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GENERAL PURPOSE STANDING COMMITTEE No. 3

Tuesday 15 September 2009

Examination of proposed expenditure for the portfolio area

MENTAL HEALTH

The Committee met at 12.00 noon

MEMBERS

The Hon. A. R. Fazio (Chair)

The Hon. G. J. Donnelly
The Hon. T. J. Khan
The Hon. C.J.S. Lynn
Ms L. Rhiannon
The Hon. R. A. Smith
The Hon. H. M. Westwood

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PRESENT

The Hon. B. M. A. Perry, *Minister for Local Government, and Minister Assisting the Minister for Health (Mental Health)*

Department of Health
Dr R. Matthews, *Deputy Director General, Strategic Development*
Mr D. A. McGrath, *Director, Mental Health Drug and Alcohol Programs*
Mr J. S. Roach, *Chief Financial Officer*

CORRECTIONS TO TRANSCRIPT OF COMMITTEE PROCEEDINGS

Corrections should be marked on a photocopy of the proof and forwarded to:

Budget Estimates secretariat
Room 812
Parliament House
Macquarie Street
SYDNEY NSW 2000

CHAIR: I declare this hearing for the inquiry into budget estimates 2009-10 open to the public. I again welcome Minister Perry and accompanying officials to today's hearing. Until 1.00 p.m. we will be examining the proposed expenditure in the portfolio area of Mental Health. I refer witnesses, audiences and members of the media to my earlier statements about procedural matters such as the broadcasting of proceedings and passing of messages. All witnesses and departments, statutory bodies or incorporations will be sworn in prior to giving evidence. I understand some of you gave evidence yesterday but we need to swear you in again because this is a different portfolio. The Committee resolved earlier that time for questions would be equally divided between the crossbench, the Opposition and the Government. We will therefore commence with crossbench questioning.

RICHARD JOHN MATTHEWS, Deputy Director General, Strategic Development, Department of Health affirmed and examined;

DAVID ANTHONY McGRATH, Director, Mental Health Drug and Alcohol Programs, Department of Health and

JOHN SIDNEY ROACH, Chief Financial Officer, Department of Health, sworn and examined:

Ms LEE RHIANNON: Dr Matthews, at the last estimate hearings you provided the Committee with some information about psychiatric emergency care centres [PECCs]. I am interested in the developments at Sutherland. At that time you said there was a commitment at St George and there would be further follow through to Sutherland. Can you give us the details of where that is up to?

Dr MATTHEWS: As you have said, St George was one of the first hospitals to get a psychiatric emergency care centre. The planning has resolved that the south-east Illawarra area will have four PECCs—St Vincent's, Prince of Wales, St George and Wollongong—and that will give quite good coverage for that emergency care across that area health service.

Ms LEE RHIANNON: At that time I raised some concerns that had been expressed about support being given for people living in the community of Wollongong and the commitment to help them to continue to live in that community. Can you outline how the PECCs are able to give that support to help ensure that people as much as possible can stay within their community?

Dr MATTHEWS: Psychiatric emergency care centres are really designed for just that: psychiatric emergencies. The majority of people with serious mental illness, but not all, have exacerbation of that illness which might be part of the natural course and sometimes, sadly, due to drug use. In line with the policy of mainstreaming, we believe that emergencies should be dealt with in an emergency department so that concurrent physical problems, which may sometimes be a cause of behaviours, or maybe the result of behaviours, can be dealt with as well. In terms of supporting people living in the community, these services are obviously linked to not just the acute facilities but also the community mental health services and the non-government support services, such as those provided in the Housing and Accommodation Support Initiative [HASI].

The PECCs are actually designed to care for people who are having acute exacerbations, who may need admission or may not, and who need to be appropriately assessed in that setting, as would anyone with a broken leg or a myocardial infarction. They are not specifically to assist people to live in the community but they are strongly linked to those services that do assist people. I think you have to view them in an analogous sense with the way an emergency department might function for someone who has had a heart attack. The care of their underlying cardiac condition continues to be provided in the community, but if they suddenly have a heart attack, then clearly they need the services of an emergency department. We try to keep those analogies with the general health system as our guiding principles in the way that we design the mental health services.

Ms LEE RHIANNON: Does that mean with this shift—and I think there has been a shift with these units—that therefore fewer people are treated within the community? I take your point about comparing it with someone who has had a heart attack but it is not quite the same—there are obviously shades of difference there.

Mrs BARBARA PERRY: With the greatest of respect, if I understand it correctly, you should view the PECCs like any other emergency ward; they are a separate part of the hospital designed clearly to look after people who have an emergency mental health issue. From there appropriate assessment is undertaken and then it could be that a person might need further acute in-stay. Then we have models of where they get better, then

there is a step down and then back into the community where the appropriate services are linked in. So it is a holistic approach across the health system. Not just from the hospital setting, but from the hospital setting to the community setting. The PECCs are simply emergency beds for appropriate emergency situations where people are having some difficulties.

Ms LEE RHIANNON: Minister, I would also like to ask about the Building Strong Foundations for Aboriginal Children, Families and Communities program. I think there was an increase in money.

Mrs BARBARA PERRY: Is that our program?

Ms LEE RHIANNON: That is not you?

Mrs BARBARA PERRY: With the greatest of respect, I do not think that is our program but I am quite happy to talk to you—

Ms LEE RHIANNON: I thought there was a mental health component within it?

Dr MATTHEWS: No, it falls within my responsibilities in other parts of the department but it is not specifically within the Mental Health portfolio of the Minister. It certainly will add resilience to the community, which you can argue is important for mental health, but it is actually part of the portfolio of the Minister for Health.

Ms LEE RHIANNON: You probably can guess where I was going. I will drop the question about that program. I am interested in targeted mental health program for Aboriginal communities. Could you give some examples? I am particularly interested in the degree to which programs are being delivered in the Penrith area.

Mrs BARBARA PERRY: I am pleased to talk to you about that because we have done very well in that regard and I am quite proud of it. It is not only about what programs are in the community, it is also about what we have done to empower Aboriginal people in the workforce and ensuring that there are appropriate Aboriginal people who are trained to work with Aboriginal communities. I will indicate, firstly, the programs that we have within the workforce. There is the Aboriginal mental health workforce program. In relation to the Penrith area in particular, I will ask the director to respond.

Mr McGRATH: The Aboriginal mental health workforce program is rolled out in two stages. It has developed out of the pilot program done in the Greater Western Area Health Service that began about four or five years ago. The first stage of that program was rolled out to rural areas. This year it has been rolled out to metropolitan areas and Aboriginal community-controlled organisations. So there will be trainees in the Penrith area in this cycle.

Mrs BARBARA PERRY: In relation to particular programs, there is a core component of the program that relates to the HASI component, the Housing and Support Initiative, which is equally rolled out across New South Wales. The unique aspect of that program is the utilisation of staff that have a specialist understanding of the specific needs facing Aboriginal communities. That program operates across New South Wales and takes in the Penrith area. It is simply about reconnecting people back to the community, helping them in the recovery phase to gain employment or to go back to education, and ensuring appropriate medical treatment—all of that holistic approach across government. Mental Health and a number of other agencies work together in collaboration on that program.

Dr MATTHEWS: One of the things we are particularly proud of is the work we are doing in developing the indigenous workforce. We recognise how difficult it is in health to meet the targets around the indigenous workforce because the majority of our workforce has clinical training and there are not significant numbers of Aboriginal people with that training. We have specifically developed a program for Aboriginal mental health workers where we support those people in full-time study through, mostly, Charles Sturt University to undertake a certificate in mental health non-clinical work. They get strong mentorship, which is necessary to make sure they complete it, and they are full-time employees while they are in full-time training. We think that is really important, not just because they will be part of the workforce but also because the more Aboriginal people there are who achieve tertiary qualifications the more that will build resilience within the community. I think, David, we are up to about 40 positions—

Mr McGRATH: Forty-seven positions.

Dr MATTHEWS: —across the State. Those sorts of things build generational capacity into the indigenous people.

Ms LEE RHIANNON: Congratulations, that is excellent. For my understanding, when you said some were rolled out this year and some were rolled out last year, I assume there is ongoing funding?

Mr McGRATH: Yes.

Dr MATTHEWS: It is recurrent funding.

Ms LEE RHIANNON: In relation to the community mental health emergency care plan, you now have these 24-hour operations. What areas do they operate in? How many people can access them?

Mrs BARBARA PERRY: You are referring to the Psychiatric Emergency Care Centres [PECCs], in particular, and the rural and remote mental health services. I can tell you where the PECCs are. Going off the top of my head—

Ms LEE RHIANNON: Is this the same area we were talking about before?

Mrs BARBARA PERRY: I am not sure we are on the same—

Ms LEE RHIANNON: This under the "A new direction for Mental Health".

Mrs BARBARA PERRY: I am sorry, I misunderstood your question.

Ms LEE RHIANNON: It is 24-hour community mental health emergency care.

Mr McGRATH: There are a number of streams to the emergency care program. The PECCs are one part of that stream, that is, the in-patient component co-located with emergency departments. There is a rural model that provides an equivalent to the PECCs in rural communities. Then there is the community mental health emergency care program, which provides a 24-hour community program with emergency care.

Ms LEE RHIANNON: That is the one I want details on.

Mr McGRATH: They are often co-located with PECCs. The reason for that is, obviously, the sort of population that they are seeing is similar, the presentations they are seeing are similar and the skill sets required of the staff are similar. So it makes sense to co-locate them. That particular initiative allows for those staff to go into the community, if required and appropriate, to deal with people in the community who may have symptoms that require addressing.

Ms LEE RHIANNON: What is the split between coastal and rural and regional areas?

Mr McGRATH: The community mental health emergency care program has been rolled out in packages of $200,000. Those packages have been spread relatively evenly across the State. To provide you with a list would take some time because there are quite a number of locations.

Ms LEE RHIANNON: No, your information is useful. What do you get for a $200,000 package?

Mr McGRATH: There may be multiple packages at a given location. A given location might get two or three packages. A package will get you two nursing staff, clinical nurse consultants.

Mrs BARBARA PERRY: You must remember that is part and parcel of everything else, the other aspects as well. That is one part, one component.

Mr McGRATH: Obviously, a busy metropolitan location may get three packages.

Ms LEE RHIANNON: A package sounds like it is more than just for salaries.

Mr McGRATH: It is an increment that we use to determine the base level of need for a given location. It provides for the operation of that particular service. Predominately it is for the service delivery component, which is for salaries and goods and services.

Dr MATTHEWS: There is a different model in rural areas because of the distances and the scarcity of psychiatrists. So we have rolled out the tele-psychiatry. If someone presents, say, in Mudgee Hospital, which is clearly not going to have a well-developed mental health workforce because of its size, one of the clinicians there, generally a nurse, takes a history of the patient in front of the camera and they will be interviewed by a psychiatrist from Bloomfield in Orange, who can then build on the history of the mental health state taken by the nurse and go on to make a diagnosis and, if necessary, prescribe over the television the appropriate medication for that patient. So there is a different model depending on whether we are in the middle of a city or we are dealing with the geography of rural New South Wales.

Mrs BARBARA PERRY: In addition, we have supported the Centre for Rural and Remote Mental Health in conducting across rural New South Wales the mental health first aid programs. These are one aspect of a number of things that are going on in both rural and metropolitan settings. That one component that David referred to is just one component of a number of other building blocks, and they cannot be seen in isolation.

Ms LEE RHIANNON: I may get this wrong because sometimes I struggle to work out the division between health and mental health. Do you cover dementia?

Mrs BARBARA PERRY: That is very interesting because it is Dementia Awareness Week. Dementia is not necessarily a mental health issue. However, in relation sometimes to older age people who have mental health issues, dementia is part of their ongoing condition or ongoing illness. Am I right in explaining what is technically a medical aspect?

Dr MATTHEWS: It is one of those areas in health that could be said to be subject to a demarcation dispute. Dementia is a neurodegenerative disorder. The reason there is an overlap is that we have dementia services and they sit outside mental health in another part of my portfolio. Sometimes people with dementia have challenging behaviours. Sometimes people with dementia either as part of the neuro-degeneration or as a separate issue have mental health problems, so you get this issue of comorbidity and you get both parts of the team looking after a considerable number of the patients. So there is a crossover.

Ms LEE RHIANNON: What I was interested in, but maybe it is a question for Health, is respite care and whether there is any expansion of respite care in relation to people with dementia?

Mrs BARBARA PERRY: We support a number of non-government organisations being able to support carers, and that is an important part of the mental health program. It is not just about caring for the patients; it is also about caring for their families who support them. We pretty much fund two peak bodies here in New South Wales to advocate on behalf of both consumers and carers—the Consumer Advisory Group and the Association of Relatives and Friends of the Mentally Ill [ARAFMI] New South Wales. ARAFMI mainly deals with families and carers of people with a mental illness.

Ms LEE RHIANNON: Has there been an increase in recent years in funding for respite care in this area?

Mrs BARBARA PERRY: We will spend over $7 million in 2009-10 on the Family and Carer Mental Health Program and over $35 million over the next five years. So there is a significant investment in that.

CHAIR: We will now go to the Opposition for questions.

The Hon. TREVOR KHAN: I refer to a number of the recommendations in the Garling report. Obviously, Ms Rhiannon asked a number of questions relating to her degree of knowledge from, I think, a previous hearing, so I am coming in a bit cold. With regard to recommendation 107—

Mrs BARBARA PERRY: Which is?

The Hon. TREVOR KHAN: Which is a recommendation that within 18 months each hospital which operates an emergency department shall establish a safe assessment room at a location if not adjacent to then approximate to the emergency department—assuming that my quote is accurate.

Mrs BARBARA PERRY: I just could not remember which one was which. There are about three recommendations in the Garling report that are specific to mental health and I just did not know which number was which.

The Hon. TREVOR KHAN: This is not a memory test.

Mrs BARBARA PERRY: We have already created 11 safe assessment rooms specifically for mental health patients in emergency departments, which is what Mr Garling was referring to, in both rural and metropolitan areas, as well as creating 63 multipurpose safe assessment rooms in hospitals throughout the State. To better support patient care only hospitals with emergency departments have a level three role description, and they are considered clinically appropriate for safe assessment rooms as they are able to provide the requisite level of staffing. We are currently consulting with area health services on further sites that require establishment of safe assessment rooms. There are issues around that and we need to be aware of that. We need to balance Mr Garling's recommendations for the need to provide those rooms with the appropriate requisite level at the relevant site and the need to staff it appropriately, as well as the interests of the community.

The Hon. TREVOR KHAN: I do not wish to cavil with what you say but my understanding is that the Garling report found that there were 11 safe assessment rooms in existence at the time of the issuing of the report in November of last year. If that was the case, what further assessment rooms have been established since the recommendations of Garling were issued in November and, further, what are your specific plans for the rollout of the establishment of further safe assessment rooms in the coming months and years?

Mrs BARBARA PERRY: With respect, I think I answered that and said to you that we are consulting with area health services for future sites, that this is an ongoing thing and that there are conditions that need to be satisfied. Not every place can be appropriate for a safe assessment room, and I think that is something Mr Garling himself recognised as well.

The Hon. TREVOR KHAN: Do I take that to mean that since Garling's report came out some two months ago no further safe assessment rooms have been established?

Dr MATTHEWS: We have created a total of 63 multipurpose safe assessment rooms, so there is an ongoing process that was already occurring before Mr Garling's report. As to how many of those have been completed since he made his recommendation, I would have to take that on notice and give you a list of those. As the Minister said, NSW Health has got 252 facilities that keep people overnight, and many of them are nothing more than aged-care facilities. So we are working with the police and with the carers and friends of people with a mental illness to work out where it is appropriate for people to be taken if they require urgent assessment, because there is no point in taking someone to a place which is purely an aged-care facility—they are simply going to have to be moved to another place.

We are making it a process involving a safe assessment room, the appropriate staff to do the assessment, the availability of telepsychiatry facilities to assess at a distance, matched with the geography of New South Wales, which means that inevitably sometimes people are taken a fair distance. But, as I say, as to how many of these have actually been finished since that report I would have to take on notice and find out from capital works.

Mrs BARBARA PERRY: I think it is fair to acknowledge that this is something that has been an ongoing process even before Mr Garling's report.

The Hon. TREVOR KHAN: Minister or Dr Matthews, including taking on notice the establishment of multipurpose assessment rooms, would you be able to broaden your on-notice commitment to cover the establishment of any specific safe assessment rooms and also whether you plan to establish any further safe assessment rooms or multipurpose assessment rooms in the coming year or two?

Dr MATTHEWS: Yes.

Mrs BARBARA PERRY: We will do that.

The Hon. TREVOR KHAN: Recommendation 108 is that within 18 months each hospital which does not have a PECC [Psychiatric Emergency Care Centre] within a peer group down to and including a B2 major

non-metropolitan hospital and which operates an emergency department ought also to establish a PECC at a location if not adjacent to then approximate to the emergency department, unless there is access to a PECC located at another hospital within a reasonable transfer distance. I think there was a document that was handed up before that dealt with this issue. Are you able to comment on the response to recommendation 108?

Mrs BARBARA PERRY: Again, this was ongoing work even before Mr Garling's report, and something that we are quite proud of. PECCs are working well. We have already got a number of PECCs across the State, as we have discussed. You are wanting to know what is coming up, basically, in the next budget year?

The Hon. TREVOR KHAN: The Garling report would be conceded by everyone to be a significant initiative and providing a roadmap forward. What I am essentially asking you is, in the light of the Garling report, what has been the Government's response with regards to the recommendations and, more specifically, with regards to recommendation 108?

Mrs BARBARA PERRY: Firstly, not every site is appropriate for a PECC, for obvious reasons, but they work best where there is sufficient patient demand and where expertise is provided through the local mental health units. So it does not suit all facilities with an emergency department, and that is something that needs to be recognised from both a clinical and a community perspective. We have already established nine PECCs, I think, and two will be coming online I think in the next year.

The Hon. TREVOR KHAN: Which are?

Mrs BARBARA PERRY: Prince of Wales and Wollongong.

The Hon. TREVOR KHAN: Beyond those additional two, are any further ones in the pipeline?

Mrs BARBARA PERRY: Just to add to that: There will be four new PECC beds at the Prince of Wales by July 2010; four new PECC beds at Wollongong by June 2010; I have no doubt, where appropriate, there will be some PECC beds at the Royal North Shore Hospital coming online; and there will be additional PECC beds at the Liverpool Hospital as part of the redevelopment. Of course, they will continue to come on line as a result of ongoing reviews. We must plan for these things; they do not happen overnight. They are part of the general health and mental health initiatives that this Government is implementing, and I am proud of what we have achieved so far.

Mr McGRATH: It is important from a capital planning perspective to recognise that when a PECC is developed it has an impact on the overall emergency department footprint. When a new PECC is being planned consideration must be given to any changes that need to be made to the emergency department. As the Minister said, those that are coming on line are part of redevelopments of emergency departments already in train. The PECCs are being built into the redevelopment. As that continues we will continue to build PECCs in conjunction with emergency department refurbishments. We cannot do it independently.

The Hon. TREVOR KHAN: In recommendation No. 108 Mr Garling appears to have identified a subgroup of hospitals. I will not read it out again, but it starts with "should have a PECC within a peer group down to and including B2" et cetera. It gives a definition of what hospitals should have it. Has anyone identified the hospitals that meet the definition that Mr Garling provides in recommendation No. 108?

Dr MATTHEWS: We have. B2 takes us down to hospitals that have fewer than 5,000 acute separations each year. They are quite small hospitals and many of them are in rural areas. It is important to remember that we originally developed a metropolitan strategy, which included the PECCs. The hospitals we listed in the metropolitan area have pretty well got Sydney covered in terms of its geography. We have developed a rural strategy dealing with geography, telepsychiatry and the other things I referred to. B2 does cause us a problem because we get down to hospitals where the medical staff are almost exclusively general practitioners, and many of them are old. Getting the workforce is the key. A PECC requires 24/7 nursing staff. In many of these places it is just not feasible to recruit mental health nurses 24/7. I do not want to sound like Kevin Rudd, but I am sure that the next question is about how we are going to resolve that.

The Hon. TREVOR KHAN: It actually was not my next question, but go ahead and answer it.

Dr MATTHEWS: It will be difficult. We will resolve it by providing within the limits of our workforce and geography the best possible emergency care we can for our mental health patients. We must do

that within the constraints of the capital program, the workforce and the existing hospitals. The reason Wollongong Hospital has taken so long is that it is an emergency department and the site is constrained: there is no room to expand that hospital. We have had to get additional capital to complete the refurbishment of the entire emergency department to add this new component.

The Hon. TREVOR KHAN: I grew up in Wollongong, so I know the emergency department.

Mrs BARBARA PERRY: It is good to know that we are now getting an entire emergency department and the PECC will be part of that. That is a good example of some of the constraints.

The Hon. TREVOR KHAN: I do not wish to cavil with the last answer, because it was very informative; however, at the same time it was non-responsive.

Mrs BARBARA PERRY: I thought it was very responsive.

The Hon. TREVOR KHAN: Can you give me a list of the hospitals that fit within the definition that Mr Garling included in his report of hospitals that he envisages are covered by recommendation No. 108?

Dr MATTHEWS: Absolutely. The list is on the New South Wales Health website. All hospitals are on the website displayed by category. It is easy to see what those hospitals are. There are also clear definitions of B2 and B1.

The Hon. TREVOR KHAN: Noting the ease with which it can be done, I take it that you will take the question on notice and provide me with a list.

Dr MATTHEWS: Absolutely.

Mrs BARBARA PERRY: Bearing in mind that that is provided along with the information that has been given in evidence today that it is not as simple as saying this is a B2 hospital and therefore it should have a PECC.

The Hon. TREVOR KHAN: It seems clear that Mr Garling did not simply envisage identifying B2 hospitals in his definition. He identified B2 hospitals that met certain other conditions as well. I am asking for those hospitals that fit within the No. 108 definition, not simply B2s.

Dr MATTHEWS: Absolutely.

The Hon. TREVOR KHAN: Recommendation No. 108 with regard to that subspecies of B2 hospitals proposed that there be compliance within 18 months. What do you say about that being achieved?

Mrs BARBARA PERRY: With respect, you responded to my deputy director's question by saying that it was evasive.

The Hon. TREVOR KHAN: No, I did not use that word; I said "non-responsive".

Mrs BARBARA PERRY: I think he answered the question.

The Hon. TREVOR KHAN: No, I asked: What is the capacity to achieve recommendation No. 108 within the 18 months specified by Mr Garling in his report?

Mrs BARBARA PERRY: I indicated that I thought that question had been asked before in a different way and responded to appropriately by Dr Matthews. If he would like to add to that, I am happy for him to do so.

Dr MATTHEWS: Many of Mr Garling's recommendations, not only this one, are a challenge and we are attempting to meet those challenges. One would expect them to be a challenge.

The Hon. TREVOR KHAN: Yes. I refer to recommendation No. 109, which states:

Mental health patients re-presenting to a mental health inpatient facility or psychiatric emergency care centre (PECC) be admitted to that facility without prior admission to emergency unless, in the opinion of a triage nurse or medical officer in emergency, that person requires specialist emergency medical care.

Mrs BARBARA PERRY: What Mr Garling recommended is consistent with current policy. Mental health clients, including those attending within 28 days of a previous admission period, whose general health and mental health issues are known are able to access inpatient care without needing to attend an emergency department.

The Hon. TREVOR KHAN: What happens if an event occurs outside the 28 days?

Mrs BARBARA PERRY: I assume that that would depend on a clinical assessment of what is required. We cannot talk about this in isolation because that person might be receiving ongoing care in the community. It all comes together as part and parcel of that.

Dr MATTHEWS: I come back to my analogy to physical illness. If someone requires admission to a hospital with a physical illness, that can occur in two ways: First, as a booked admission through the front door; or, secondly, as an emergency admission through the emergency department. If our community mental health services are looking after someone in the community they make the clinical decision that Richard Matthews needs readmission, but we know his problems and he can go in as a booked admission.

On the other hand, it could be decided that Richard Matthews needs to go to the emergency department and undergo triage to ensure there is no medical condition that is contributing to or part of the problem. Having done that, he should go to the PECC. Once he is in the PECC he will undergo an expert assessment. We attempt within 48 hours in the PECC to decide whether Richard Matthews needs to be admitted to an acute unit or whether he has been stabilised and can be discharged back to community care. That is exactly the same way that my chest pain would be dealt with if I were a cardiac patient.

The Hon. TREVOR KHAN: Last year there were, for example, three inquests held into debts that occurred with regard to mental health patients in Tamworth, one of them in a facility and, I think, the other two at or about the time of admission. Obviously, findings were made by the coroner with regard to those matters—and certain commitments, I would take it, by the Hunter New England Area Health Service with regard to certain changes in procedure. Minister, where you made privy to the findings of the coroner? If not, why not? Secondly, who monitors whether the undertakings or changes in procedures to be undertaken by the Hunter New England Area Health Service have been acted upon?

Mrs BARBARA PERRY: I will have to get the details of the three, because I do not know whether they are still ongoing at this stage.

The Hon. TREVOR KHAN: I can tell you they are not.

Mrs BARBARA PERRY: I do not know whether that is right.

The Hon. TREVOR KHAN: I appeared in one and I can tell you they are not. Findings were made.

Mrs BARBARA PERRY: Can I tell you generally how it works, because part of your question requires a general response. When a coroner addresses a recommendation to New South Wales Health the Corporate Governance and Risk Management Branch is responsible for ensuring relevant bodies within the health system consider the recommendations and take appropriate action. Both the Government and the department clearly take very seriously any recommendation made by the coroner. As a result of all of the coroner's inquest recommendations that have been handed down since 2001 we ensure we continue to build on the safety and care provided to people with a mental illness.

Dr MATTHEWS: We have a very formal process, as the Minister said, around all coronial recommendations, not only around mental health. When the coroner makes his recommendations we would always formally respond to the coroner. I sign off on the mental health ones and some of the other ones, not all. We put in place an implementation plan around those recommendations and that is very strictly monitored, as are recommendations by the Ombudsman and other watchdog bodies by a branch within the department known as Corporate Governance and Risk Management. I will have to check on the three in Tamworth—I do not keep those in my head—but I assure you there is a very rigorous process of following up on those recommendations. Many of the coroner's recommendations are challenging as well.

The Hon. TREVOR KHAN: Doctor, I am happy to give you one of the names but I am just not going to do it publicly.

CHAIR: You have the option of placing questions on notice up to two days after the hearing. The time for Opposition questions has expired. We will now go to questions from Government members.

The Hon. HELEN WESTWOOD: Minister, already today you have given the Committee a bit of information but I wonder whether you have any more information you can provide the Committee to update on efforts being made to increase the number of mental health beds in New South Wales hospitals?

Mrs BARBARA PERRY: I am proud to say that as a government we have demonstrated commitment to mental health generally with the investment of over $1.7 1 billion in this current budget year. That is an increase of $81 million on last year's budget. As of June 2009, there were 2,450 mental health beds in the State. Since 2000 we have delivered more than 560 additional beds. This includes inpatient mental health beds in both rural and metropolitan locations. We are also determined to open a further 323 beds in the coming years to 2011. That is part of our planning. In addition to we are also boosting community-based care and other initiatives to help people manage their mental illness in the community and reduce the need for hospital readmissions. That is providing great outcomes for participants.

Already in 2009 we have opened new specialist mental health facilities. We have a new 20-bed mental-health rehabilitation unit at Shellharbour; a 12-bed specialist child and adolescent unit at Concord, the Walker Unit; a 20-bed non-acute unit at Coffs Harbour that we have recently opened; a 14-bed specialist older person's mental health unit at Wollongong; a 96-bed facility at the Mater at Newcastle; a 20-bed non-acute unit at Sutherland; a new 135-bed forensic hospital at Malabar, and that is providing 36 additional beds; and also a new 40-bed hospital at Long Bay prison. I have had the pleasure of being able to visit many of those new units, including the Wollongong older persons unit, the rehabilitation unit at Shellharbour, the child and adolescent unit at Concord and the new forensic hospital at Malabar. The staff and facilities are first class. They provide an extremely therapeutic and compassionate environment for patients to progress on their recovery journey. We have come a long way in our design as well as in the way we treat people with a mental illness.

The child and adolescent unit at the 174-bed Concord centre for mental health is providing an Australian-first level of intensive support for young people. It is dedicated to intensive treatment for up to six months for the most severe cases in the one unit, rather than the traditional mixed case shorter stay adolescent ward. That is combined with a comprehensive rehabilitation program so young people can receive some vocational or educational training, coping and living skills and return to living with their families sooner. It is also useful that we are able to use the resources at the Rivendell unit, and the two units combine very well together. I am pleased to confirm there are more beds on the way across New South Wales, including 82 forensic and tertiary unit beds at Bloomfield Hospital at Orange and 20 bed non-acute unit at James Fletcher Hospital at Newcastle.

These things establish the Governments commitment to deliver inpatient services to the people of New South Wales. These beds also represent a mix of both acute and non-acute levels of care, recognising the importance of a stepping down transition back into the community by those admitted to hospital. We are also building the capacity of large metropolitan hospitals to provide that rapid specialist mental health care 24 hours a day, seven days a week.

We have talked about the psychiatric emergency care centres that provide 24/7 mental health assessments in major metropolitan hospital emergency departments. One of the good things about the psychiatric emergency care centres is that they take pressure off hospital emergency departments by diverting people presenting with mental health problems to specialist clinicians, reducing delays in accessing care and therefore delivering better outcomes for patients. We have also invested $1.7 5 million in the 2009-10 budget to the new psychiatric emergency care centre at the Calvary Mater in Newcastle. But that will provide a special service to the people of the Hunter. The Mater obviously joins a number of other psychiatric emergency care centres that we have across the State.

In 2009-10 the Government is also investing more than $23 million in new inpatient mental health facilities, including $6.8 million for the 20-bed non-acute unit at James Fletcher Hospital in Newcastle and, as I indicated earlier, $5.2 million for the psychiatric emergency care centres at Wollongong and Prince of Wales, $3 million for the child and adolescent inpatient units at the Sydney Children's Hospital and Shellharbour Hospital;

$6.6 million for construction of the new 30-bed Mandala mental health unit at Gosford hospital, and $1.8 million for a six-bed mental health unit at Bega while the new Bega hospital is under construction.

We are also delivering more services for people with a mental illness. We work hard to establish good balance between inpatient and community-based care. This includes our recognised and award-winning program the Housing and Support Initiative. As I indicated earlier, it helps people with a mental illness to maintain their tenancies. It also provides them with home mental health support to help them manage their illness in the community. I think the program has had great success in engaging participants with their local community and reducing hospital readmissions. In fact, for participants there has been an 81 per cent reduction in time spent in hospital and emergency departments. In addition to the Housing and Accommodation Support Initiative [HASI] program, we have also established the Vocational Education, Training and Employment Program, which links people with employment and further education. The program is not only helping people to become job ready in many cases, but also restoring their confidence and their feeling of self-worth.

This Government is determined to improve outcomes for people living with a mental illness. Our focus is delivering on that commitment. It is about providing the best standard of care possible. Providing state-of-the-art facilities is one way we can promote the most therapeutic environment for recovery and healing. But it is not just about beds or buildings; it is about education and support through various advocacy groups, constant education, and supporting our staff to do the best job they can.

The Hon. GREG DONNELLY: Can you elucidate your answer about the work done by the New South Wales Government to assist people with mental health emergencies?

Mrs BARBARA PERRY: We have talked about some of that today. We have implemented a range of initiatives to support people in a mental health emergency. That involves not only ensuring access to specialist care and support when people need it most but also giving people with a mental illness the best possible chance to recover from their acute episode and get back on track. That initiative has three main targets. The first is building the capacity of large metropolitan hospitals to provide rapid specialist mental health care 24 hours a day, seven days a week. The second target is to develop innovative and flexible service models for regional and rural hospitals to provide rapid mental health care locally and effective processes to move those people who need more intensive mental health care to appropriate specialist mental health facilities. The third target is improving the collaboration and capacity of emergency services to respond to mental health presentations.

We have talked about psychiatric emergency care [PEC]. In hospital emergency settings there are invariably four to six specialist mental health beds sitting alongside the emergency departments. They can admit patients, as Dr Matthews indicated, for up to 40 hours for observation and immediate care. The advantages are that they take the pressure off emergency departments—it is about delivering better treatment to people. The presence of mental health staff to support emergency departments also allows a larger number of people presenting with mental health problems at emergency departments to be assessed and referred to the appropriate community support. Not everyone who comes to the emergency department will end up in psychiatric emergency care or in acute care. Our staff are able to assist the general emergency department as well.

In August I joined the Premier at the opening of the newly completed PEC at Calvary Mater Hospital in Newcastle. The Mater joins 10 of our busiest hospitals—Nepean, Wyong, Blacktown, Hornsby, Campbelltown, Liverpool, St George and St Vincents—in providing PEC services in their region. We are also investing more money in PEC services. In the meantime, the interim PEC services are operating whilst we are rebuilding the emergency departments at both Wollongong and Prince of Wales hospitals.

In rural New South Wales we have implemented a number of initiatives to assist people with a mental illness and overcome the geographical barriers that affect people in rural areas. In 2009-10 we have invested over $1 million across four area health services to increase the after-hours capacity of local mental health services to respond to emergency and acute mental health events in the community identified by police, general practitioners, families and carers in the wider community. The Rural Mental Emergency and Critical Care Program has now been implemented in all four of the rural area health services, each tailored to the local needs and location of the area. Those modules include expanding the availability of mental health nurses and supporting smaller rural emergency departments through 24-7 mental service resource hubs. These four hubs provide us with videoconferencing to emergency departments in more than 50 hospitals across the Greater Western Area Health Service and the Greater Southern Area Health Service.

This is a way of providing rapid access to specialist mental health assessment and support. It also allows consumers, their carers and families to actually stay closer to home, which is really important. It means spending less time travelling to services. It reduces the need to utilise police and ambulance resources to transport people long distances for hospital admission. For the year ending June 2009, a total of 675 videoconference mental health assessments were completed. That initiative enhances local management of mental health emergencies. It has now been in operation for more than 18 months.

An important part of the mental health care rural access project is also collaboration with local services, such as general practitioners, general nursing staff, ambulance, police and non-government organisations. I have been to a number of rural areas where different organisations are working together to provide a service, and it is really fantastic. The project I have talked about is improving local capacity to deal with emergency mental health problems. It includes training to all local services within the Greater Western Area Health Service in the area of mental health emergencies. It gives them the support and skills needed to provide a high standard of care.

Another important priority of this Government is to ensure that mental health is everybody's business. We are working hard to ensure front-line workers and the community have a strong awareness of mental illness and that support is available. So far, more than 21,000 people have completed the mental health first-aid training, which gives people the skills to recognise and respond to mental health crises in the community until professional help arrives. It includes more than 800 people from rural and regional communities in New South Wales and is funded through the drought mental health assistance package, which has been boosted by another $2.3 million in 2009-10. Every Department of Community Services and Juvenile Justice caseworker in this State is undertaking that program. Participants are better informed on mental illness by being given information on symptoms and strategies to help someone when they really need it. It also helps to break down the stigmatisation of people with a mental illness. These programs in rural areas are also available to members of the public.

In addition, police officers are receiving specialist mental health training. The department has committed funding to support that training. There was a successful pilot program. The New South Wales Police Force has established the mental health intervention team to provide specialist training to police officers across New South Wales. That program seeks to help police officers identify at-risk individuals in the community and develop skills and strategies to communicate with and assist people during a mental health crisis. There is a fantastic partnership between the New South Wales Police Force and New South Wales Health. They have jointly funded program, including the provision of the clinician responsible for developing and helping to implement the training.

Our ability to respond to mental health emergencies is possible only through a commitment to the workforce. This year we are investing a further $2.9 million to expand our 24-hour community mental health emergency care through recruitment of additional mental health professionals across the State. This ensures that from Bega to Bourke, and everywhere in between, these initiatives provide highly responsive and supportive assistance to people with a mental illness when they need it most. Investment is but one part of it. The incredible work and compassion shown by our staff across the sector is amazing. They often face difficult and challenging issues and deal with difficult clinical presentations. They are very compassionate and encourage the family to be a part of the process. I am very proud of what our staff achieve out there. Each and every member of this community should be very proud of what we have here in New South Wales mental health.

The Hon. HELEN WESTWOOD: Minister, you have already spoken a little about mental health services for Aboriginal people. Do you have any further information you would like to provide to the Committee on initiatives supporting Aboriginal mental health?

Mrs BARBARA PERRY: We know that, on average, Aboriginal people live 17 years less than the rest of the Australian population. They suffer from significantly higher levels of psychosocial distress, and the rate of suicide and self-harm in Aboriginal communities is at least twice the national average. Aboriginal people have elevated levels of incarceration and problematic substance use, and also a high prevalence of grief, loss and trauma. The complexity of needs prevalent in Aboriginal communities presents a significant challenge to health services. Children and young people, in particular, continue to experience high levels of distress and have poor physical health and emotional and social wellbeing compared with the non-Aboriginal community.

The New South Wales Government is investing in specialist indigenous mental health staff and services to tackle the disproportionate levels of psychosocial distress, suicide and self-harm in the Aboriginal community. In response to the need for further support, my predecessor launched the New South Wales

Aboriginal Mental Health and Wellbeing Policy 2006-2010 in July 2007. The policy sets out a detailed framework to address Aboriginal mental health and wellbeing problems in New South Wales in a culturally sensitive and appropriate manner. The policy is supported by significant funding from this Government, including $9.64 million this financial year. As we have talked about, this includes the rollout of a specialist indigenous housing support program and funding 47 Aboriginal mental health worker traineeships across New South Wales. Over $38 million will be spent on Aboriginal mental health and wellbeing programs and projects in New South Wales over the life of the policy, in addition to core funding received by area health services.

A hallmark of this policy is the Aboriginal Mental Health Workforce Program, which we talked about a little bit. The program is aimed at building a workforce of Aboriginal mental health workers—Aboriginal people who are working for and with Aboriginal people—which is a key recommendation of "Bringing Them Home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families". The New South Wales Government is investing $14.5 million in the program over five years, comprising $7.38 million for the training program, $3.4 million for the Aboriginal Clinical Leadership Program, and $3.75 million to place an additional 10 Aboriginal mental health workers into Aboriginal community controlled health services. Under the program, trainees are employed full time with the area health service whilst undertaking a Bachelor of Health Science (Mental Health) degree through Charles Sturt University, taking part in clinical placements and gaining valuable on-the-job training, mentoring and supervision.

By employing and training Aboriginal people who know the community and who are likely to stay in the community, the Aboriginal Mental Health Workforce Training Program seeks to break down barriers and increase the accessibility of mental health services for Aboriginal communities; address health workforce shortages in remote areas; enhance the cultural appropriateness of mental health services; improve workforce retention; increase awareness of issues affecting the local community; build communities' capacity to respond to their mental health needs; provide role models and mentors for local youth; and create cultural awareness throughout New South Wales health services. As I mentioned earlier, there are now 47 trainee positions across the State. This brings the number of Aboriginal mental health workers in New South Wales public sector mental health services to over 75. The workforce program is one of the first of its kind in Australia, and we in the department are very proud of it. As a result, I believe New South Wales is leading the way in the provision of a skilled and competent Aboriginal mental health workforce. The Aboriginal Clinical Leadership Program ensures the employment of clinical leaders in Aboriginal mental health in key area health services. They play an important role in supporting the rapidly emerging Aboriginal mental health workforce. They also play a vital role in helping to promote service utilisation by Aboriginal people and to ensure the provision of culturally appropriate services to Aboriginal communities.

Area mental health leadership, both clinical and managerial, will ensure the effective development of the New South Wales Aboriginal mental health program over the life of the policy and into the future. In another critical link to the workforce program, an additional 10 Aboriginal mental health worker positions were allocated to the Aboriginal community controlled health services in June 2009, bringing to 24 the number of Aboriginal mental health workers in the Aboriginal community controlled sector that are funded by New South Wales Health.

CHAIR: Minister, we may have to call a halt to your answer there, I am afraid, because we have run out of time. If you like, you could table the remainder of your answer.

Mrs BARBARA PERRY: Thank you, that is fine.

CHAIR: I would like to thank you for your attendance today. I also thank Mr McGrath, Dr Matthews and Mr Roach for their evidence. The Committee Secretariat will contact you regarding any questions taken on notice. The Committee would appreciate the responses to those questions on notice be provided within 21 days from the date on which you receive the questions. Committee members have two days from today's hearing to place extra questions on notice.

(The witnesses withdrew)

The Committee proceeded to deliberate.