EDUCATION AND HEALTH STANDING COMMITTEE

HEARINGS WITH THE MENTAL HEALTH COMMISSION

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 11 AUGUST 2021

SESSION TWO

Members

Mr C.J. Tallentire (Chair)
Ms L.L. Baker (Deputy Chair)
Mrs L.A. Munday
Ms C.M. Collins
Mr K.J.J. Michel

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Hearing commenced at 10.32 am

Ms JENNIFER McGRATH
Commissioner, examined:

Ms KIM LAZENBY
Head of System Development, examined:

The CHAIR: Thank you so much for joining us today. I will just begin with a few formalities. I would like to begin by acknowledging the Whadjuk people of the Noongar nation and I pay my respects to their elders past, present and emerging. On behalf of the committee, thank you again for appearing. My name is Chris Tallentire; I am the member for Thornlie and Chair of the Education and Health Standing Committee. I would like to introduce you to the members of the committee today: Caitlin Collins, member for Hillarys, and Kevin Michel, member for Pilbara. Going around the table, we have our Hansard reporter; Rachel Wells; and Catie Parsons, our principal research officer.

I just have a few other few formalities to do as well in terms of the procedures. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege. However, this privilege does not apply to anything you might say outside of today's proceedings.

If it is agreeable to you, I am happy if we can use first names, just to assist the flow of consideration.

Ms LAZENBY: Absolutely, yes.

The CHAIR: Thank you very much for that. You have provided us with some information packs. If you would like to begin with an opening statement and perhaps guide us through some of this information, we have a series of questions to work through with you as well. I have no doubt there will be some overlap, but I am sure we will be able to accommodate that. So, Jennifer, over to you.

Ms McGRATH: Great, thank you. Yes, I did not want to bombard you with lots of papers, but I thought that, given your initial questions, the paperwork would probably be useful when we refer to it, just to make it a bit easier. Yes, if I can provide an opening statement, that would be good. It might just give a bit of context and help with some of the questions, if that is okay.

The CHAIR: Yes.

Ms McGRATH: Okay. Thank you for having me here. I think this is my third time coming to this committee, once previously in this role I think probably about 18 months ago; is that right?

The CHAIR: Janine Freeman would have been the chair of the committee.

Ms McGRATH: I think it was, yes, and then once previously at least probably a year before that when I was deputy director general of Education. It is always a great experience. It is fantastic, so thanks for the invitation here today.

I brought Kim with me because in Kim's role, head of system development, which sounds like a weird name, really, does it not—but her role is really the strategy, policy, reform part of the commission, so a lot of the questions you are talking about today are quite relevant in terms of that.

Just an overview in that in Australia, further funding for different types of mental health services are provided by different levels of government, as you probably understand—commonwealth funding and state funding, so some of the documents today will help explain some of that. The

commission commissions about $1 billion a year for mental health and alcohol and drug services. Interestingly, we are the only commission in Australia that actually has purchasing power and the mental health funding as part of it, so we are the only real commissioning body for mental health. In other jurisdictions it goes through their health department.

The mental health treatment services within WA are provided by the public health system, so the health service providers, predominantly, and there are obviously private mental health services out in the community as well, and then we have our non-government services that provide the accommodation, supported and community services, so we basically have the health service providers and then the NGOs as part of who we commission. The actual Mental Health Commission only provide a couple of services themselves. Unlike a lot of other government agencies that actually provide services, we do not; we commission most of them. However, we do run the Next Step drug and alcohol hospital—"hospital", we call it; it is a hospital—and we do provide some other training-type services as well, but that is a very small portion of our entire remit.

We are guided by, in terms of strategy direction, our 10-year plan, we call it. Its technical name is *The Western Australian mental health, alcohol and other drug services plan 2015–2025*. That has obviously been in existence for about six-odd years now, so we are six years into that, but it does provide us our strategic direction and our road map for services, and it is based on the foundational planning framework, which is a national framework of services.

Last year the then Minister for Mental Health released a document called the *WA state priorities* for mental health, alcohol and other drug, and that is one of the documents we have provided there, which was really to focus in on what would be the priorities for the next four years, because that 10-year plan is obviously quite big, there is lots to do, so what would be the four years. That has really been our focus target, so a lot of things we will talk about today flow from that document. It also aligns with the sustainable health review. As you know, that was all about, you know, trying to do that cultural shift for all health and mental health services towards preventive and community care rather than being so hospitalised, so that is very much aligned. The 10-year plan is basically saying the same thing. Currently, we have three reform projects, so that transformation that we are talking about that will move us in that way, moving away from just hospital services to more community and preventive-type care. There are three. One is the infant, child and adolescent task force that was being established earlier this year that will really focus on children and adolescent mental health services, so zero to 18-year-olds. That is currently nearly halfway through; the final report is due in November and an interim report will be coming out by the end of this month. That will look at basically the rebuild of the zero to 18 public mental health services for that age group.

[10.40 am]

The second transformational project is the development of a road map for our what we are calling community mental health and emergency response for the state. Community treatment services are—I will use the word; people do not usually like me using this word—the outpatient services for hospitals, so when we fund the health service providers, we pay for inpatients, so that is bed-type services, and then the other side of it is the outpatient services, so all the clinical supports for people who are still quite unwell but once they leave hospital and then we look after them in the community. That is significant, about a third of the funding that goes into all mental health, and we really need to pull that apart and look at contemporary models of care. Those services are under a lot of pressure at the moment. There is a huge focus in the next 12 months on developing the way forward for that. Then the third project or reform initiative that you will have heard of is the Graylands task force, which is the decommissioning and reconfiguration of mental health services at that site.

Finally, also late last year, and it is another document that we have provided you there, we did a lot of work around young people, so the zero to 24-year-olds, and priorities for action. This was work that we did to bring people from across the state, community members, young people themselves, to really say—a lot of work has already been done, but what needs to be done first, what can be done and then prioritised, and we can talk more about that. That is an important piece of work. Finally, and it was one of the questions that you also asked about, is the structure of the Mental Health Commission and the work that we have done around that, so we have provided you a couple of documents there. That final structure will be put in place on 4 October—very soon.

The documents I have provided—there are a couple of pictures there that help explain the mental health system, which was one of your questions about where are the services provided. We have provided a copy of our interim structure and the final structure I just mentioned. We have also provided a couple of documents there that outline the governance arrangements for the mental health sector, so not the commission but the whole sector, which is very new, which we only put in place just over 12 months ago. There are three documents that were released last year, which I have mentioned: the *WA state priorities*; the young people's priorities for action; and one I have not mentioned, which is the workforce strategic framework, which was released last year as well. There is one other piece of paper, which is a quarterly update, which we actually keep on our website, which actually tries to list all the current initiatives that we are doing for the state priorities. That might be some of the things you want to talk about as well.

There we go. Hopefully that gives a little bit of context and helps with some of the questions.

The CHAIR: Sure, yes, and you will guide us to some of these documents as we go through?

Ms McGRATH: Those documents, yes.

The CHAIR: Great; that is good. I will kick off, then, with a general one, a COVID-related question. Can you talk to the main impact still being felt by the commission as a consequence of COVID-19? If you could talk to that, please.

Ms McGRATH: Yes. So, interestingly—when was it, March last year—when COVID hit, the first couple of months in that, probably three to four months, really, we actually were seeing presentations go down at hospitals, because people were trying to stay away from hospitals. But then after that first initial lockdown, then we got back to if you want to call it normal—it is not really normal, is it—but presentations continued, they got back. We soon got back to where—we had seen that happen. There was an initial "That's great, our hospitals are not being overwhelmed with people with mental health issues", but then they came back. Anecdotally, people were saying that people came back probably a little bit more unwell because they had not been able to get services over that period of time. Also, initially, what we tried to do in terms of the COVID response was we provided some additional support, probably for about six to 12 months, for especially some of our services outside of the hospital sector, where people were still trying to be able to access services—supporting those services to move to digital ways of working or non-face-to-face ways of working, and that actually was really encouraging. For the providers, our NGO partners, that worked really well for them in most cases. There were certain clients that it did not work for, especially if they were new clients, who did not really have the relationships. There are some really positive things that have actually come out of the COVID experience.

From a hospital side as well we worked with, especially, the community treatment teams to try to do a lot more outreach rather than having patients come to the community. For example, in our hostels, where we have quite a lot of people with fairly serious mental health issues, we even got them iPads and all those types of things to actually start to ensure that they still got some services over those periods when it was more difficult.

One of the other things that we are still doing is we have bought—this is an example, I guess—some additional beds that are on standby just in case we have an outbreak. People with serious mental health issues—getting them to understand what they need to do and isolate and all that sort of thing could be quite difficult, so we have got some on standby, and if there was an outbreak in a residential facility, it could be quite difficult to manage, so having a place that we could take people and manage well. We have been doing that and we will continue to do that for the remainder of this calendar year, and then we will reassess whether we still need those beds then. Is there anything else that you would want to add to that?

Ms LAZENBY: We participated in the COVID recovery planning, and there are a number of initiatives that the Mental Health Commission commissioned in that. That is included in the WA COVID recovery plan. We could provide some further information about those programs, but that was both in the youth and the adult space to try to provide support into the recovery period.

The CHAIR: WA police reported a decrease in drugs coming into the state, and a decrease in drug usage, as well. Did that have an impact on your operations?

Ms McGRATH: Yes, and I should have mentioned that, because that was another positive. Meth use definitely went down, which was good. It is starting to go up a little bit again, but overall what we found is there has been a lot more alcohol use, and more softer drugs, if you want to talk about, like cannabis, so some people have moved, because it has been easier to get cannabis and alcohol over that period of time. That is what we have seen, and I think the meth drop was definitely just because of difficulty to get access to it, but I think, over time, people work out how to.

Ms LAZENBY: There are also new challenges, I guess, presented in the alcohol space. In particular, what people in the community were raising concerns about was the online sales of alcohol, being able to have alcohol delivered to houses, to people's homes, therefore making it more difficult to monitor and enforce that people over 18 are being served alcohol. That was being raised with us, and we have been working with the licensing authorities to try to figure out what is the best response to that. It is not such an issue now, I must say, because now we have gone back to normal opening hours et cetera, so it has much more gone back to normal patterns, but during that period, during lockdowns or when people were not able to go and sit in hotels et cetera, definitely there was a big spike in concern about people under 18 getting access to alcohol that was delivered at a moment's notice by ringing up and ordering it.

The CHAIR: A lot of people reported anxiety issues in general around COVID. Was there ever any sense that this was a shared community pain and therefore that the anxiety was somehow shared across the community?

[10.50 am]

Ms McGRATH: Look, I think one of the positives, again, from COVID is the understanding about mental health, because there is still a fair bit of stigma around mental health and alcohol and drug, but from the mental health perspective, the positive thing I think around COVID is there has been so much more discussion around what mental health is, and it is a pretty fine line between being okay and not okay, and the community's desire to help one another. Anecdotally, we know—I am not quite sure if there is any evidence out there—there are a lot of things being written about how COVID has brought communities together. In terms of loneliness and all those types of things, there have been a lot of things that actual community groups—we know, from the commission's perspective, and we know this is part of where we want to move further into and take a greater role in, is: how do we help? Because we know that there are individuals or community groups out there all saying, "We want to do more, we want to be able to help, we just don't really know how or what to do." That is part of the work that we actually want to expand our role in. We traditionally have

not really got into that sort of nitty gritty—how can we help individual groups, whether it is local councils or just sporting groups et cetera. What role can we provide in supporting and helping to facilitate, whether it is training, resources et cetera to help general community people help one another. I will come back to that when we talk about our role as the commission in terms of why we changed our structure and that as well, because that is an example of why. That is where we see our role: how can we actually provide that greater support across to the community? That is a positive.

I think the jury is out in terms of the evidence and the stats around what real impact has COVID had on people's mental health. We do not know the answer to that yet. We know from some studies that have been done, especially in younger people, that it has impacted them. How much is it impacting people in WA compared with other states if they have had more lockdowns or even compared with overseas where they have had a lot of deaths? If you sat back, you would think, "We've been pretty much not impacted here", but people, I think, especially young people, still have been impacted in terms of understanding what does this mean for my future. Is the world a place that you can—there is all that uncertainty.

The CHAIR: Were there any particular services you wanted to mention, or perhaps wait for the governance?

Ms McGRATH: No, no, we can wait.

The CHAIR: Can you talk about some of those services that you have brought in to deal with the COVID problem?

Ms McGRATH: Yes. Look, I guess, in terms of COVID itself, we probably have not said, okay, we need to then do more of these types of services. As I mentioned, we did do some specific funding in the COVID period to actually help agencies and organisations get themselves into that sort of non-face-to-face, and if there was increased demand. That has slowed down now, but our overall direction is still the same. We need more services that are in the community to support people so that they do not end up in crisis and end up in a hospital. That is the long-term plan, and there are lots of things that we have done over the last 12 months, and with the recent pre-budget announcement, which we could talk to you about now today. We did not know that that was going to happen; we thought we might have had to wait until September, but we can talk to you about some of those services, that that is the direction that we are heading in.

The CHAIR: Okay. I will hand over to Caitlin now to ask some questions around the governance, but we can come back to that.

Ms C.M. COLLINS: We understood that the commission last year commenced the new interim governance structure in place. Can you just tell us a little bit about that new structure, how it is working so far, and, given that it is an interim structure, when it will be replaced or reviewed?

Ms McGRATH: Yes. I think there are two things here. One, we did a lot of work around the governance of the sector. That came out of the clinical governance review, the Bryant Stokes report from a couple of years ago. When I first came to the commission two years ago it was, okay, we need to actually work on some of those things. That was about governance of the sector and how do we bring all the players—in the mental health area, there are a lot of players— together to actually make decisions and manage and support the transformation. The second part, which I think you might be actually talking about, is the internal structure of the Mental Health Commission itself. Again, when I started at the commission, one of the first things I did was talk to people internally and externally about the commission's role, what we did well, what we did not et cetera. The minister was very keen to explore and be clearer about what our role is into the future. Long story

short is that the Mental Health Commission's role is to take a system view and ensure that the mental health system for WA is to work. That 10-year plan, that is the whole system. That includes state-funded and commonwealth-funded services, it includes hospital services, it includes NGO services, and then general community around prevention et cetera. We had to take a whole-of-system, whole-of-government view of that. In terms of doing that, we then had to look at internally how we worked, because we were not set up to manage and support that leadership role, because we would not have control. We do not have control of all of that, but if our role is to lead all of that, how are we going to make that happen? One was that governance that we needed to bring in place, and I will talk about that in a minute, but also there was the internal component.

We worked through how we wanted to operate. There was work with staff over a period of about six months to go, okay, so what are we doing well, but what do we need to do and change and look different to actually take that whole-of-leadership role across government? There were six guiding principles that came through from staff and with external consultation that we did. One basic one, which had not changed, is that services need to be people-centric, but we needed to take a systems focus rather than looking just narrowly at sort of implementing a service or a program—so, a whole-of-system view. We had to have the capacity to reform, so it is not business as usual in the mental health space. The future is about transformation. It cannot be the same as usual because we will not get the outcomes we need. We had to have the ability to collaborate, because we cannot do it all on our own. We have a couple of hundred people at the commission, but it was about how do we bring the system together, the leaders in the system, to get that change. End-to-end ownership of outcomes—interestingly, alcohol and drug came into the commission in 2015 when it was amalgamated. There was still no amalgamation between alcohol and drug and mental health services, so our new structure and the way of working had to actually reflect that, and it will, and that is happening now. That is an example of end-to-end outcomes. And, obviously, everything we did had to be based on evidence.

We went through that process; then, that created a new senior executive structure. The leadership of the organisation was really important. If we are going to be leaders, I need the right leadership team. We put an interim structure in place, because we had to go through, for the longer term and the final structure, the Public Sector Commission, and that took about six months. We took the decision last year to put the interim structure in place. It was quite a flat structure, but it was a structure that focused on those principles that we talked about there. No longer was there alcohol and drug over there and mental health there; under each of the positions, that was all together, alcohol and drug was together. But it was also to try to break down some of the silos that we had in the organisation—one part of the organisation did not know what the other was doing, so it was bringing that together.

We recently got sign-off on the final structure from the Public Sector Commission, so we are now actually implementing getting people into the new positions of that structure, and we will be formally starting the final structure we are planning on 4 October. It is one mechanism. Structures do not fix everything, but it is one mechanism of helping us to achieve that bigger picture transformation reform–type agenda. Does that make sense?

Ms C.M. COLLINS: Yes, absolutely. As part of this restructuring, in 2020, the role of the Chief Medical Officer Mental Health was created. Is this a response to COVID? Is that why it was created, and do you think it will be a permanent role?

[11.00 am]

Ms McGRATH: It will definitely be a permanent role. She has enough work for the next 20 years. But, no, that actually came out of the clinical governance review—the Bryant Stokes review.

Ms C.M. COLLINS: That is what you said, sorry.

Ms McGRATH: I should have mentioned that. That was a really critical part of the commission having the credibility and expertise to actually bring together the whole system. We did not really have that clinical expertise. It is pretty hard for us to sit at the commission there and think that about all the things that need to be done from a clinical perspective if we do not have that. It was really important to get someone who was highly respected, understands what they are doing, to actually be that interface and work with them. That is critical to the governance of the system. There is a picture that we have provided you there on the governance, which is the creation of a mental health executive committee, which reports to the minister, and also a community mental health, alcohol and drug council.

In a beautiful world, where we want to head towards, you would actually have one committee and all those stakeholders would actually be in one. The maturity of our system at the moment is that that would be a little bit dysfunctional right now. The first step was to get both of those committees working well, so one is really around the health service providers and getting them to work together. Health service providers have only been in existence for about five years now. What we need from mental health is one system in WA, and each health service provider has their own board and their own responsibilities. What we were seeing is that we were getting five health service providers rather than a whole system for mental health. This is the mechanism that we are using to try to bring and create that. Then, on the other side, is the community mental health, alcohol and drugs. As you will see, the people who we have represented there are all the other parts of our system, in particular, WAPHA, the commonwealth service component there.

We have mechanisms in place to make sure that both know what they are doing and understanding, because it is all one system. Where I would love to move to is maybe in 12 months' time—that has been in operation just over 12 months—we will have a review in a couple of months on how we are going. We are actually surveying all the participants at the moment, asking, "How is it working?" Ultimately, we want to bring that together as one because for the whole system transformation, it is about integrated services and we cannot have hospitals doing their thing over here and then the community services here, so it is how we integrate that. The Chief Medical Officer is an important position in that process.

Ms C.M. COLLINS: Thank you. That answered my next question.

The CHAIR: Just switching to some of the priorities and major projects, which of the projects that the commission is undertaking as part of the *WA State Priorities Mental Health, Alcohol and Other Drugs 2020–2024* work is proving to be the most challenging? Which ones would you care to nominate?

Ms McGRATH: I might answer that in a different way. Challenging but most important were the two that were funded out of last year's budget process and are part of the state priorities, those two being the establishment of a community care unit. This was a 20-bed facility. If we explain our system, you have all these hospital beds over here that are always full. We know that on any one day, 25 per cent of people in those beds should not be there; they should be in the community, but they are still quite unwell and need a lot of care, 24-hour, seven day a week assistance. In our current system, the services that we have outside of hospital in that supported accommodation space do not have services that are highly supported enough, so they are low on need. This gap that we need to fill, and what we call rehabilitative-type services—one of the models of care is a community care unit. This will be the first facility in the state. That will take people who are sitting in a hospital bed now and could have been sitting there for a couple of years, not even with a bedside table; you know what I mean, you are in a hospital bed. It is not rehabilitative; you are just keeping them safe.

Those people could be in a facility like a community care unit that has 24/7 supports, every day clinical in-reach, supporting people. Usually support anywhere from six to 18 months in there can get people to a point where they can move further down into the system and then move into the other types of services that we do have for lower-needs people. We actually help people get well rather than at the moment with our system, where we do not have these types of services. They are high cost, so they are not easy to establish.

The CHAIR: These are the locked wards and things like that?

Ms McGRATH: No, they are in hospitals. The community care unit, which will open in the next few months, will be in Orelia in a community area. It is actually an old aged-care facility. We are just modifying it. Yes, it will be 20-bed. It will be in the community. People will start to learn to live in the community well rather than being stuck in a hospital. You would not necessarily be in a locked ward; you would maybe be in a bed. There are people who could be involuntary. We call them secure beds, or still voluntary but high-need type people. The high-need type people, hopefully we will get them out of hospital into these facilities and they will be there for a period of time but then be able to move on and get well and only have to go back to hospital when they are in crisis rather than always being in hospital and actually not really getting better. That is challenging because it is a new model of care. Mind you, it is done in the eastern states, so it is proven models of care. Like any new model of care, that will be something that we will be continuing to work with. Richmond Wellbeing was the NGO, the provider, which is a great organisation—very mature. It is a partnership between them and South Metropolitan Health Service. They will be providing the clinical in-reach. They have a great team that are working together. One reason it is a challenge is because this will be a model of care that is an integrated model. That is a good thing because we want integrated services—hospital staff working with the community. That is a challenge for people to get used to and actually start to work in that sort of way. All the initial signs are that it is starting to work well. In the next two to three months, that facility will start taking patients from within hospitals. That is really exciting.

The other one was the interim youth facility. There will be a permanent one built. There is some capital money that is being provided and, hopefully, that will start up at the end of 2023. We wanted a service up and going as soon as possible. We found a facility, again, a similar type of model but for 16 to 24-year-olds. That will be at Queens Park, as announced tomorrow. It will open a bit later this year as well. Again, Richmond Wellbeing is the NGO provider there, with East Metropolitan Health Services providing the in-reach. They are probably the two most important and probably the more complex.

The CHAIR: And those announcements, they are tomorrow?

Ms McGRATH: They are already out there. Where the site is will be announced tomorrow.

The CHAIR: Great. Just going back to the issue of anxiety, but this time in terms of climate change and the anxiety that people are feeling with regard to climate change—is the commissioner addressing this specifically with any work?

Ms McGRATH: No, we have not, but we were part of work that the Department of Health did around their climate change and it came out of the sustainable health review—the work they did there. We are not doing anything specific but we are linked into the work that they are doing across their health service providers in terms of understanding climate change. There are some other specific things that we have done previously—for example, working with farmers because of drought and all of those types of things that can impact there. Kim will probably say that it picked up in young people.

Ms LAZENBY: I do not have the exact stats on me, I am afraid, but we could probably have a look at the data that we collected. For the young people's priorities for action work, we wanted to understand some of the concerns about young people as part of the basis for that. We engaged YACWA to work with young people on our behalf to talk to them about anxiety—what is concerning them. Issues around COVID, climate change and general anxiety came up. In my recollection, they were not the real highlight standout issues. One of the standout issues was stigma and discrimination. For CALD young people, racism came up as the key thing, particularly racism exacerbated by COVID.

[11.10 am]

In the early days when it was all the talk about it being the virus that came from China, what young people reported as part of those consultations was that they then suffered racism, particularly young people from Asian backgrounds, and stigma and discrimination. And LGBTIQ young people, who we made sure were included as a particular vulnerable group, also talked about stigma and discrimination, both generally in the community but also from services et cetera. All of those issues, I guess, were issues that came up. I know climate change definitely came up. I cannot give you the exact data on that, but we have some information that YACWA provided to us. They not only talked to young people individually, they ran some focus groups and workshops. Also, we ran a number of workshops ourselves. We organised those and we made sure that young people were invited by reaching out to our key stakeholders.

Touching on some of the information that Jen talked about previously, we also reached out particularly to sports groups and arts and culture groups. We worked with our colleagues across government to mine their distribution lists to make sure that we invited the multicultural services et cetera, so that we had as broad an invitation list as possible. We got really good participation from youth groups, sports and culture et cetera, who we would not traditionally see as part of the mental health sector but we connected with them. They bring forward those sorts of concerns when we talk to them. They want to participate because they are the interface with young people. They have young people come to them, of course, and young people participating in their activities who may have mental health issues—potentially anxiety or something more serious. These groups do not know exactly what to do about that, so they want to be engaged in those sorts of community efforts to support young people.

We got some really interesting feedback. We found that people were really keen to be involved in those sorts of community-wide efforts. Currently, one of the things we are doing to build on that is to expand our methods for communicating with what we call stakeholders—basically, people across the community broader than just the mental health system—to enable them to connect with what the Mental Health Commission is doing, to be involved, to provide feedback and even to be involved in the co-design of services et cetera. The Mental Health Commission has a really strong track record of people with lived experience being involved in co-design and in our governance arrangements, which we could talk about. We want to make sure that we maintain and strengthen that involvement of lived experience, but also broaden that to the broader community groups et cetera so that we can really harness the efforts of the whole of the community in a more systematic way, I guess.

The CHAIR: It would be good to talk about that and how you did bring those people in, but I just want to go to another issue, something that is in the sustainable health review and the state public health plan, and that is reducing alcohol consumption. It just seems that alcohol is still too cheap.

Ms McGRATH: It is the biggest harm.

The CHAIR: Yes. If you can talk to that, please.

Ms McGRATH: We have been really successful in some of our public education campaigns—"Alcohol.Think Again" and the one about young people and parents. Lots of other places around the world have used some of the material. But we need to start, and we have been, trying to tackle all different parts around the harm. And it is alcohol; alcohol is the biggest harm of all the drugs that we have. We had commissioned a piece of work from—I cannot remember the name—around the minimum floor price. That is a way that lots of other jurisdictions are starting to tackle that. We have just got that report back. It is saying what we thought it would say in terms of, yes, there is a lot of evidence out there that it could work. We are just getting that QA'd with a couple of our very respected people in the area and then we will be hoping to work with government about where to next with this. You know, where does that fit, and is that what our community wants? I think it is a bit about educating as well.

The CHAIR: Sure. Is there a tendency for people to think that alcohol is about physical harm and to overlook the mental health harm that it does?

Ms McGRATH: Look, I think it is both. With our recent campaign, you have probably seen that one around cancer impacts. I still do not think that most people realise that alcohol is actually related to cancer specifically, so there has been a lot of good feedback from that education campaign as well. I think the broader thing around understanding the link between mental health and alcohol and drugs is still something that is a work in progress. It is like, well, which one started first, you know what I mean? It actually does not matter, but there is a link. There is a lot of work we are doing at the really hard end of co-occurring—both alcohol and drugs and mental health—but I think where you are coming from is even down the lower end, you know what I mean, in just the general community understanding the impact that alcohol can have on the rest of your life and then internally.

The CHAIR: I think I might have even seen it mentioned in some of that advertising, and it is excellent work that has been done. How does WA rate compared with other states, other jurisdictions? Are we particularly bad? I think I have heard that.

Ms LAZENBY: With alcohol consumption, we are relatively high. We can get you the exact data on that but we are relatively high.

Ms C.M. COLLINS: I read an article a while ago that there may be a decrease in the consumption in ages 18 to 25, but we are seeing a huge spike in middle-aged women in particular. Is that true?

Ms McGRATH: We have done really well, I think Australia-wide, in terms of younger people. There are less younger people drinking at levels that probably is not acceptable or appropriate. There is still a lot of work to be done, but it sort of is on the right trajectory—going downwards. But you are right: in other age groups, we are seeing differences. So it is changing.

Ms LAZENBY: And also we have some of the largest outlets by sales volume in Western Australia of the country, if you look at it that way as well. There are surveys which ask people how much they are consuming which give you certain data. There is also data that is collected through the licensing regulatory processes around sales volumes by outlet. WANADA have some very good information about that, I think, on their website that we draw on and use as well in targeting our campaigns. There is no doubt that some of the big outlets across the country are actually located in WA.

Ms McGRATH: Kim is right; we actually have really good data on where alcohol is being purchased, which then is great for us. It is good to do the whole-of-public education campaigns at one level, but we also have to look at different levels in terms of targeted campaigns. For example, if it is with an Aboriginal community in the Pilbara or something, that would be very different from doing a targeted campaign in the south west or something like that. We are really looking at how we target.

That is what we have been doing with the work around FASD as well, in terms of using all of that data and then actually working with specific communities about how best to help educate and that early intervention and prevention stuff.

Mr K.J.J. MICHEL: With regard to the alcohol consumption you are talking about, do you think it is related to lifestyle and the hours you are working? I mean, I went up to the Pilbara in 2000 and the Pilbara was the biggest drinking capital in Australia. Today, it is still the same. What I noticed was that when the hours changed, that is when the whole concept changed. I think people were more active, they were doing more sports with their children and also the family, but now that has gone away.

Ms McGRATH: I am not aware of any specific link to that.

[11.20 am]

Ms LAZENBY: Well, I guess that is the sixty-four million dollar question, in a way, is it not: why are some communities drinking more than others? The public health approach, I guess, would say that the key question is: what should you do about it from a public health measures perspective? I know that people like WANADA are absolutely on the record as saying that in those areas that you have just talked about, alcohol is cheaper than water, so what you need is things like minimum floor price and all of those other measures that were taken with tobacco to both deal with supply as well as deal with demand. So, yes, you can work on sort of changing the kind of cultural factors, if you like, in the community, but the success of the tobacco campaigns was also not just trying to convince people not to smoke, but putting in place what is referred to as those public health measures to regulate supply, to prohibit supply under certain circumstances, you know, packaging, making it illegal to sell tobacco under certain circumstances, and raising the price et cetera. That whole suite of public health measures is really the area that we need to, as a community, be focusing on, but there has to be community licence for those, and that has to be built. There was in relation to tobacco, but it is not clear that there is in relation to alcohol.

Mr K.J.J. MICHEL: The reason I put the question up was that if you go to a camp, you can get a $1 can of beer, and you are allowed to drink from seven to nine. It is just like speed dating; everyone is just drinking.

Ms McGRATH: Yes.

Mr K.J.J. MICHEL: I mean, I do not know if the Mental Health Commission is working with the mining companies to say, “Hey, hang on, you need to start cutting your hours of supply or limiting the number of drinks”. The law states that if you are intoxicated or found that you cannot drink, you cannot supply that person, but up there, I have seen guys who will drink two cases and they are still fine.

Ms McGRATH: There are all the occupational health and safety rules and all that sort of stuff that are really driving it, and mental health is now part of that as well. I think, in general, most organisations—so, all those mining companies—have this at the forefront of their mind. I know only the other day that I heard—I cannot remember who it was—but one organisation now only sells mid-strength beer et cetera and they are limited to X number of days, and they are actually having difficulty recruiting people now because they do not want to go to that. But I think it is front of mind for organisations, because they know that for the long-term to have a very productive, healthy workforce, they actually have to have some of these things in place. But it is something that we are continuing to work with. Look, one of our focuses is working with workplaces, specifically around mental health, but also in those preventive measures from a health perspective.

The CHAIR: Thank you. To another topic: children and young people. Caitlin, please.

Ms C.M. COLLINS: The Minister for Health recently announced $129.9 million in the state budget for youth mental health services, as you know. Can you please just give us some detail about how this specifically will be used?

Ms McGRATH: Yes. It was fantastic to see those election commitments happen, and they actually came from some of the work that was done with the *Young people's priorities for action*. In that piece of work that we did, we were very keen to find out what things could be done that young people and service providers et cetera said could be done without any money. There are plenty of items in there. I think is it close to 50 or something that we identified that could be done with no money. So that is just a bit of hard work—organisations and government getting together to look at providing services or doing things differently with what we already do. But the other part was also trying to identify the gaps in the system of services that young people said were needed, and then prioritising them. The election commitments for youth that were announced actually come predominantly from that process. There is lots more to be done, but we are really happy, because we are sure that these were the things that young people actually said.

I have a piece of paper here. In terms of young people, for the first time, we will have a child and adolescent and youth forensic outreach service. This will be a specialist service to assist existing community and inpatient services that will provide support and assessment for 10 to 24-year-olds who have been in the state system—for example, young people who have ended up in Banksia. We did not have a dedicated service that looked after the needs for those types of kids. It was just part of a normal service that we had, and really a forensic service needs to be something specific. This will be the first time that we have a service for that. That was $13 million and will start in January. There are really successful programs that are run by North Metro Health Service called Youth Axis, YouthReach South and YouthLink. They are all really great services but with huge waiting lists. There was money to expand those services, so they will start just after Christmas as well and will basically reduce the waitlist down. We had a program called the youth community assessment and treatment team—YCATT is what people call it. This is a service that is run out of south metro and it is an outreach team. A lot of our services are actually in-reach teams, so people have to come to the service. A lot of young people do not like to come to services. We are talking about young people who really need some support. This is a service that does work really well, but we only had one in south metro. That one will be expanded, but we will also have one in north metro and east metro to provide support for those young people. There were psychological support packages. One of the issues that we have is when families end up in an ED in, say, the children's hospital, or it could be in another hospital, with their 16 or 17-year-old. When they leave hospital, there are often very few supports to help parents. It must be terrible to just be told, you know, "Off you go", when your child has tried to attempt to take their life et cetera. What we were able to get up as one of the election commitments was some support packages that would help people and families once they leave, so more in-reach coming to the home and helping in the home or providing support to parents. One is a youth step-up, step-down facility. As you know, there are step-up, step-down facilities for adults that have been rolled out around the state from the previous election commitments from the Labor government, but this is a youth step-up, step-down, so this will be the first one in WA. That might look different to an adult one, but basically a service for young people—so 16 to 24-year-olds predominantly—coming out of hospital if they need just a little bit more support. They are usually only about a 30-day service, so it is to sort of to help you transition back out. But, importantly, the step-up is if you are in the community and you are starting to struggle with something, to really prevent getting into crisis and ending up in ED—this is how the adult ones work, anyway—there is a 30-day admission to this unit, where you have supports around you to help deal with usually a specific issue. That can prevent them ending up in crisis—that sort of thing. That will be really

exciting. We have not had one of those before, but it might look different to the adult one, as I mentioned.

Ms C.M. COLLINS: Is the task force that you mentioned the task force into public mental health for children and adolescents aged zero to 18?

Ms McGRATH: Yes.

Ms C.M. COLLINS: Because I thought you said before it was to 24?

Ms McGRATH: Yes, these were election commitments. The $129 million was for actual services for election commitments, so they are the things that I am just mentioning now. The task force is a separate piece of work that is looking at zero to 18-year-olds. Predominantly, the services that we are going to give through the election commitments are for probably about 16 years, so young people—16 to 24-year-olds. The ICA—infant, child and adolescent task force—is zero to 18, and that is the public mental health stuff. That is the inpatient and the outpatient services. These election commitments will absolutely help and complement, but the ICA will actually look at the services that are needed statewide, not just in Perth Children's Hospital, in CAMHS—statewide. They are complementary pieces of work. The election commitments are like a start on those services in the community, but the ICA final report will talk about how we support the zero to 18s. So, yes, there is some overlap, because they are quite different types of services that are needed for really young people.

[11.30 am]

It is not, I guess, well communicated in terms of thinking that, you know, really, really young children would need mental health services. I think a lot of people think: oh, no, mental health issues, you find them when they start at 12, 13, 14, and then, you know, we start to address it when kids get to 16 to 18. That is very wrong. We can actually head a lot of these things off if there are services for really young people. We are no different to every other state in Australia. Everybody's system has moved to dealing with the kids when they get to 12, 13, 14 and then teenage years rather than actually having services for really young people and stopping them getting to there, or by the time they get to there, it is sort of manageable. The normal prevention, early intervention type stuff is really what we need to do. So that is more the ICA, and the $129 million is about actual services for young people.

Ms C.M. COLLINS: The report you mentioned; is that the emerging directions paper?

Ms McGRATH: Yes. Yes.

Ms C.M. COLLINS: Will that be released soon?

Ms McGRATH: Yes.

Ms C.M. COLLINS: I think you mentioned this paper as well. The *Young people's mental health and alcohol and other drug use: priorities for action* paper was released in December 2020, and the commission is now working on the implementation plan. We were wondering what exactly this plan will look like, and what services are supported by this plan? You may have touched on some of that already.

Ms McGRATH: Yes. Did you say that was the drug and alcohol?

Ms LAZENBY: No, the YPPA.

Ms McGRATH: Oh, that is the YPPA, yes, sorry.

Ms LAZENBY: Do you want me to talk about that?

Ms McGRATH: Yes, you can talk about that.

Ms LAZENBY: We have pulled together the agencies that were involved in the development of the young people priorities for action—YPPA, as we call it for short; it is a bit of a mouthful—so we pulled together those agencies again and we have asked them to start thinking about how they will take forward and progress the initiatives that they suggested as part of the YPPA, given that it had a range of initiatives across different government agencies. The implementation plan will have several components. One will be the immediate actions, so we are asking agencies to think about that now and to commit now to how they are going to take forward those immediate actions, which are, by and large, things that, as Jen said, things that can be done straightaway without the need for submissions for further funding et cetera. Some of those have already happened, for example, things like the regional Aboriginal suicide plans, the Think Mental Health campaign et cetera, so some of those have already started. That will be a key component of the implementation plan, but we have also asked agencies to start thinking about, given the lead times in some of these things, those initiatives that we have identified as top priorities in the YPPA.

The YPPA, as you would have seen, is split into immediate actions, top priorities and next steps, which are longer term things. The top priorities are things that we know we really need to do, but we do not have a model of care, there is no established initiative, it is not a matter of just expanding something we are already doing to a different site, for example, and would need considerable development, but is something that is really important. In particular, it might be that we need to co-design those to make sure that they are really relevant for communities. So anything that we would do in terms of Aboriginal communities, we would want to work very closely with those communities to co-design those initiatives so that they are culturally appropriate. It might be even that we want to work with different parts of the education system beyond just the Department of Education, who we have good close links with, as you can imagine, and so there might be some relationship building as well as some design that we need to do. So that will be another key element of the implementation plan. It will include—the top of those top priorities, I guess, we have already identified, which are the things that have been announced through the budget. Those things have been funded, and some of that co-design and development work will get underway straightaway if it has not been already as part of the preparation of the advice to government about what is needed. They will be identified.

Ms McGRATH: One other thing that is really important about that document, rather than it being just a piece of paper—we did that because, really, what we wanted it to be, it is not just about the Mental Health Commission. This was whole-of-government, about young people, because it is not about just the services we are providing in our system; it is the services that are provided across lots of government agencies, and the NGOs that they work with. Because one of the main things that comes up when you talk to young people—now or even 10 years ago, young people want services that are holistic services. They do not want to go over there for mental health service in an office environment, and then go over here for an alcohol and drug service, because we do not really want to be known as going to get an alcohol and drug service, or even a mental health service. The feedback that comes all the time is that young people, to get them to engage, there are services that do not look like the services that we currently have, you know what I mean. They are totally different. I might have a mental health issue, but I am also really struggling at school and really need some employment, or I have family issues at home, or I am homeless. Those types of things. You cannot fix someone or help someone's mental health issues if you are not fixing the other things, and government does not work that way. We do not work in terms of those holistic things. It was a really important piece. This document went through the director general's implementation group, so basically the health and human services DGs supported it. We took the lead, but the implementation of it is through basically all the social sides of government actually coming together

to do this. That is part of the work that we are doing now, in terms of changing the role of what we used to do, is very much from there. So, we see mental health, alcohol and drug as sitting in the middle of all those other government services that are provided, and how do we actually make that integrated so we actually get the outcomes for individuals and they are integrated—they are not sitting off on their own. That is a big part. This was sort of a real first step of us really trying to get that whole-of-government approach. It is not about even the commission having more services and more money to do things; it is about the whole system, how are we actually making it work so that individuals can get those services. I hope that makes sense, anyway.

Ms C.M. COLLINS: Yes, absolutely. Thank you.

Ms McGRATH: Sorry, Kim.

Ms C.M. COLLINS: Just finally, the Telethon Kids Institute uncovered some statistics about poor mental health in transgender youth in the Trans Pathways project; for example, 48 per cent of trans young people have attempted suicide. Can you tell us whether this is a priority of the commission?

Ms McGRATH: Look, we are really, really aware of that. Some of that will get picked up in the ICA some of the services that we actually do have huge, huge waitlists, and we do understand that those waitlists—that is where young people are very vulnerable for suicide et cetera.

Ms LAZENBY: Yes. We are very, very aware of that. I mentioned before, young people from LGBTIQ et cetera backgrounds were included in the consultations that we did to develop the YPPA, and we heard very loud and clear that stigma and discrimination were issues. Things like if they go into a service and they get rebuffed or some sort of discriminatory response just from the reception, then they will never go again. They are really things that totally make sense when you think about it from your own personal perspective. They are very important things and simple things, in a way, that we could take up that do not cost lots of money. We very much kind of heard those things, as well as, as Jen says, the need for services, specific services, but also support for practitioners and clinicians to work more effectively with young people from different groups, including those groups. What we are trying to do is in all of the different activities that we have in place, we are taking into account that group, as well as other groups that are particularly vulnerable. We talk about it as being vulnerable. With the implementation plan for the YPPA, for example, we have again made sure that we are incorporating the voices of young people, and, again, working with YACWA but also our own youth mental health network to, in a slightly different way this time, support a group of young people who are co-designing a way of providing us with advice and engagement with decision-makers and policy developers across the system to provide that advice directly to them, so that is something we are pretty excited about.

[11.40 am]

That steering group has got about 12 or 13 young people on it, and half of them identify as LGBTI, for example. There was an expression of interest done for young people to participate in that steering group and there was a really great response. We definitely are trying to make sure we hear those voices and we understand the issues specifically because, like any target group, we could miss the mark if we really do not pay attention to those voices and if we just do things in the standard way. We are trying to pick up on those issues in everything we do.

Mr K.J.J. MICHEL: I have one question on the $129.9 million: how much is going to regional WA, and specifically to the Pilbara?

Ms McGRATH: Specifically, for the regions, Hedland is getting an election commitment for a step-up, step-down facility, but that is not for youth. That is an adult facility.

Mr K.J.J. MICHEL: So there is nothing for youth? Do all the step-up, step-downs come under this $129.9 million?

Ms McGRATH: No. The step-up, step-down facilities that were provided in the previous election commitment across the state for adults did not include one for Port Hedland. But in this next one, there is one for adults in Port Hedland. From a youth perspective, out of the $129 million, there is a youth step-up, step-down, but that will be metro-based. That will be the only one in the state to start with.

Mr K.J.J. MICHEL: Thank you. So there is none in the regions then?

Ms McGRATH: No.

Mr K.J.J. MICHEL: We have a massive mental health issue.

Ms McGRATH: Yes, we know.

Mr K.J.J. MICHEL: Out of that, the share is $30 million going down to the regions. There is a constant cry in regional areas about mental health. From Perth right up to Broome, there is no mental health at all.

Ms McGRATH: We are absolutely so aware that for the regions, there is not equity of services across youth and adults for mental health—there is not. We have a long way to go to get equity. What I would say is that the infant, child and adolescent task force for zero to 18-year-olds is statewide. Again, as I mentioned, it is not about the children's hospital. It is way more than that; it is statewide. We are actually about to do some consultation out in the regions around that. We know that the services are going to have to be different there than they are in the metro, but we have to try. One of our principles for the ICA is equity of services across the state. So, I hear you.

Mr K.J.J. MICHEL: My next question is based on suicide prevention—if I can carry on to the next one.

The CHAIR: Yes. We are coming to the end of our time, Kevin, but please go ahead.

Mr K.J.J. MICHEL: So with the suicide prevention that we had, we had five deaths in one year. This should tell you a story that we need more facilities there.

Ms McGRATH: Yes, absolutely.

Mr K.J.J. MICHEL: The step-up, step-down facility was part of the election promise in 2017. We have still not delivered in Karratha, and we are talking about Port Hedland.

Ms McGRATH: The Karratha one was held up because of land issues with the way that the council —

Mr K.J.J. MICHEL: I know, and I tried to sort the problem out. I did a lot of consultation and it went back and forth: "It is the Mental Health Commission's issue; we have told them and given them land." It is just back and forth. You are not getting the actual story about it. I think we are playing with people's lives here.

Ms McGRATH: We absolutely know.

Mr K.J.J. MICHEL: Knowing something and not doing something about it is two different things. Sorry, I am getting a little bit difficult; I am very passionate about it.

Ms McGRATH: So are we.

Mr K.J.J. MICHEL: I have a lot of kids up there who have committed suicide, and two were good friends of mine.

Ms McGRATH: I know.

Mr K.J.J. MICHEL: Mental health is such a silent killer. We are not addressing the issue and seeing how we can all, as an agency, come together and try to get the step-up, step-down up and running.

Ms McGRATH: Yes. One of the things that was part of the WA recovery, which I did not mention but it is a really, really important part, is that we did manage to get approval and funding to develop specific Aboriginal suicide plans for each of the regions. This is the first time ever that that has been done Australia-wide. This is working with Aboriginal organisations and communities within each of the regions to develop their own plans. All those plans have now been developed. There will be a community liaison officer that will be funded through an ACCO in each of those regions to help work on grassroots-type initiatives to help the community where they see fit, because all communities are in different spaces and have different priorities. But youth is in most of the plans. I have been told it has been an absolute priority. Communities themselves want youth to be involved and to be a focus. I am not saying that is going to be everything and that is the answer and we are going to sit back and say we have sorted it, because we absolutely have not, but it is an important part of the way forward. The ICA will definitely look at equity of services across the state, which will include the Pilbara and all the regions. We are actually doing some consultation in the Pilbara in a couple of weeks' time.

Mr K.J.J. MICHEL: When I look at this plan that you have given me here, it does not say anything about Port Hedland. It is for 2024; it is a 2021 promise.

Ms McGRATH: Yes. Just to let you know that that update that you have there is not up to date yet. It is as at May. All the commitments that have just been announced last Sunday, and more detail that will come out in the next couple of days, will need to be added to that. That is always on our website, so you can actually see all of that on there. All the new stuff that has been just announced will not be on there. Sorry, I should have mentioned that.

Mr K.J.J. MICHEL: Do I take it the hospital treatment also still has not been updated? I do not see one region. I do not see the Pilbara region at all. From Perth right up to Broome, there is not one region there. Are we the forgotten nation?

Ms McGRATH: I will just mention that we do not have equity of services across the state and it is going to take us a while.

Mr K.J.J. MICHEL: You have Bunbury there. You have got Geraldton there. It is sad that all the mining wealth comes from there and there is nothing coming back to the regions.

Ms McGRATH: We have done an analysis. Where we have got to now, where the services are now, has taken years and years. It is not like we have an equitable plan that says: "Okay, greatest needs go there." That is not necessarily how services are actually developed over time. That is what we are trying to do to get to that. Our 10-year plan does that. It looks at all the demographics across the state and works out what services are needed. We know, for example, that the wheatbelt has less services than any other region. The least amount of services are in the wheatbelt. That is the worst, and it is such a big area that it has to cover. It is by far the worst. I take your point. Port Hedland absolutely needs more services, but every area needs more services. Our challenge is how we actually provide those services in the regions with a workforce that we can attract there. There are all different ways that we can do it, but that is our challenge and we need to continue to work on that.

Mr K.J.J. MICHEL: Is the Mental Health Commission talking to mining companies and seeing how they can work with them to finance a few things? They put $10 million into the hospital in Newman, and the one in Karratha I think they put in about $25 million. Is there an opportunity for the Mental Health Commission to have these conversations with the mining companies and put in some money

to get these step-up, step-down centres faster? I went to Punmu and Parnngurr and the commonwealth-built clinics, which were trucked in and plopped onto the bed—done and dusted. Why are we not doing things like that? We are just waiting for builders to come, build them all up and it is taking years and years for it to happen.

Ms McGRATH: That is with the two facilities that we are opening in a couple of months. If we had waited to build them—first, we had to get the money to build—it would have taken four years. We said, "No, we need facilities right now." We did an expression of interest and we found out what facilities actually exist out there in the community, and, look, there are some. I would have to say there is not a lot, but where we can use those and then modify them where we need to to make them suitable, that is great, because at least we can get a service up within 12 to 18 months rather than four years if we go to build. But we are going to have to do a bit of both. Building and doing anything at the moment takes a long time.

Mr K.J.J. MICHEL: We had an old hospital in Karratha. We just demolished the old hospital, which we could have repurposed and used as a step-up, step-down centre and other NGO offices. No-one seems to be—sorry.

The CHAIR: Kevin, I think we will have to come back to this. It has been a fantastic, really comprehensive introduction for us, as a committee, to really get a sense of where the commission's work is going. Thank you very much for that. It was an excellent overview. The issues that Kevin is raising are just an example of the sort of detailed work that I am sure we will be getting into over the course of this Parliament.

Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of transcribing errors only. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript of evidence.

We did not get through all the questions, so we might send a few on to you and we will also go through these papers a little further as well. Thank you again for the evidence today.

Hearing concluded at 11.51 am