out of communities when there is a crisis. Based on the evidence, that tends not to work particularly well. We are here for the long haul to build those relationships and make sure that the community has trust in us and the system, and can get what it needs when it needs it.

Mr R.H. COOK: That is supplementary information on suicide prevention coordinators, resourcing for their areas and salaries.

Mr W.R. MARMION: I will clarify what I am after. I am after the actual town in which the person will be located and the salary allotted to that person. Obviously, they have to be accommodated. I just want to know the costing data. I understand the importance of the coordinators and I agree with what they do. It is a good outcome. I just want to know the costs.

The CHAIR: Can you restate that, minister?

Mr R.H. COOK: If I can paraphrase the member, we are looking for the location of each suicide prevention coordinator, salary levels, resource to support —

Mr W.R. MARMION: Basically, the allocation. The person is lobbed into a town. How much money is needed to support them over the next three years?

Mr R.H. COOK: The member is after support resources, including accommodation costs.

[*Supplementary Information No B5*.]

Mr B. URBAN: My question is on page 145 of volume 1 of budget paper No 2. The heading is "Outcomes and Key Effectiveness Indicators" and the subheading is "Outcome: Reduced incidence of use and harm associated with alcohol and other drug use". How is this government working to reduce demand for services and the community costs associated with the misuse of alcohol in the community?

[12.30 pm]

Mr R.H. COOK: I thank the member for the question. Obviously, alcohol remains the single biggest cost factor associated with mental health in our community. In 2010, nationally, the direct cost of alcohol-related problems was in excess of $14 billion. It is an ongoing issue and we have to put a lot of resources into harm minimisation and alcohol and other drugs services, and particularly step up, step down facilities. One of the things that we need

to be cognisant of, member for Darling Range, is the extent to which we allow alcohol to continue to wreak such harm on our community. This is something that ultimately we have to come to grips with. The member would have seen recent media about the Commissioner of Police's suggestion that we reduce the availability of full strength beer in the west Pilbara. I note the comments of the member for Pilbara in this morning's media. Ultimately, as a society we will have to come to grips with the availability of extremely cheap alcohol in our community. I draw the member's attention to—I think it is pretty close to his electorate if not in his electorate—the recent application by Aldi to make available cut price alcohol from one of its stores. In that instance, the suggestion was that wine would be available at a cost of $2.78 a bottle. As a community we have to acknowledge the harm that alcohol does to the community and, at some point, we have to respond to that harm in a way that limits the abuse of alcohol and the impact of alcohol abuse. The Mental Health Commissioner has recently done some work on minimum pricing models and how they might be brought to bear to mitigate some of the impacts of alcohol use in our society. I will invite the commissioner to make comments about our alcohol programs. It ranges across the appropriate elements of alcohol and other drug programs and relates to prevention. The Alcohol Think Again campaign is a really important campaign to raise awareness in our community. In addition, there are other drug programs, such as the step-up, step-down facilities, which are about giving people an opportunity to address their addictions and get the help they need to get off alcohol in particular. We also have to be aware of the costs of associated with policing violence and other issues associated with alcohol. We have to come to grips with the costs associated in our emergency departments. Up to one-third of patients who present in an emergency department do so because of alcohol. From that perspective, a moment of reckoning is coming in our community about our attitude to alcohol and the extent to which we continue to allow it to impact on the community. In particular, as I said, what is of the greatest concern is what is essentially a flood of cheap alcohol that is coming into our community. We cannot expect the liquor and gaming commissioner to hold back that tide. He tried to do so with Aldi, but he failed because the application was upheld on appeal. As a community, I think we need to take broader steps. I will ask the Mental Health Commissioner to comment on the programs that address the impact of alcohol use.

Mr T.M. Marney: As the minister said, we have been doing some work on minimum pricing per unit of alcohol. We continue to do research in that area and provide the minister advice. It is under active consideration. Certainly from an economic standpoint, what we are doing at the moment is not working particularly well given that based on data from the Department of Health, every 18 minutes on average someone presents to an emergency department with alcohol-related harm. In part, in response to that and to be accountable for changing the rate of hospitalisation, we have added to our key performance indicators performance indicator 2.3, which is rate of hospitalisation for alcohol and other drug use, so that we can gather evidence over time to see what effect we have. We know from individual programs that we are having a positive effect. The Alcohol Think Again program, which the member would be aware of, is a very successful program in terms of its evaluation of outcomes. There is the alcohol harm to your body campaign. The member might have seen the glass body in that international award-winning campaign which, again, is all about trying to change community attitudes towards the consumption of alcohol and reduced harm. Our programs aimed at particularly young people have shown to be extremely successful. When targeting parents and young people, we have seen a change in attitudes in young people towards drinking and also a change of attitude in parents towards supplying young people with alcohol. Those prevention campaigns are absolutely crucial but they are one part of a suite of levers that we need to make the most of to change the impact that alcohol is having on not only the health of individuals, but also, in some cases, entire communities.

Mr W.R. MARMION: Can the minister provide feedback on how the alcohol interlock programs are going? What has been the feedback from stakeholders? How many people have gone through this component of the scheme? What is the cost of delivering that scheme?

Mr R.H. COOK: I will ask the Mental Health Commissioner to comment on that.

Mr T.M. Marney: The allocation in 2017–18 for the alcohol interlock scheme is just under $1.4 million to purchase the alcohol assessment and treatment services for the estimated 750 people per annum who are likely to access treatment through that scheme. A number of assumptions have been made in estimating that potential number. The start of that scheme is kicking in in the 2016–17 financial year. Since the scheme's commencement in late October 2016 to 30 June 2017, 1 003 people were convicted of alcohol offences that include the penalty of an interlock condition once their driving disqualification period has been served. Of those, 40 people have completed their disqualification. There is quite a lag because these people are eligible for an interlock only because of the severity of what they have been convicted of and therefore they have to serve out the time of disqualification of their licence. Only 40 people have finished that disqualification period out of that 1 003 and they have subsequently been granted licences with an interlock condition. Of those 40 people, 25 entered the scheme and of those, three breached the conditions of the alcohol interlock scheme and were referred to alcohol assessment and treatment. We expect that there will be quite a delay in people flowing through to the scheme. I think we probably underestimated the time period of disqualification. The amount allocated in 2017–18 is likely on that basis to be generous.

Mr W.R. MARMION: Sure. Good answer.

[12.40 pm]

Ms M.J. DAVIES: I refer to budget paper No 2, volume 1, under "Asset Investment Program", and the funding for the step up, step down mental health facility in Kalgoorlie. I note that under the goldfields plan that the Labor Party took to the election, it said there would be a $9.35 million commitment for this facility, but there is only $7.3 million in the budget for this facility. Has there been a change in what the government is delivering? What is the reason for the difference between what was in the election promise compared with what is now in the budget? Once that facility is up and running, will the funding for the recurrent expenditure come from royalties for regions, the Mental Health Commission or the Department of Health? Where will it go?

Mr R.H. COOK: I thank the member for the question. The Kalgoorlie step up, step down facility is an important development and I am a bit bemused as to why we have taken so long to get there, to be honest, but it is good that we are now making progress. The member will recall that our 2017 election commitment was for a 10-bed step up, step down facility. She mentioned some numbers in terms of what our election costings were —

Ms M.J. DAVIES: The government's promise was $9.35 million, and in the budget papers I can see only $7.3 million.

Mr R.H. COOK: Yes, that is essentially just a reconfiguration in terms of getting better advice about what is needed to provide a 10-bed facility. One assumes that the $10 million estimate was probably from the vantage point of opposition. Now, in government, we are advised that the appropriate arrangements are, for 2018–19 to 2020–21, a total of $7.3 million—$5.6 million for capital and $1.7 million to operate the service in 2020–21. It is expected to open in January 2021.

Ms M.J. DAVIES: Is the recurrent expenditure coming from royalties for regions as well?

Mr R.H. COOK: No, I do not think any decision would have been made at this stage as to where it is coming from, but I anticipate it will come from within current government resources. Depending on the budget configuration in 2020–21, we will find the appropriate resources to do so. With regard to the $1.7 million in 2020–21, I think that has been allocated to royalties for regions, but obviously how that rolls forward outside the forward estimates will be subject to further consideration.

Ms M.J. DAVIES: So is the $1.7 million in 2020–21 anticipated to be the full cost of running the facility under current assumptions?

Mr R.H. COOK: No; I assume that $1.7 million, given it is operating from January 2021, is six months' worth of operation.

Ms M.J. DAVIES: It has been allocated to royalties for regions?

Mr R.H. COOK: That has been allocated to royalties for regions at this stage, yes.

Mr W.R. MARMION: Just for a bit of clarity around that, because it is important, with regard to the planned step up, step down facilities in Kalgoorlie and Geraldton, has the government specified the actual sites at which they will be located, and can the minister tell me what they are? I know the government is presumably doing a business case around it, but can the minister give us an estimated capital cost and an estimated recurrent running cost for each of those two facilities?

Mr R.H. COOK: Not in relation to Geraldton; that is still being worked through, unless the Mental Health Commissioner has some further information. The facility in Kalgoorlie is at 13 Davidson Street, as I mentioned to the member earlier. It is $5.6 million in capital and $1.7 million in operating costs in 2020–21. The suggestion is that the running costs will probably be between $2 million and $2.5 million per annum.

Ms E. HAMILTON: I refer to page 140 of budget paper No 2, the heading "Spending Changes", and the subheading "Election Commitments". I have the following questions about the line item "Mental Health Recovery College at Royal Perth Hospital and in Wanneroo". Can the minister please expand on the work that is being done to deliver a Mental Health Recovery College at Royal Perth Hospital and Wanneroo? How will these recovery colleges assist the communities in those areas? When will they be likely to be open to the public?

Mr R.H. COOK: I thank the member for the question. Mental Health Recovery Colleges are an important election commitment, and one that we are very committed to. They are essentially an innovative way of delivering healthcare services that will be made available to consumers, their families and carers to build our capacity in the community to have the skills to deal with mental health issues. It is all about the continuing destigmatisation of mental health and bringing in mental health services and training in an education environment. This is about turning around the stigma that mental health often has to provide people with an appropriate environment in which to get the skills for themselves and their loved ones. The important aspect of recovery colleges is that they are based upon a recovery model, or a focus around recovery—that is, mental health is not something that people need to be burdened with forever; people can build the skills and have the capacity to manage these issues and move into a recovery mode of life. It is a really important initiative. The member made the comment—I think we are

guilty of doing this in the election campaign—about it being at Royal Perth Hospital. It would be around the Royal Perth Hospital precinct; that is, a central location. We drew some crabs following the announcement from people saying that they did not want it to be in a hospital environment, because recovery colleges are not about hospitals; they are about community-based arrangements for people who want these sorts of services. As the member mentioned, we have two models in consideration—one in Wanneroo, which is an outer suburb, and one around the central Perth precinct, to really test the program through that sort of pilot.

We have allocated $200 000 in 2017–18 for the Mental Health Commission to continue to do work around the model for that. As I have learnt in the short time I have been in the portfolio as minister, in mental health there are often varied and strong views about the most appropriate ways to deliver these services, so it is important that we move forward in a way that is consultative and will bring the community with us. We want a fair amount of consensus about the co-design of this program. Once the co-design model of service is developed, the Mental Health Commission will finalise a formal business case for it, which we look forward to delivering through the 2019–20 budget process. I will ask the Mental Health Commissioner to make some further comments.

Mr T.M. Marney: Thank you. Yes, the recovery college model is very much about educating and building skills to enable individuals to manage their own mental health issues and those of loved ones in the case of carers and family members. There are various models around the world, and we are in a process at the moment of unashamedly pirating all the resources of other recovery college models, with their cooperation, which has been really good. But we need to then use that information in a co-design process with our local consumers, carers and families, and, importantly, clinicians. Part of the role of recovery colleges is to involve and educate clinicians as well in what recovery focus is about and to change the culture more broadly within mental health clinical services. That will be a fairly intensive process that we will embark on over the next six to nine months to then come up with a model that is agreed and uniquely Western Australian. I mention that we currently fund the Broome Recovery Centre, so we will build on the learnings from that as well. It is an exciting opportunity and one that, as I said, needs to be driven by consumers, carers and clinicians.

Mr W.R. MARMION: Just exploring this particular item, it sounds like it is a good idea. The minister must have a rough idea of how many people it might service. There will be a capital cost and an ongoing recurrent cost. Does the minister have a bit of a feel about the cost, based on the Broome Recovery Centre model? This seems a more expansive model than that. Can the minister give me a ballpark figure of what it might cost for both the Royal Perth Hospital location and the location at Wanneroo, which I presume the government does not have a location for yet?

[12.50 pm]

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

Mr T.M. Marney: At this point I cannot give a cost estimate. From observations of recovery colleges elsewhere, we know that they predominantly link in with existing sites and facilities, as a network. The actual training facilities are networked across existing training providers, and that is part of the model that we need to explore further. It may be that we partner with training organisations, and we do not need to invest in any capital in that sense, but that we have a central hub that runs, if you like, the curriculum and the administrative side, but then it links into community-based training facilities that are already out there. Again, we want the recovery college and its executive process to be embedded in communities, so that we are bringing communities with us in supporting individuals as they proceed through recovery from a mental illness.

Mr R.H. COOK: I just want to add to that, Chair, if I may. Obviously, the temptation in the election campaign was to talk about Royal Perth Hospital, because it was anticipated that assets there could be utilised. We want to make sure that this is rolled out in the most efficient and cost-effective way possible. We look forward to that information coming to light as we build the business case.

Ms M.J. DAVIES: I refer to the service summary on page 144. Item 1 is prevention. I need an explanation of why the amount allocated for this item seems to decrease across the forward estimates, given that the minister has put significant emphasis in the past on the importance of preventive programs and having a proactive role in seeking to prevent people from requiring those services.

Mr R.H. COOK: I might ask the Mental Health Commissioner to make a comment.

Mr T.M. Marney: The declining prevention expenditure in 2017–18 predominantly relates to external revenue sources. We do a lot of work for other organisations, including the commonwealth—for example, the WA Footprints to Better Health program, which is funded by the Department of Health, and the Strong Spirit Strong Mind program, which is also funded by Healthway. Some of those specific commonwealth initiatives actually cease during that period, so as those finite resources cease so do those programs.

Mr R.H. COOK: I think the Minister for Mental Health would have a very strong view about Footprints to Better Health continuing past July 2018.

Ms M.J. DAVIES: By way of supplementary information, can the minister provide a list of the programs that are being discontinued? Essentially, this is showing up as a fairly significant decrease in the prevention budget for the commission.

Mr R.H. COOK: Obviously, in relation to the income for that program that comes from something like Footprints to Better Health, it would be anticipated that the funding would continue. It is just that the current program will expire in June 2018, but I am very happy to provide that information by way of supplementary information. I think that the information the member seeks is the details of all the programs under the prevention line item —

Ms M.J. DAVIES: And what is being discontinued.

Mr R.H. COOK: —the funding arrangements into the forward estimates, and which programs, at this stage, are being discontinued.

[*Supplementary Information No B6.*]

Mr W.R. MARMION: I have a general question on the appropriation of money to deliver services, which is shown on page 140, as it relates to the National Disability Insurance Scheme. People involved in the mental health field say that the NDIS should provide more for mental illness as a disability. I would like to hear the view of the Mental Health Commissioner, firstly, on whether there is an allocation in the forward estimates based on the NDIS and, secondly, whether some of the mental health services come from that scheme.

Mr R.H. COOK: I thank the member for the question, and obviously I am not in a position to talk about the NDIS, and how it will operate generally, but I have certainly seen some media coverage recently of a general anxiety about how the NDIS will support people with psychosocial conditions, particularly schizophrenia and so on. That is obviously something we will have to focus on very carefully as we move forward to this new sector. I will ask the Mental Health Commissioner to make some commentary where he can.

Mr T.M. Marney: The NDIS is obviously an evolving service model with complexities associated with the individual planning for care and support packages for individuals, including those with mental health issues, requiring community-based support and care. Where we fund existing support and care, we will continue to do so. The Mental Health Commission, in working with all stakeholders and service providers, has been adamant in its stance that it will not step back from its current service provision or funding provision in anticipation of the NDIS coming to fill that gap. Our consumers come first. Where those consumers transfer across into the NDIS and elect to continue, as part of their plan, existing supports and care packages that are purchased through the commission, that will remain the case, and will continue to be in place, so long as they opt to maintain those as part of their overall care and support plan. We have been very aware of the anxiety amongst our consumers, carers and families about the loss of service and discontinuity, and often the relationship with the service provider is as important as the service they get from that provider. It is an area, as I said, that we are incredibly conscious of and are diligent in protecting for our consumers, carers and families. We have had the benefit of seeing the two different trials, and seeing what works well and what can work better out of that process, and also the benefit of, in some cases, seeing the more advanced implementation in other jurisdictions, which has seen some of those things quite frankly go wrong for people. We are taking those lessons very seriously and, not surprisingly, it would be expected that I would protect every dollar that I have, like Captain Blackbeard with his buried treasure, so we absolutely will hang onto the dollars until we are confident that the individuals themselves will be well catered for, their plans are stable, and their relationships with their administrators and service providers are stable.

Mr C.J. BARNETT: I accept that the NDIS is evolving, but given that my understanding is that the NDIS will deal with disability, I do not see mental health as its responsibility. My question therefore is: how does the minister see the Mental Health Commission relating to the NDIS in Geelong, given now that many people with both physical disabilities and mental health issues get both cared for by an existing provider? I accept what the commissioner said about the current situation, but there will be growth in that area.

The CHAIR: Minister, given the time—we are about to hit one o'clock—do you want to finish this appropriation before one o'clock?

Mr R.H. COOK: I will invite the Mental Health Commissioner to answer, very quickly, Chair.

Mr T.M. Marney: So far, our dealings have been with service providers in both the hills trial and the south west trial. Our relationship is directly with them, and we undertake an advocacy role as well, on behalf of our consumers. We have not experienced some of the dislocation that has occurred in other jurisdictions. Both trials have taken a focus on the individual, and rigorous assessments for individuals, including in cases when mental health issues are likely to cause permanent or lasting functional impairment. That is the key test criterion that we oversee and ensure that the service providers are looking at when they are doing their planning. I understand the risk and, as I stated in the previous answer, it is something that we are watching very closely. Again, we will not let go of a dollar until we are comfortable that everything is in place as it needs to be.

The appropriation was recommended.

Meeting suspended from 1.00 to 2.00 pm

[2.00 pm]