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INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

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NSW PARLIAMENTARY INQUIRY INTO THE EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

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<u>PLEASE NOTE:</u> The following information represents the views of a group of frontline Community Mental Health Clinicians and does NOT in any way intend to represent or reflect on current Mental Health service or Local Health District Management policies or practice.

Introduction

My name is . I am currently employed as a Senior Staff Specialist Child and Family Psychiatrist with the in Western Sydney

staff completely agree with Dr Amanda Cohn, Chair of this Inquiry, regarding "the critical importance of outpatient and community mental health services to the health and wellbeing of communities across New South Wales." An effective and efficient Community Mental Health Service will reduce the burden on acute hospitals, Emergency Departments and Emergency Services by having capacity to provide comprehensive assessment and management for clients and their families before severity escalates to a crisis, timely crisis response and a clear 'step-down' service for clients who have required acute hospitalisation. There will always be some clinical presentations that will require acute management in hospital but proactive integration between adequately resourced inpatient, outpatient and community mental health services within a Local Health District would ensure that community members can receive the care that they need as close to home as possible and within an appropriate timeframe.

(a) equity of access to outpatient mental health services

The creation of a specific community mental health team in Western Sydney for children aged 2-12yrs living across the LHD has only been achieved in the past 12 years. This team was "enhanced" in 2018-19 by the 'realignment' of tertiary/quaternary child and family mental health services at Redbank House, Westmead, into a secondary level service providing community-based therapy and case management. As a result of this realignment all families in WSLHD lost access to the school-based Day Program operating in conjunction with a Department of Education School for Specific Purposes (SSP) that was designed to target children with severe emotional and behavioural disturbance that was placing their education trajectory at high risk of failure. WSLHD had previously operated a residential Family Admission Program for families from across New South Wales. Unfortunately, this program was consistently under-resourced for years until MHCYP and the Minister for Mental Health deemed it unsustainable and directed its closure in 2009. The only remaining clinical services of this nature in New South Wales are located at Coral Tree Family Service in the grounds of Macquarie Hospital. This program currently has a waiting list of at least 18 months.

The allocation of resources to the WSLHD Mental Health Service, including the Child and Family team, has never been provided on a per capita basis or an assessment of the actual needs of this multiply challenged and vulnerable population. It is never politically palatable to divert resources from the traditional bastions of service provision in Northern, Eastern and Central Sydney. This was attempted with the relocation of the Royal Alexandria Hospital for Children to Westmead in 1998, but resources allocated to the new Westmead Children's Hospital (WCH) remained cossetted within that building and remain largely inaccessible to the general paediatric population of WSLHD. This is particularly the case with the Department of Psychological Medicine (Psychiatry) at WCH, who accept referrals only from Paediatricians within the Hospital. An Emergency Department Assessment team is available to children presenting in crisis, but the majority of these families are referred out to be followed up in their local community.

There remains an entrenched discrimination against the residents of Western (and South Western) Sydney across all NSW Government Departments in relation to allocation of resources. On average, families in Western Sydney experience higher levels of socio-economic disadvantage, physical ill-health, transgenerational trauma, domestic and family violence, reduced education and employment opportunities, housing stress and, unsurprisingly, mental ill health and distress. Each of these factors individually are known to increase an individual's risk of developing mental illness. The client population serviced by the Therapy for Kids and Families team, both children and their family members, are consistently struggling with multiple if not all of these factors simultaneously. The trajectory to mental ill health is far too predictable for repeated generations of Western Sydney families.

Despite this, there are some sound multi-agency initiatives based in the research evidence for extensive coordinated early intervention and prevention services that are beginning to impact on these trajectories. Unfortunately, none of them has yet moved beyond "pilot project" stage and will require significant resource allocation to scale up to the levels required to meet actual need. From an economic perspective, this allocation of resources is a 'no-brainer' in terms of savings to government agencies and return on investment. The real challenge is to change the ingrained discrimination that prevents the evidence being translated into policy at scale.

Other facts of living in Western Sydney also impact on equity of access to outpatient and community mental health services. These include very limited public transport options to allow families to travel directly to service hubs, the cost and availability of childcare options, and the limited availability and use of outreach/home visiting models in children's community mental health. Home visiting models require adequate fleet vehicle resourcing and are more labour intensive, in that travel time is added to the actual time required for therapeutic intervention. Inclusion of any home visiting capacity within community mental health teams would also require an adjustment to the basic expectations of allocation of clinical time for each clinician on the team to acknowledge the additional travel time per client that inevitably takes away clinical time from seeing another client family.

At present all clinical activity for mental health clinicians is recorded using the CHOC platform. Outcomes are recorded via the Mental Health Outcomes and Assessment Tool (MHOAT). It would be helpful to note that both of these platforms, which Child and Adolescent Mental

Health Clinicians are required to use to record clinical activity, hours worked and therapeutic outcomes, ***are based solely in adult individual medical models*** of mental health care and do not take into account the very different, necessarily systemic frameworks and models of care that are required for effective mental health therapeutic interventions with children, adolescents and their families. Repeated NSW Governments and Ministers for Health and Mental Health have refused to consider this major challenge to the provision of best practice clinical care to children and their families. Surely in 2023 it cannot be impossible to acknowledge that children are inherently different from adults and require models of mental health care that are provided in inherently different ways.

Each of these factors continues to impact on the equity of access to community mental health services. In Western Sydney the only potential ***outpatient*** service for children experiencing mental ill health is through an internal Westmead Children's Hospital referral. There are simply NO outpatient mental health services for children and adolescents beyond this. Lack of staffing to adequately operate existing services is a common theme. Any expectation that Consultation Liaison and Outpatient mental health services be available for children and adolescents in WSLHD's Blacktown and Mount Druitt Hospitals will require specific creation of new multidisciplinary teams, fully funded on a recurrent basis, as this service cannot be provided from existing very sparse resources. If existing Community Mental Health team staff are diverted into providing services to ED and inpatients it is not possible for this clinical time to be recorded in CHOC under the current data collection system. This then reduces the Community-based Client activity statistics for individual clinicians, including child psychiatrists, which in turn impacts on the team's Activity-based funding and requests for enhancement funding.

On a completely separate issue, there are currently very few community mental health practitioners and public sector teams who are allowed to provide service to parents/clients who have a past history of being a person of concern in relation to Child Protection, even if the allegations were unsubstantiated at the time and there have been no recent concerns that a parent is in any way a current risk to the children in their care or to the community. This is a serious exclusion of a highly vulnerable cohort of clients who are trying to provide care to children and young people despite their own extensive trauma histories. A model of care based in a systemic understanding of families presenting for mental health care across all agencies involved with the family would go a long way to removing this impediment to care.

(b) navigation of outpatient and community mental health services from the perspectives of patients and carers

The experiences reported to our Team by parents, carers and other professionals seeking to access services for a child are varied. Some report that the referral process was straight forward, while others report multiple attempts to refer that are diverted by other teams within the PCYMHS and/or the Mental Health Telephone Access Line (MHTAL) Centralised Intake process within WSLHD. Unfortunately, there is lack of integration between the teams of PCYMHS in WSLHD, and significant dislocation from the physical health services and the Integrated and Community Health Service, particularly the Community Counselling Teams across the LHD. Localised efforts are being made to establish common sense connections between these teams at a local level, but these are dependent on the individuals involved rather than a coordinated approach to service provision endorsed by management of either the Mental Health or Community Health services within WSLHD. This inevitably creates more challenge for families and external stakeholders seeking to refer to our team.

There are some client populations who have particular difficulty accessing a mental health service in an appropriate timeframe. These include children living in permanent out of home care, children who have recently been placed in out of home care, children with an intellectual disability of moderate – profound severity, and some children already receiving individually-focused therapies via the National Disability Insurance Scheme (NDIS).

There are significant **gaps in services for children in out of home care, particularly for those with no permanent address** due to repeated placement breakdown. These children present with complex and multiple care needs, and there is a lack of services capable of meeting these needs in one consistent care setting. Whilst the Elver programme has been set up for this purpose, there appear to be gaps when it comes to how it actually works in practice. This may simply be a matter of resource limitation but may also reflect a recent preference for public mental health service "enhancement" teams to provide specialist assessment and consultation but no ongoing service provision for complex care management. The underlying concept appears to be "all care but no responsibility". Instead, following assessment, this team, and other specialist teams, has an expectation that they can refer clients back to the local LHD generalist community mental health teams for children and adolescents. These teams rarely have the resource allocation to provide the intensive case management and case coordination required for best practice care of these highly vulnerable young people.

Workforce training for carers working with OOHC kids (particularly in group homes/ those without stable care) is also an issue as it directly impacts on children's mental health, though this may be a separate issue to the focus of the enquiry. This highlights though, that a more holistic approach is needed to address the wellbeing and mental health needs of children in out of home care, in addition to simply examining equity, accessibility to and delivery of mental health services. IF the systems were set up to ensure that all children had access to the safety and stability required for healthy child development there would be a significant reduction in the need for mental health services. Instead, the current environment needs to wait for an extreme crisis to occur before reacting to treat the "pathology" now conveniently located in the individual child completely disconnected from the pathological systems that

have created the unhealthy environments that result in symptom development in our most vulnerable community members.

(c) *capacity of State and other community mental health services, including in rural, regional and remote New South Wales*

From the perspective of a small outer metropolitan community child and family mental health team that has difficulty obtaining management support for ongoing training during work hours, our observation is that our generalist team is increasingly expected to provide care to families who have previously been able to access specialist mental health clinics as outpatients of the major Children's Hospitals. Such services include Eating Disorders Units, Intellectual Disability and Mental Health clinics, Functional Neurological Disorders (FND) clinics, children displaying problematic and harmful sexualised behaviours and children in OOHC noted in **b)** above.

This 'consultation and refer out' model of sub-specialist mental health service provision is exacerbated by recent 'enhancements' to the workforce in the form of new positions and teams to provide brokerage and navigation services to ensure that referred clients arrive at the team that can best meet their needs. In our team's experience these brokerage services are unnecessary and unhelpful, adding another layer of engagement for a family before they arrive at our team. Families are often very confused about who is doing what, particularly when a service navigator's response is 'I don't do the work I just make a referral'. This is an unhelpful complication at the beginning of a family's involvement with mental health care. It would be far better, and more cost effective, to use these resources for actual clinical intervention services, attached to the community mental health teams.

This observation of a trend towards "brokerage" services instead of actual clinical care is a feature of federal government programs as well. Many Non-Government Organisations (NGO) have shifted their models of care to access Government funding as Community Organisations who receive funds to navigate systems instead of providing actual care. This can be in addition to the NSW Health 'brokerage' services and again diverts resources away from actual provision of direct clinical care.

Another solution favoured by the Federal Government in recent decades has been allowing Allied Health professionals in private practice to access Medicare rebates for some services. In theory this can create more clinical capacity, but the current experience is that very few if any of these practitioners are bulk billing any of their clients and are only able to offer a time limited service within each year. It is a mistake to refer to these services as "private" when the reality is that they would not function without Federal Government Medicare funding. It would be more helpful and transparent to identify both the NGOs and "private" practitioners as Federal Government funded, in contrast to State Government funding. This clarity may help to identify pathways for more informed integration between services provided by both levels of Government, similar to the thinking behind the GP Clinics proposed to function in public hospitals in NSW.

If this efficiency could be achieved, it might be helpful and possible to direct funding to more sessions within the Federally funded system to allow for the tertiary State government

services to work with the more complex presentations and hence reduce the overall burden on the public system.

(d) ***integration between physical and mental health services***, and between mental health services and providers

As a Child and Family Mental Health Service our team operates in a conceptual model based in biological child growth and development across the age range, from infancy into adolescence. A child's physical health and development are fundamental to their capacity to follow a healthy mental health trajectory. Unfortunately the trajectory of the development of Children's Community Mental Health services since the first National Mental Health Plan has been a complete separation from our Paediatric physical health colleagues. Local efforts dependent on the accidental co-location of services in the community and on the individual staff providing community physical and mental health care to the same client population have resulted in efforts to bridge this gap, but there is no leadership in this area from Ministry of Health or Mental Health that extends beyond the Children's Hospital Network.

Other interfaces that could benefit from integration efforts include the incorporation of family and systemic models of care across the perinatal, child, adolescent and youth services. Families are the key context for all children and hold prime position to effect any change to promote mental health, wellbeing and recovery from mental illness. This invaluable resource must be incorporated in all service models to ensure that effective and efficient care is being delivered. The family-based approach needs to be expanded to the Federally funded services eg HeadSpace, YESS, and so-called "private providers" who are rarely funded to hold appointments with parents and carers without the child present. This model excludes the reality of the child's lived environment, and the actual resources available for their recovery. Incorporating Family systems models of care would require significant upskilling of all clinicians and managers but would yield a significant return on investment across a child's development and recovery.

Co-location of community physical and mental health services for children 0-14yrs in the NSW Health system would improve the effectiveness of referral pathways between these two services and build capacity within both services to more adequately recognise and meet the complex needs of this population. At present many children can 'fall through the cracks' due to not exactly meeting the Intake criteria for either service or presenting as too complex and difficult for one or other team to manage independently. A holistic service that is integrative and communicative would enhance the capacity of both teams to meet client care needs.

For example, many children referred for mental health assessment and management also require Occupational and Speech Therapy but cannot access this due to extensive waiting lists for limited NSW Health community resources. The only way that these families can access any of these essential services is via the NDIS. The option to access OT and Speech Therapy with private practitioners has reduced to almost zero since the arrival of the NDIS, as most of these providers are now working in group practices that implement excessive price gouging because clients who do have access to the NDIS are now able to pay triple or more than what was previously affordable out of a family's own pocket. This has created a significant service gap, with any parent of a child for whom Speech Therapy and Occupational Therapy is needed

being told that they must apply for the NDIS for their child or go without any service. When these sessions are being offered at $250- $400 per half hour, it is easy to see how they quickly fall beyond the reach of most families to afford.

(e) ***appropriate and efficient allocation of mental health care workers***, including psychiatrists, nurses, psychologists, GPs, counsellors, social workers, allied health professionals and peer workers

It would be helpful if the NSW Governments and Federal Governments were able to be transparent about the full range of practitioners available to provide mental health services within a specific geographic region or Local Health District. Once this information is available it will be possible to assess the per capita allocation of resources, matched with the areas of highest need. NSW Health, in the First 2000 Days report, already has extensive information about the geographic areas with highest vulnerabilities and unmet needs. These can be mapped to population growth statistics to determine the appropriate allocation of resources across the state. There are existing benchmarks for the adequate workforce establishment to provide best practice mental health care to a population, including recommendations for inpatient, outpatient, day program, residential and community mental health care settings. This data is already available. It would be amazing if either or both State and Federal Governments developed policies to enact the solutions that present out of this data to ensure that all residents of NSW have equitable access to the resources they deserve. Of course, any change to the existing resource allocation and distribution, that currently favours the wealthier sectors of the community, who tend to need them less, will be challenged as unfair by the services who will be required to share their inequitably high proportion of the funding.

(f) the use of Community Treatment Orders under the Mental Health Act 2007
This part of the Mental Health Act is not relevant to the age group serviced by our team.

(g) ***benefits and risks of online and telehealth services***

During COVID the rapid pivot to be able to provide telehealth and online clinical services allowed our team to continue to operate when in-person contact was not permitted. There were particular challenges with management acknowledging the need for a range of delivery options to meet the varying needs of clients requiring care. Since the move back to in-person appointments, several families have requested to continue with online appointments due to time efficiency as it reduces travel time to and from the service hub, as well as allowing them to attend appointments by taking an hour out of their work day instead of having to take a whole day of leave from work to attend an appointment.

The provision of online treatment modules for mild – moderate severity symptoms can be effective and efficient methods for delivering mental health care at a time and pace that can be determined by the client. However, the majority of clients referred to our community Child and Family Mental Health Team have complex presentations, variable literacy, computer literacy and resources available to access online programs consistently.

The risks of online and telehealth services include:

- limited privacy for the client if they are joining from home or work
- unstable internet connections and insufficient computer hardware to host a video call for an extended duration eg 1 hour This is a significant disadvantage for clients of lower socio-economic status
- Clinicians not being able to create an environment in which the client can give their undivided attention to the session eg the TV may be on in the background and client is unwilling to turn it off, client may be in a noisy environment, other family members may intrude on the session
- Other people may be present in the room but not visible on the camera, creating an unsafe environment for the session to proceed if they refuse to identify themselves on screen or to leave the room.
- Limited internet capacity and technology (computers, headsets, internet connections) within the Community Mental Health facility for multiple online sessions to occur at once.
- Some clients prefer to only attend in-person sessions and will be excluded from a service if online or telehealth services are the only engagement options available.

(h) *accessibility and cultural safety of mental health services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability*

- The collective wisdom of the Therapy for Kids and Families team is that there is a benefit to MH services more broadly of separating children's MH from adolescent, youth and adult MH. At present quite young children (0-14yo) are expected to share waiting rooms and clinical facilities with young adults up to 25yo ("youth"), and in some locations adults, who are often unwell with serious mental illness. Young children can be disruptive for a variety of reasons and the adults can have very limited tolerance for this behaviour when they are unwell. There have been incidents of children being approached by unwell adults in the waiting rooms of our service. This is inappropriate for both clients and presents an avoidable risk of harm.

- There is an increased need for transcultural and bilingual/multilingual clinicians to be working within the Child and Family MHS on a regular basis, not only in a consultative model such as provided by the Transcultural Mental Health Service.

- There is a need for more time and funding to support opportunities for community development for First Nations Peoples and people across cultures to share their own knowledge about strategies for successful prevention and early intervention with early symptoms of mental ill health, and to identify how services can increase accessibility for these families when they do need to engage with Mental Health Services.

- There is a need for increased availability of other case management services for First Nations Peoples, aside from DCJ, Brighter Futures and KARI (which do not service all areas). The pilot KEYS (Kids Early Years Service) program is an example of what can be possible and outcomes that can be achieved for local families when there is proactive coordination between NSW Government Departments providing services to highly vulnerable families with at least one child aged 5yrs or less. In this model, Manager level staff from DCJ, Housing, Education, Health, and caseworkers from various Non-Government Community Operated Organisations meet to coordinate the service responses by each Department. This model has resulted in some very effective service provision that has prevented the burden of starting afresh with each government department impacting on the complexity of a family's challenge and the family 'falling through the cracks'.

- A significant challenge is the provision of mental health care to children with a comorbid intellectual disability. There is a lack of services available to provide comprehensive assessment of cognitive and neuropsychological impairments at an affordable rate. This is another service that has effectively priced itself out of the reach of ordinary families since the arrival of the NDIS. Public mental health services rarely consider it part of their remit to employ sufficient Clinical Neuropsychology staff to be able to provide this assessment capacity in-house. While some clinicians are suitably qualified to complete these assessments, if they are employed as a general clinician on the team, they are expected to carry a full caseload and account for their clinical time, with questions asked if they are not seeing as many clients as colleagues working the same number of paid hours per week. The CHOC Clinical Activity program that NSW Health requires us to use to account for our clinical work is again unfit for purpose in this case, as it does not have the flexibility to allow for specialist work to be easily accounted for in its generic format.

- It would be helpful if NSW Health was able to engage in a proactive discussion of how best to capture the clinical activity and relevant outcomes of clinicians working in Child and Family Mental Health services. This would require an acknowledgement that children are innately different from adults and therefore require a very different service model to meet their needs. It is possible to establish clear therapeutic goals, clinical review and appropriate discharge planning within this broader, reality-based understanding of how children's mental health needs are met.

(i) ***alternatives to police for emergency responses*** to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER)

- Allowing patients to remain in hospital until they are actually well enough to be discharged without a high risk of immediate relapse would be a great start to reducing the involvement of Emergency Services when they deteriorate in the community.
- Enhancement of Acute Mental Health Teams to provide 24/7 service to In-reach to Emergency Departments as well as being able to attend to clients who are deteriorating in the community, including to administer medication to manage severe symptoms under the supervision of an on-call psychiatrist.

- Education of Police and Ambulance staff to allow children who have been extremely distressed, impulsively aggressive to themselves or others BUT have now settled at home, often sound asleep after the outburst TO REMAIN asleep and settled at home. Too often Emergency Services staff have insisted that because they were called to a scene (often taking hours to arrive) it is their responsibility to transport the child to hospital for a mental health assessment. This results in a further outburst by the child when they are woken up unnecessarily. The most recent event occurred only last week and is not uncommon in our LHD.
- The Safeguards Teams being rolled out by NSW Health are intended to provide a capacity to attend to urgent mental health crises for ***children and adolescents*** in the community – homes, schools, other areas – and implement a management plan to ensure safety without the need to present to an Emergency Department. In some LHDs the Safeguards team has been established as a Business Hours community mental health team for ED follow up, instead of an Extended Hours team capable of responding to crises in the community. Therefore, it is not meeting the goals of NSW Health in establishing the team. Other LHDs have been able to implement the Safeguards teams effectively to provide the community crisis capacity as intended, under the direction of experienced Child Psychiatrists.
- As noted above, increasing the skill level and capacity of Residential Care Staff caring 24/7 for children and adolescents in OOHC would translate into more sophisticated management of distress at the home when this occurs, the safe administration of "PRN" (as needed) medication in alignment with a management plan written by a treating Psychiatrist (preferably Child Psychiatrist) would go a long way to reducing the need for Emergency Services being called to these situations. It is also necessary to make a very clear distinction that the medications being administered in this situation are part of a Treatment Plan and are NOT "restrictive practices". Foster carers can also be trained to administer PRN medication in the same way that biological parents do in response to their children's needs and treatment recommendations.
- Educating Care Staff and all professionals responsible for raising children in the safe and appropriate use of behaviour management strategies, including therapeutic holding when indicated, would create capacity for situations to be managed at home or school without requiring the involvement of Police and Ambulance. I am very aware that the current restrictions on care staff and teaching staff have arisen as a result of institutionalised abuse, however the current position has removed all authority from the adults who are supposed to be nurturing children's development and created a subgroup of children who have never experienced the reality that the rules apply to them too.

(j) any other related matter.

- There is an accumulation of research evidence that highlights the value of having early intervention services available to all vulnerable families across early childhood and primary school ages years, with services that are family focused, to assist families to navigate the crucial stages of development – as mental health **prevention**

- The benefits of early intervention and prevention include demonstrated cost-effectiveness across the full range of State and Federal Government Departments,

particularly when this is proactively targeted to the under 12 yo population. One of the challenges for Governments to address is that it may outlay funds in eg Health, DCJ and Education portfolios only to realise the impact in reduced need for Adult Health and Mental Health Services, Drug and Alcohol Services, Juvenile Justice, prisons, supported housing and welfare payments. The Federal Government may also realise increased tax revenue by increasing the number of adults participating constructively in the workforce.

- It would be helpful if all levels of Government applied evidence to provide enhanced funding where there is clear need and increased demand for services.

- There is a need for family-based systemic services within the government-funded adolescent mental health system.

- Funding for existing clinicians to provide therapeutic group programs as part of the suite of therapeutic options available to families. This would include adjustment to the CHOC Activity collection platform to allow this to be captured as direct clinical activity.

- The current MHOAT platform places inordinate emphasis on time-consuming collection of data that is not a meaningful representation of the complexity of client presentations, nor the therapeutic work being completed. Insistence on collection of data that is irrelevant to accurate measurement of outcomes for children and families continues to undermine morale in an already stretched workforce.

- There is a need for more integration between the Education system and Mental Health system from a structural perspective e.g. the previous Redbank SSP for children under 12's and their families.

- There is a great need for more collaboration and attitudinal shift by Emergency Services and all related Government Departments to prevent and intervene early when a family is experiencing Domestic and Family Violence and Child Protection concerns. Especially further support for DCJ to be able to remain involved with therapeutic services and to reduce burnout for clinicians. The recent shift within DCJ to become a "brokerage and triage" service instead of an assessment and case management service has resulted in yet another Government Department moving into "all care but no responsibility" for the (inevitably poor) outcomes created by their very slow response to immediate risks and refusal to accept a role as ongoing service coordinators with oversight of ongoing safety of children within a family.

- The current predominant focus on short term metrics to measure outcomes for children, and for mental health team staff, is not realistic and is not building a sustainable mental health system that is capable of responding flexibly to actually meet the needs of the children and families presenting for care.

There are many complex issues raised in this submission, touching on a wide range of NSW Government services. The earlier down the age range that one seeks to provide prevention

and early intervention for mental health, as opposed to treating mental illness, the greater the need for coordinated and 'wrap-around' care with a 'whole of government' approach. Collaborative care is best provided by co-located services in geographically accessible areas. Some LHDs have moved to providing a range of children's physical and mental health services at local schools, as these are readily accessible by families with a range of difficulties. One underlying principle might be that IF services are designed to meet the needs of our most vulnerable community members, then the needs of all community members will inevitably be met in the process. It remains to be seen whether NSW Government can accept that it has a responsibility to all members of the NSW community, not just those who live in their neighbourhoods and who donated to their political campaigns.

I would be willing to speak to the Inquiry about any of the issues raised above if invited.

Your attention to this matter is greatly appreciated.