REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

CORRECTED

At Macquarie Room, Parliament House, Sydney on Friday 3 December 2021

The Committee met at 9:15.

PRESENT

The Hon. Greg Donnelly (Chair)

Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Emma Hurst (Deputy Chair)
The Hon. Trevor Khan
The Hon. Natasha Maclaren-Jones
The Hon. Walt Secord

The CHAIR: Good morning everyone and welcome to the thirteenth hearing of the Portfolio Committee No. 2 inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales. My name is Greg Donnelly and I am the Chair of this Committee and inquiry. The inquiry is examining health outcomes, access to services, patient experience, planning and capital expenditure in rural, regional and remote New South Wales. Before I commence I acknowledge the Gadigal people, who are the traditional custodians of the land on which the Parliament sits. I pay respect to Elders past, present and emerging of the Eora nation and extend that respect to other Aboriginal people viewing the broadcast wherever they may be today.

Today's hearing is being conducted virtually and in person. I ask for everyone's patience through any technical difficulties we may encounter. If participants lose their internet connection and are disconnected from the virtual hearing, they are asked to rejoin the hearing by using the same link as provided by the Committee secretariat. Today we will hear from a number of stakeholders including mental health and advocacy groups, the NSW Farmers Association, allied health and other health services. I thank everyone for making the time to give their evidence to the inquiry today.

Before we commence I will make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcast guidelines, media representatives are reminded that they must take responsibility for what they publish about the Committee's proceedings today. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing. Therefore, I urge witnesses to be careful about comments you may make to the media or to others after you complete your evidence to the inquiry.

Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, it is important that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. There may be some questions that a witness could answer only if they had more time or with certain documents at hand. In those circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days.

Finally, a few notes on hearing etiquette to minimise disruptions and assist our Hansard reporters. I ask Committee members to clearly identify who questions are directed to and I ask everyone to please state their name when they begin speaking. Would everyone please mute your microphones when you are not speaking and remember to turn your microphones back on when you are getting ready to speak. If you start speaking whilst muted, please start your question or answer again so it can be recorded accurately in the transcript. Members and witnesses should avoid speaking over each other, so that we can all be heard clearly. Also to assist Hansard, I remind members and witnesses to speak directly into the microphone and avoid making comments when your head may be turned away.

JENNY LOVRIC, Manager, Community Engagement and Partnerships – Aboriginal Legal Service, Just Reinvest NSW, before the Committee via videoconference, affirmed and examined

The CHAIR: Welcome on behalf of the Committee. We have noted that Ms Judy Duncan, who was going to join us this morning, is unavailable. That is unfortunate, but pass on our regards to her. I acknowledge and thank the organisation for the provision of its submission to the inquiry. It has been received and processed and stands as submission No. 706 to the inquiry. The submission has been uploaded to the web page for the inquiry and stands as evidence to the inquiry thus far. We have you here today to provide additional material, which will become evidence to the inquiry and will help inform our deliberations over the report and the preparation of its recommendations. I invite you, Ms Lovric, to make an opening statement and once that is done, if you are agreeable, we will move to questions and move between the various groupings around the table. We have representatives here from the Opposition, the crossbench—the Animal Justice Party and The Greens—and the Government. We will share the time for questioning. Is that format suitable to you?

Ms LOVRIC: That is fine. Thank you so much.

The CHAIR: Over to you for your opening statement.

Ms LOVRIC: Thank you. As you are aware, a representative was going to give an opening statement about some people's experience of health care in Moree, but they are no longer available to give evidence today. I will commence by giving an opening statement by Just Reinvest NSW and then I will move over to some reflections for Committee members which were going to be given by that lawyer representative, if that is okay.

The CHAIR: Thank you, that is good.

Ms LOVRIC: Firstly, I would like to acknowledge country and ancestry of the lands we are meeting on today. I am personally speaking from Gadigal country of the Eora nation and I pay my respects to Elders past and present. I also pay my respects to the Gomeroi people, whose experiences and reflections will be in this statement and certainly were reflected in our written submission. Again we thank the inquiry for hearing from Just Reinvest NSW. The inquiry may be wondering why Just Reinvest NSW is interested in the area of health. Justice reinvestment, in practice, is about addressing the underlying issues that drive interactions with the criminal justice system and shifting resources accordingly. Health is a key driver into the criminal justice system.

We of course are not medical experts but Just Reinvest does bring expertise on local and Torres Strait Islander people's lived experience of receiving and sometimes not receiving health and hospital services in Moree. Serious disparities and challenges accessing health services and getting outcomes that people want or need in a remote location will not be news to your inquiry. The people we work with in Moree are aware that undiagnosed and untreated health issues and in particular mental health, alcohol and other drug issues left unaddressed result in interactions with the criminal justice system. The Special Commission of Inquiry into the Drug "Ice" sat in Moree, and this Committee will no doubt be aware of its findings and recommendations.

Moree is one of the richest agricultural regions in New South Wales; however, this richness does not always appear to be reflected in the availability or quality of health services in Moree. Access problems are evident across the spectrum of health services. Access to seeing a GP can take more than four weeks. Most specialists are only available on a fly-in fly-out basis, with people waiting months for appointments. Allied health services are also infrequent. As is often the case in access to justice issues, a person's postcode should not be determinative of whether or not a person can access appropriate medical treatment.

Much of the focus of Just Reinvest NSW's work is around young people. We know that young people in custody are nearly six times more likely to experience psychological disorders. The 2015 Young People in Custody Health Survey, conducted by the Justice Health and Forensic Mental Health Network and Juvenile Justice—now Youth Justice—found that over 83 per cent of surveyed participants met the threshold criteria of at least one psychological disorder and 63 per cent of two or more, compared with the general population prevalence of young people of 13.9 per cent. We also know that undiagnosed and untreated health issues in children can be determinative of positive education engagement and retention and employment outcomes. We know about the pipelines of education exclusion into the juvenile justice system, with the Young People in Custody Health Survey showing over 93 per cent of young people were suspended prior to entering custody.

We know that behind all these issues is the unaddressed impact of colonisation and intergenerational trauma and harmful child protection policies and practices. Service system dysfunction contributes to a high rate of contact with the criminal justice system. In the case of health services, silos, chronic service gaps, lack of cultural safety and instances of racism and discrimination mean that many people's health issues are unaddressed. There is a growing and substantial body of evidence that points to racism and discrimination as determinants of poor health outcomes. We know that many of the policy and practice levers to make important systemic changes

are often not directly in communities' hands. But communities we work with tell us, again and again, what the solutions are and they are around community voice and community control. I may just leave my part of the evidence there and move on to the Moree community's reflections, if that is okay?

The CHAIR: Thank you.

Ms LOVRIC: Great. Thank you. Moree Aboriginal community have told us of families' lived experiences and the challenges of getting adequate and respectful health care in Moree. Moree has its own Aboriginal community controlled health service called Pius X Aboriginal Corporation—Pius—and the Aboriginal community have great pride in this service for their community. But people also need to access mainstream and hospital services outside Pius. People can reflect how rich the Moree community supposedly is, but this wealth is just not reflected in the access to health services. Many of the issues that come up in Moree are, and include, long waitlist to see a GP [audio malfunction] services including things like MRIs, orthopaedic treatment, detox, tonsillectomies. It is expensive to travel out of town. People have to leave their jobs and their families and pay for travel, accommodation and food. If they were to take someone else to support them, that is even more expensive. Transport options are limited and it is stressful.

These stressors could all be prevented if services were local. People feel they do not always get the experienced doctors that they deserve in Moree. There is a feeling that some people visiting hospitals end up leaving the hospital without adequate treatment and some people are sent home with very serious issues that are not treated without investigations of the [audio malfunction]. People also do not know how to complain about the poor health services they receive and there is little trust if anything would be done anyway. People also feel they cannot complain because they do not have alternatives and they do not want to risk being viewed as a complainer and the repercussions from that.

Untreated mental health and drug and alcohol issues are a big concern. People with acute mental health conditions cannot get the crisis mental help they need, and this is not just Aboriginal people. There are many suicides in Moree, but it feels like these mental health issues—sometimes related to drug use, sometimes not—are not being addressed in any systemic way. We know that lots of people with mental health problems end up in the criminal justice system. Some people may have got mental health treatment when in prison, but their mental health plans and medications are not followed through when they are released back into the community. Without ongoing health treatment, they may end up reoffending and back in prison.

Mental health diversions from the criminal justice system are not easy in Moree as there are not enough—indeed, sometimes not any—psychologists to support mental health plans. Accessing drug and alcohol services is also difficult in Moree. There is no Magistrates Early Referral into Treatment, the MERIT diversion option, in the Moree Local Court. There is no detox service in Moree and people are forced to leave town to detox before they can get a rehab bed. There are no specific drug and alcohol services for young people in Moree and there is inadequate emergency department treatment in Moree for people seriously affected by drugs.

When the "ice" inquiry sat in Moree, a lot of people gave evidence about these issues and nothing has been done. We also hear about concerns about the way Aboriginal people are treated by the health system in Moree. For example, some Aboriginal people sometimes feel that some of the staff in the hospital and emergency do not treat them well. Some people feel uncomfortable and judged, and that they are discriminated against. There is a feeling that people's medical problems are regarded as self-inflicted, due to addiction issues and the like. Some Aboriginal people in Moree feel staff at the hospital are dismissive and do not take their concerns seriously. There are too many stories of people being sent home with very serious conditions and some of the people get very, very sick at home with their very serious conditions, and some people, in fact, have died. Nothing seems to have been done about this.

For many people, it feels like the services are not culturally safe—they do not understand or try to understand how Aboriginal people experience the system. There are big concerns around the high levels of cancer in the Moree community. There are no specialists in Moree and, again, it feels like this is not being addressed. In the end, poor treatment and the feeling their concerns are not being heard makes people mistrust the health system. I do have some recent examples of how people were treated through the recent COVID outbreak, if the Committee would like to hear about some of those?

The CHAIR: Yes, just with this caveat—depending on the nature of the content, the appropriateness of de-identifying specific individuals, in terms of using their names.

Ms LOVRIC: Absolutely.

The CHAIR: Please proceed.

Ms LOVRIC: Thank you. Through COVID, access to medical services became even harder. Appointments with specialists who come up to the Aboriginal Medical Service [AMS] were cancelled, including appointments for ear nose and throat specialists, dentists and optometrists. It was also hard to get specialist medication through COVID. There were sometimes long waits to get COVID test results. People in Moree knew that in Sydney it can take sometimes only eight hours to get test results, but some people in Moree had to wait many, many days to get their results. Some Aboriginal people in Moree felt they were treated differently and unfairly due to COVID.

There were reports that the recent COVID outbreak in Moree started from a funeral in Moree; however, COVID was already present in the sewerage system well before the funeral. As a result of the misinformation around that issue, some people in town were making discriminatory assumptions that anyone who was Aboriginal was at the funeral and they were banned from entering shops. In one case, a person who put his car in for service was charged for cleaning his car, on the assumption that he and his car were a COVID risk. Being unwell is stressful enough. Being treated with such contempt and unprofessional behaviour only makes this worse. I will include my written statements from Just Reinvest and those collection of statements from the community. I welcome questions.

The CHAIR: Thank you, Ms Lovric. With respect to those two documents you have just read from, are you able to provide them to the secretariat or email them in to us to help us to accurately record what you have said, just to enable us to double check?

Ms LOVRIC: Indeed, I will.

The CHAIR: Thank you for that. With respect to the second part of what you said, could you pass on our thanks to Ms Duncan, who obviously was involved in its preparation. We acknowledge and thank her for her contribution.

Ms LOVRIC: Yes, I will do. Thank you.

The CHAIR: We will move to questions now—approximately nine minutes or thereabouts for each grouping. We will start with the Opposition. The Hon. Walt Secord?

The Hon. WALT SECORD: Ms Lovric, thank you for your evidence and thank you for your time. I would like to start off on your mention of no detox services and no drug and alcohol services. If someone wants to seek treatment or assistance for drug or alcohol addiction, what would be the nearest service to the town of Moree?

Ms LOVRIC: Moree, in fact, does have a small rehab centre in Moree. I think it has between eight and 12 beds. However, to access that service, a person has to be detoxified first. So there is no admission without detox. There are no detox beds or centres in Moree, so people have to travel three or four hours away to either Tamworth or Armidale for detoxing.

The Hon. WALT SECORD: Is there a waiting list? Or is that not the way it works?

Ms LOVRIC: You mean for the rehab or for detox?

The Hon. WALT SECORD: For both, actually.

Ms LOVRIC: The process is that someone cannot get a rehab bed in Moree until they are detoxed, so there is a kind of confusing timing issue that one has to find themselves a bed in the detox and then transfer straight over to Moree for the rehab. So that is a logistical issue, but also it raises those issues that were raised earlier around transporting oneself down to one of those centres and then finding oneself back to Moree and hoping that there is a bed available at the rehab centre in Moree.

The Hon. WALT SECORD: As part of the Committee's response, we make recommendations to the Government as part of a final report. Without putting words into your mouth, would you like to see one of the recommendations be an expansion—what would you like to see as a treatment facility in Moree?

Ms LOVRIC: I would refer the Committee, again, to the special commission into "ice", which indeed sat in Moree, and one of the recommendations there, I believe, was for better access to drug and alcohol services in Moree. So, yes, of course, we would like to see detox facilities in Moree; we would like to see more availability of beds. But also, in particular, we would like to see drug and alcohol treatment for young people, because that does not exist in Moree at all.

The Hon. WALT SECORD: You mentioned in your opening statement that there was a four-week wait to see a GP. Is that for Indigenous or non-Indigenous, or is that everyone in the Moree community?

Ms LOVRIC: My understanding is that it is everyone in the Moree community, and sometimes it is well over four weeks.

The Hon. WALT SECORD: What is the availability of medical services in Moree? Is it a district hospital? Is it a multi-purpose service [MPS]? What is the health facility in Moree itself?

Ms LOVRIC: There is a hospital in Moree, and I mentioned earlier that there is Pius, the Aboriginal medical service, in Moree as well. But, as the Committee would appreciate, care is a continuum of care. People may visit the Aboriginal medical service for day-to-day medical issues. In better times there are visiting specialists on a sessional, fly-in fly-out basis, but there are times when critical care will be needed, in which case people will have to visit the hospital.

The Hon. TREVOR KHAN: It is a district hospital.

The Hon. WALT SECORD: Okay, so it would be a group D?

The Hon. TREVOR KHAN: I think that is right, yes.

The Hon. WALT SECORD: One of my colleagues just said that it would be a district hospital. You made mention of cancer treatment. We have received evidence across the State. How does treatment for oncology occur? Do patients go to Tamworth or would they come to Sydney? I would assume there is no treatment locally.

Ms LOVRIC: My understanding is that there is no treatment locally because there is no oncologist. As far as I am aware, there are no specialists in Moree whatsoever, so people would have to visit other, larger places, like Tamworth, Armidale or Sydney.

The Hon. WALT SECORD: And what is the population of Moree?

The CHAIR: Approximately.

Ms LOVRIC: The town is approximately 8,000 or 9,000, and the Aboriginal community there at the last census was around 2,800. That was in 2016.

The Hon. WALT SECORD: I have actually visited Moree, but I just wanted to get that as context.

Ms LOVRIC: Yes. The local government area [LGA], which includes the satellite towns, may bring it up a bit higher.

The Hon. WALT SECORD: If someone appears before a magistrate, are there any options for treatment as part of the sentence or rehabilitation? What happens in Moree in that regard?

Ms LOVRIC: There is a local court that sits in Moree. Many courts around New South Wales will have a justice health nurse that sits on the court and that the magistrate can refer those people to for an assessment of their mental health. There is no justice health nurse that sits in Moree local court. Other courts around New South Wales, as we mentioned, have Magistrates Early Referral into Treatment for drug and alcohol treatment. That exists in many courts around New South Wales. That does not exist in Moree. [Audio malfunction] how those options are again—

The CHAIR: Ms Lovric, we just lost you for about four or five seconds. Would you mind circling back and covering what you said?

Ms LOVRIC: Certainly. Other courts around New South Wales have the MERIT program—the Magistrates Early Referral into Treatment program—for people affected by drug and alcohol. That does not exist in Moree. Defendants before the court who may have mental health issues can have access to diversions to seek mental health support, but those options are indeed very limited in Moree because of the absence of psychologists and the ability to make case plans that may support those diversions.

The Hon. WALT SECORD: In your submission, you make mention of a phrase called "postcode justice". Can you elaborate on that?

Ms LOVRIC: Yes. I live in Sydney and my postcode is very well heeled. I have access to any number of medical specialists. I have access to any number of lawyers. I have access to any variety of education I might choose from. In the case of justice and postcodes in Moree, that availability is disparate. When we talk about postcode justice, we refer to the differential between access to support across a whole array of human services domains, which are not available in Moree compared with other postcodes where they are much more available.

The Hon. WALT SECORD: In other inquiries that have been held in the past six to eight weeks on First Nations imprisonment, we heard evidence that the female Indigenous population in New South Wales comprised about 1.7 per cent of the population but 35 per cent of the female Indigenous imprisonment population.

Do you find similar evidence in the Moree region and in the impact on the female Indigenous population, and could you comment on that?

Ms LOVRIC: I do not have those statistics on hand about what is particularly happening in Moree, but we certainly do know that there is that terrible cycling in and out of prison of First Nations people, and that certainly has been on the rise in the past 10 years. Yes, that is the case.

The Hon. WALT SECORD: How does that impact on health outcomes for children, women and the community in general?

Ms LOVRIC: What are the drivers into the criminal justice system in the first place? That is what justice investment is around. It is around those untreated [audio malfunction] that lead to people's interactions with the criminal justice system. Once again, untreated mental health issues, untreated drug and alcohol issues, lack of access to appropriate housing and health care are what see people become more in the face of the criminal justice system, combined with over-policing in particular places, which means people are more likely to unfortunately have a criminal justice response rather than a health response or a housing response.

We have an issue in New South Wales that first responders are often police because they are the 24-hour service. I think the police would agree that they would prefer not to be that first responder. The issue is that we do not have the services either available or available at the right times when people need that assistance, and so the criminal justice system becomes a kind of stopgap. We would like to change that. We would like to see the resources shifted so that those underlying issues that see people drawn into the criminal justice system are better redressed and better funded so that we do not have a criminal justice first response.

The Hon. EMMA HURST: Thank you for joining us this morning, and thank you so much for your detailed submission. You have highlighted that there are very high rates of suicide in Moree, and I think you said in your submission that it is not being addressed in a systemic and coordinated way. Obviously this is extremely concerning. Can you give us an idea of what needs to change and what needs to happen on the ground?

Ms LOVRIC: As I said earlier, in Moree there needs to be appropriate, culturally safe mental health care that needs to be available at all hours and needs to be available to young people as well as older people. The service sector in Moree, and indeed in many regional places in New South Wales, is very siloed. There are chronic gaps. There are duplications in places where you do not need it. To address those issues around suicide, one needs to be looking at those underlying issues and, in the case of First Nations people, all those services need to be informed by culturally safe practices. People have a well-founded distrust of many of the mainstream systems, so there needs to be a rethinking of service delivery. It needs to be available 24/7 and it needs to be culturally safe so that people will feel [audio malfunction] accessing those services.

The Hon. EMMA HURST: Yes, thank you. It is interesting because we are talking about adding more services, but I also understand from your submission that there has been a psychologist position available for three years that you cannot fill. Is that still the case? Can you give us an insight into what the struggle is to get recruitment into this space?

Ms LOVRIC: Thank you for the question. I think the statement around lack of access to a psychologist is from Youth Justice or juvenile—

The Hon. EMMA HURST: Correct, yes.

Ms LOVRIC: It was not our psychologist. The issue around recruitment and retention of local professionals is an issue. It is an issue in Moree. It is an issue in many regional and remote areas of New South Wales. People do not want to move to an outer, regional, remote location, to be away from the services, education outcomes. I think there is a genuine gap in professional services. This is not only health services. It is the same in the legal sector and sometimes, I think, the teaching and education sectors as well. So I think there is a problem. There have, I believe, been discussions around particular loadings and increased salaries to help attract and retain people into those regions. I think that is an issue in terms of just recruitment.

The Hon. EMMA HURST: Thank you. I just want to jump back as well. The Hon. Walt Secord was asking questions about the detox centre. You were talking again in quite a lot of detail about the fact that everyone has to travel to detox before they can enter rehab in Moree. Just if we can pull that apart a little bit further just for the benefit of the Committee. I have worked in the space of drug and alcohol previously. There are so many hurdles to getting somebody into a detox centre anyway. But, obviously, having to travel creates more hurdles. Can I just get a bit of a feeling, on the ground, what that means for people? Does it simply mean that there is a huge number of people that are falling through the gaps because they do not have access to be able to travel outside of town and things like that?

Ms LOVRIC: Absolutely. The public transport systems between Moree and regional centres are difficult. They are expensive. They are not that frequent. People may not have access to cars. If people are unwell, they do not want to be driving somewhere as well. There are just some very practical, logistical problems with travelling. Leaving family, leaving your country, leaving your support network to go and detox only adds a further layer and a burden of stress on a person who is already, clearly, in a stressful situation. I do understand there are some government rebates available to travel, through the Isolated Patients Travel and Accommodation Assistance Scheme service, but the awareness of that service is pretty low. There are certainly restrictions in terms of accessing that. The kilometre allowance is lower than, for example, the ATO rebate on kilometre and mileage allowance. Being away from family, if you are employed, having to leave your job while you go through that process, these collectively add up to a [audio malfunction] to try and seek that help. It all seems like too much. People will not do it.

The Hon. EMMA HURST: Thank you.

Ms CATE FAEHRMANN: Thank you for appearing and for the work that you do for Just Reinvest. I wanted to firstly thank you for raising the issue, in your submission and your opening statement here today, which was a really important one, around the links to health and justice. That has not really been a part of this Committee inquiry before. It is a really important perspective. I wanted to ask whether there is anything at a State level, any programs that the New South Wales Government is doing to address or to support or help the situation of, as you say, cognitive disabilities and mental health disorders in young Aboriginal people entering the justice system. Is there anything there at a statewide level, like a program, that is working, or has been trialled firstly?

Ms LOVRIC: I may have to take some of this on notice. I do not think there is any statewide program. There are discrete initiatives that may go to providing some kind of support. There is the Justice Advocacy Service, which is a service that assists witnesses, defendants, victims, in their interactions with the police and in the courts, who may have an intellectual disability or impairment. They are there not as an advocate but really as a support person to ensure that those interactions are a bit safer, taking into account those people's abilities. That does exist. But in terms of a statewide program that actually goes to addressing the underlying issues and treatment, I am not aware of that. You are right, we think this is a critical issue. People's journey into the criminal justice system is really because of those unaddressed, underlying and untreated issues. The resources put into the criminal justice spectrum of that journey are incredibly expensive and, of course, incredibly harmful. So we say that those resources at the end, at that criminal justice end should be shifted towards those underlying issues. The communities that we work with have very strong opinions on where they should be and how they should be placed.

Ms CATE FAEHRMANN: Thank you. The statistics that you mentioned in your opening statement were just incredible, I think, 83 per cent, something like that—in the 80s percentile—compared to 13.9 per cent. There was something there that was just alarming. More broadly in terms of mental health, treatment and support for young Aboriginal people across the State, are there programs available or is that done at a local level through the Aboriginal community-controlled health organisations and through mental health support work, Aboriginal mental health support workers, at the local level? Again, a question as to whether there are any good programs at a State level that we could look at.

Ms LOVRIC: I would probably want to take that on notice about whether there are any State programs. I am not aware of those. I think you are right, there are a lot of, perhaps, ad hoc programs. There may be a government initiative or priority around a particular area and some very short-term funding will become available. There are a number of services in Moree that do really aim to get access to the funding to support those kinds of programs. But, regrettably, they are never particularly long term. The kind of ongoing training and recruitment issues around filling those positions is definitely a challenge.

Ms CATE FAEHRMANN: I did find it extraordinary, your evidence that there are no drug and alcohol services for young people in Moree. That is young people, full stop, I assume, not just those tailored towards Aboriginal young people?

Ms LOVRIC: There is headspace, which people know as a Commonwealth initiative. That is around mental health issues. But even with that service, which is not obviously a drug-and-alcohol issue, it is very limited. So headspace will not see people—sorry. Can people hear me?

Ms CATE FAEHRMANN: Sorry, no. We are talking to ourselves. If I have time for one more question—I apologise, continue.

Ms LOVRIC: With headspace, they will not address anyone in crisis situations. As the Committee would be aware, there is a strong link between mental health and drug and alcohol use. So people are excluded effectively from seeking help locally. Our view is that there are services around, they are well intentioned but not necessarily hitting the mark of what is needed and how they are needed to be delivered in a culturally safe way.

Ms CATE FAEHRMANN: Just on that, whether there have been any drug and alcohol services in the past in Moree, a question about what the advocacy for that looks like. You would think that alcohol and other drug providers or health workers there would have been advocating for this for some time. What have the barriers been, do you know, for not getting something like that in place? Firstly, have there been any? Then, what are the barriers to getting that in place?

Ms LOVRIC: There have been years and years of advocacy. Forests have been felled in the amount of inquiries there have been done around access to appropriate services in communities, including Moree. I again refer the inquiry to the ice commission. Those recommendations are still not implemented. We believe there are some elements of that being implemented. These issues do remain open and unaddressed. There is a lot of advocacy from the very wise people of Moree and their lived experience of these issues. But my understanding is there has been no implementation of any systemic approach. I do have to add that Pius does have programs, some amazing programs around social and emotional wellbeing. But it is that critical care issue which is missing.

Ms CATE FAEHRMANN: Thank you.

The CHAIR: Thank you very much. We now move to Government questions.

The Hon. TREVOR KHAN: I do not know if you can describe them as Government questions.

The CHAIR: I withdraw that, questions from members of the Committee who are members of the Government.

The Hon. TREVOR KHAN: That is a safer way of putting it. You would be aware that I have some knowledge of Moree. It seems to me if you look historically at Moree what you see is, like many centres in rural and regional New South Wales, a community that is shrinking, it is losing services over a period of time. Have you been able to identify that?

Ms LOVRIC: That is a really interesting case in point in Moree. As the Committee may be aware, it is now the site of Inland Rail and the Special Activation Precinct infrastructure, which will in fact, under their estimate, see a significant growth in the population in Moree. There is talk around building up to 5,000 new houses in Moree to house people that are going to rush to Moree to build and service that infrastructure. While there may be shrinking service delivery, there is anticipation of the growth. I think, as the Committee would be aware, that resources and services happen in fits and starts. We often hear in Moree there are 72, 73 services in Moree, a gazillion dollars is being spent on services, but we are not seeing the outcomes one would expect. It is an issue, not about the amount of services, about equality, sustainability and appropriateness of the services that are in town that appropriately meet the crying need for support.

The Hon. TREVOR KHAN: Fair enough. Let us look at the appropriateness. Yesterday we had some evidence given by the Far West Local Health District. One of the inquiries that was made was how many Aboriginal people are employed, particularly health workers, by that health district, and we could not get an answer. If you talk about culturally appropriate health services, do you agree that one of the elements of that is the need for governments to prioritise employing more Aboriginal people within those services?

Ms LOVRIC: I 100 per cent agree with you on that one. It is no surprise that Aboriginal people would feel more comfortable accessing and receiving services from—and that is absolutely the case. We do also understand that under the national Closing the Gap and State Closing the Gap agreements, that is one of the priority reform areas that Aboriginal community-controlled organisations who employ Aboriginal people are better resourced and are [audio malfunction].

The CHAIR: We just lost you again.

Ms LOVRIC: So that sector absolutely—can you hear me again now?

The CHAIR: We can, yes.

Ms LOVRIC: What I was saying—and I will just summarise—is that under the Closing the Gap priorities one of the priority reform areas is to better resource and acknowledge and support the actual community-controlled sector, and that will include Aboriginal community-controlled health services. That sector certainly warrants much more support, because that is the services that First Nations people feel comfortable accessing because of the nature of service delivery, that trauma-informed service delivery mode, and people feeling comfortable in that environment.

The Hon. TREVOR KHAN: But it has to extend beyond that, does it not? It has to extend into, we will call it the State-run health services as well. If you are turning up in accident and emergency and it is, I will describe it as an all-white workforce, the sort of issues that you identify of distrust and perhaps a feeling of discrimination are almost an outcome of the whiteness of the environment.

Ms LOVRIC: Absolutely, and people in Moree do say that there are no First Nations people in the emergency room in Moree, and we do know that people will feel safer and more trustful if there are people like them helping them with the service delivery. You would be aware though the statistics around people discharging against medical advice, which are far higher in First Nations people than in the general population, and that is around people feeling, 100 per cent feeling culturally unsafe and not cared for within that mainstream service. So, yes, while we do need to support the Aboriginal community-controlled sector, cultural safety needs to be implemented across the whole spectrum of mainstream services as well, especially in a place like Moree where a significant proportion of the population are First Nations people.

The Hon. TREVOR KHAN: The final area—and then I will hand back to my colleagues—goes back to this issue of drug and alcohol services. I would suggest that you would have seen not only in Moree but also in many other of these smaller centres—I will get myself into trouble for that—cases that are being adjourned again and again before the courts in order to get somebody into detox or a rehab bed or centre, but even if they were able to travel, there are not any beds in those other locations either. Eventually, in a sense, the magistrates sort of throw their hands up in the air: How long can we adjourn these matters for? That is not an uncommon experience that you would have seen, is it?

Ms LOVRIC: That is not uncommon and I think you will find that people are united in throwing their hands up because of the lack of appropriate options available to them that would be available perhaps in inner Sydney and Parramatta. We do see some amazing things like Youth Koori Court and we see Drug Court, and indeed soon we have a version of the Walama court starting up in Sydney as well. Those resources, regrettably, do not seem to find themselves across the mountains into regional and remote areas, where we think there is greater need. That is not to say those services should not exist or those mechanisms and courts should not exist in the city, but we do need to see some equity in how these are spread out across, and that is again a matter of resourcing.

The Hon. TREVOR KHAN: I am grateful for your evidence. I have run out of time.

The CHAIR: That brings us to the conclusion of this session. On behalf of the Committee, thank you very much for making yourself available. I know you are very busy with a range of commitments and I appreciate you carving out some time for us this morning. It has been very helpful to have your oral testimony, which will augment what has been provided by the submissions. Thank you once again.

Ms LOVRIC: Thanks to the inquiry for hearing from us and the people of Moree.

(The witness withdrew.)

KATHY RANKIN, Policy Director – Rural Affairs & Business Economics & Trade, NSW Farmers Association, before the Committee via videoconference, sworn and examined

SARAH THOMPSON, Member of the NSW Farmers Rural Affairs Policy Committee, NSW Farmers Association, before the Committee via videoconference, affirmed and examined

CATHERINE HENRY, Spokesperson, Australian Lawyers Alliance, before the Committee via videoconference, affirmed and examined

The CHAIR: Welcome to our next panel of witnesses. Ms Rankin and Ms Thompson, on behalf of the Committee, I thank both of you very much for joining us. I thank very much the NSW Farmers Association, a very well-known and well-regarded organisation participating in this inquiry. First of all, I acknowledge the submission that has been made to the inquiry by the organisation. It is a very thoughtful and detailed submission. It has been received, processed and stands as submission No. 686 to the inquiry and is available on the inquiry's webpage. I will invite an opening statement. I am not sure whether this is to be provided by one of you or to be shared. How would you like to do that?

Ms RANKIN: Chair, we have invited Sarah Thompson to make the opening statement on behalf of NSW Farmers. Thank you.

Ms THOMPSON: Firstly, good morning and thank you for the opportunity for us to speak to you today. Our role is one of advocacy on behalf of our farming membership, and our submission reflects the experience, issues and concerns with regards to health access and outcomes that they bring before us to raise in forums such as this. Health is complex and health care is complex but at its core are the people. We recognise an investment in health infrastructure has been committed to regional centres and it builds capacity for more specialised service delivery in regional cities. However, it is the human capital that has the greatest impact on the delivery of health for us. The lived experience of our cohort is one of difficulty getting access to health care in a timely, location-based way.

There is a strong value for the workforce we have. They have exceptional skills and dedication, but our communities are concerned for them. It is clear that they are underfunded, under-resourced, overworked and fully stretched. The evidence supports our knowledge that people living in rural, regional and remote areas do not enjoy equitable access to health care, nor to health and wellbeing outcomes. Accessing primary care, dental care, allied health and specialist services is more difficult for rural people and requires greater time and expense. We do not have the answers but we have anecdotal and lived experiences, which we hope will contribute to your findings. We understand the distances that people are being asked to travel and the cost burden of the impacts, both emotionally and financially, that that entails to access care.

From the most basic presentation to emergency in a multipurpose service where there is not a visiting medical officer [VMO], from driving 100 kilometres one way to attend an emergency department at night to being turned away from a smaller hospital where a pregnant mother has been booked to birth because the time of the presentation comes when there is no theatre coverage and they are then transferred to tertiary centres, to being unable to access home care to help manage keep our families at home, be it for aged-care support, palliative care support or rehab recovery, we understand that there are significant challenges to find health professionals to work in the communities, especially in rural and remote settings, from backfilled positions and maternity cover to part time, short term contracts for nurses and for allied health to full-time general practice doctors. We understand the challenges of distance. It seems that begging and borrowing from different sites provides short-term cover in one area while leaving another with a gap. However, the issues of access are not diminished over the course of time. In fact, many report nostalgically of localised healthcare models of the past. We have not got this right yet.

The CHAIR: Thank you very much. That is a very fine opening statement. I welcome Ms Henry from the Australian Lawyers Alliance [ALA]. For the record, I acknowledge and thank the Australian Lawyers Alliance for their submission. It is submission No. 694 to the inquiry, as I am sure you are aware. It has been received, processed and stands as a submission to the inquiry and has been uploaded to the inquiry's website. I thank you for that. Ms Henry, can I invite you to make a brief opening statement? Then we can open up the questioning from Committee members.

Ms HENRY: Thank you very much for the opportunity to address this important inquiry today on behalf of the Australian Lawyers Alliance. We are a national alliance of lawyers, academics and other professionals dedicated to protecting and promoting justice and the rights of the individual. As you have referred to, we have produced a lengthy submission, which I and other ALA colleagues prepared. Our members include barristers and solicitors whose practices include medical negligence litigation and who act for the many victims of medical and healthcare error in regional, rural and remote New South Wales and their families. In regard to my position, I have

decades of experience as a medical negligence lawyer practising in Sydney for 15 years and for the last 20 years in Newcastle. My firm operates from the Hunter region but we serve clients from all across New South Wales.

Through our practices, the ALA lawyers, the lawyers at my firm and I see firsthand the impact that inequitable health resourcing and other systemic issues have on those living in rural, regional and remote areas. These impacts are social, emotional and financial. You do not need me to repeat the statistics and research which show that people in regional, rural and remote New South Wales have less access to health services, have higher rates of potentially preventable hospitalisations and experience poorer health outcomes. Of particular concern is the fact that people in regional and rural New South Wales do not have the same access to mental health services and timely mental ill-health diagnosis as do people in Sydney. I have firsthand experience of that through a case I have been running in the Mental Health Review Tribunal for the last month.

I also do not need to repeat the client stories that were highlighted in our submission. The important point to take away from those stories is that people suffer avoidable deaths and significant injury because of preventable negligence caused by under-resourcing, lack of staff and systemic failures. We make 22 recommendations in our submission but today I would like to emphasise five things to the inquiry: First, an investment in health services is an opportunity to reduce significant compensation payouts made by health services, health professionals and their insurers; secondly, the need for greater and more transparent public data on adverse events causing serious injury and death; third, staffing—we know and have known for some significant time that workforce shortages and lack of experienced practitioners is the major issue; fourth, the importance of addressing Indigenous health outcomes and access to services and care; and, fifth, I do know this was not specifically mentioned as a term of reference but I do note the need for the inquiry to look at reproductive health services and access as an issue in regional New South Wales. I am not sure of the length of time I have. I have some more points and I am happy to talk further, but I do not know how much time is available.

The CHAIR: Thank you. The submission is a very comprehensive one and thank you for that. We would like to move to questions, but what do you say, Ms Henry? Do you have points for another two or three minutes, that is fine, but if it is going to go much longer it will start to carve into our questions. How much do you have left, roughly, do you think?

Ms HENRY: I think five minutes.

The CHAIR: What do Committee members say? Five minutes?

The Hon. WALT SECORD: Yes.

The CHAIR: I think the consensus is please continue because it will be valuable.

Ms HENRY: Going back to the first point, medical negligence claims are costly. I have been doing this for 35 years and I know—I have seen the data—that the data that is produced is through freedom of information legislation so it is not readily available by any means. Investment in health services can reduce those costs. Sadly, legal action and the cost of compensation or the threat of legal action is often a catalyst for health services and health practitioners to change practices or invest in additional resources. The John Hunter Hospital and Maitland Hospital in the New England area are some of the most sued hospitals in the State. Information that I have accessed and that local journalists that have accessed via Government Information (Public Access) Act [GIPAA] legislation reveal that negligence claims cost the New South Wales Government's self-insured Treasury Managed Fund, and now Gallagher Bassett, tens of millions of dollars, hundreds of millions of dollars every year.

There has been, historically, increased resistance to providing breakdowns according to specialty and practice area. This goes to my next point on the lack of public data. We do not know the number of avoidable deaths and injury due to inequitable health resourcing as access to medical data, including data by region, is unavailable. This is an area of responsibility for both State and national governments. Publicly available data helps to make governments, health agencies and health providers more accountable. New South Wales and Australia are well behind other OECD countries regarding the collection and public display of health data. I know that in England and in the United States adjusted death rates for a range of local hospitals can be obtained by the click of a button, by simply typing in the relevant postcode to a government website. Why can we not do that here?

The New South Wales Bureau of Health Information that was established after the 2008 Garling inquiry produces a quarterly report on the numbers of patients utilising hospital services and emergency departments waiting times, but not on numbers of adverse errors. The Australian Health Practitioner Regulation Agency [AHPRA] does not provide remoteness analysis for the data it collects. This is a major shortcoming and must be changed. The ALA recommends agencies develop protocols to produce meaningful data as to adverse events; for example, data recording on death certificates or for a death that is due to adverse events or a not reasonably expected outcome. Staffing, as we all know, is a key issue for access and this inquiry. It is a difficult issue to fix, clearly, but it is a crucial one. We need the development of a rural health workforce to be a national and State

priority. The lack of permanent local practitioners has led to an overreliance on locums. The system is less efficient and cost effective than using local practitioners. It prevents patients from forming trusted relationships with a doctor or healthcare provider which can cause a reluctance to attend for medical attention.

Lack of continuity of care is also a risk management issue. The inquiry is correct in not just focusing on hospital staffing; but also the general shortage of GPs, specialists, allied health and primary care professionals means people in regional, rural and remote areas are waiting longer than those in Sydney to access care. The ALA supports the directions listed in the New South Wales Government's NSW Rural Health Plan: Towards 2021: Enhance the rural workforce by seeking to attract and retain a skilled workforce in rural areas; strengthen rural health infrastructure, research and innovation by investing in regional or capital infrastructure; implementing best practice models in rural settings to expand and support the delivery of high quality services; and improve rural e-health solutions in rural New South Wales.

There is no financial incentive to account for remoteness and increased responsibility of rural and remote healthcare providers. The General Practice Rural Incentives Program and the Practice Nurse Incentive Program are a start but are not indexed. Other incentives need to be examined. Work on the national rural generalist training pathway and plans for rural generalists to be recognised as a protected specialised field are examples of needed innovations. There could be opportunities to use paramedics as well as volunteer ambulance drivers in roles and settings where there is a dearth of other medical and health personnel. Students who undertake training in rural areas are four times more likely to decide to practice in rural areas so we need to encourage more education and training, including rural rotations and training programs and degrees in regional, rural and remote areas.

In relation to Indigenous health, on the issue of the continuing urgent need to address rural health outcomes and access to health services to First Nation people the ALA supports and endorses the submission of the National Justice Project and its submission deals very comprehensively with discrimination, which is unfortunately encountered. Another important point to make—and I made this point in the opening address but it was not addressed in our submission—is the need to look at reproductive health services. One example is access to abortion services. Abortion is the most performed therapeutic procedure in Australia. Women in regional, rural and remote New South Wales do not have appropriate access to these services. They are largely provided by NGOs. I do know that this week there has been an announcements about a pilot program being rolled out in the Hunter. I thank the efforts of the local member for Wallsend, Sonia Hornery, in her efforts in this area of health services.

My final point is to implore each of you to ensure that this inquiry delivers recommendations that are then actioned. I was well entrenched as a medical negligence practitioner when the Garling inquiry was held in 2008. I attended some of the public hearings that were held in the geographical area administered by Hunter New England. The same issues as were discussed 13 years ago are still being discussed today. We need a properly funded databased strategy to improve rural and regional health care. People in regional, rural and remote New South Wales are suffering. They suffer physically, mentally and financially because of failings to ensure equity in access and quality of health care. I will be happy to answer any questions. Thank you.

The CHAIR: Thank you for that. We will now move to questions, which will be shared between the groups represented at the table. We will start with the Opposition and the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, Mr Chair, and I thank the witnesses for their submissions and their opening statements. Ms Henry, you made reference to the difficulty in getting information about adverse events. Yesterday we asked questions about Broken Hill Hospital and it is was very difficult to get information out of it. How do you secure information on behalf of clients involving what the Government calls "adverse events"?

Ms HENRY: It is not something that I do as a matter of course. It is in the policy work in my practice—I just know from the work that we do, and we can see that the work that we do comes, more often than not, from rural and regional areas. When you are acting in a case, you do not need to know how many times this particular outcome has occurred. But when I have been involved in policy work—I took quite a substantial role in preparing the submission that is before you in this inquiry and I have long been involved in the activities of the Australian Lawyers Alliance. That is why it is very disheartening to have to make the same points year in, year out. I was president of the New South Wales branch of the ALA in 1995 and in 2021 the same points are being made. The access to information is not as readily available as it is in the UK and the US. You have to search long and hard and make applications through the Government Information (Public Access) Act 2009 and freedom of information to get the information that should be readily available. We just have no idea. The Government has no idea, other than anecdotally and through the media reports, of this as a problem. The extent of the problem—we have no idea.

I can hark back to the only study that has been done in Australia—and this goes back to 1995—which is an inquiry which showed that 1 per cent of those who suffer adverse outcomes actually do anything about it. In the

US a study was done, which was reported in the *British Medical Journal*, that showed that iatrogenic injury—or adverse medical outcome—was the third leading cause of death. A similar study was done in the UK. In 1995 the Quality in Australian Health Care Study, commissioned by the then Federal Government, showed that we had an alarming rate of adverse medical outcome. It was called the Tito review, after the name of the bureaucrat who had the primary role, Fiona Tito. That data is very old and was very hard to obtain. [Inaudible] what was done.

The Hon. WALT SECORD: Have you found that there is a disproportionate representation of adverse outcomes and preventable deaths in rural and regional areas?

Ms HENRY: Yes, I have.

The Hon. WALT SECORD: Can you give me a bit of a context, proportion or illustration of that?

Ms HENRY: I cannot. I can only refer to my experience—the cases. I have worked in Sydney, I have worked in Newcastle. I have only done medical negligence litigation since 1989. Prior to that time I was at the Health Care Complaints Commission. My experience is that work has come in from regional New South Wales, from towns like Brewarrina, Coonamble and the North Coast of New South Wales. You leave Sydney and travel west, north or south and we do not have volume practices. We do not have numbers of doctors. We do not have doctors with specialised skills, so of course the incidence of adverse outcomes will increase. But I guess I just cannot—my point is that data does not exist but needs to exist. It was a recommendation of the Garling report back in 2008 and has not changed. It has not been dealt with.

The Hon. WALT SECORD: Thank you very much. I would now like to speak to Ms Sarah Thompson. Ms Thompson, you have made public statements about your consideration of an overemphasis on health infrastructure rather than staff. You would be familiar with a number of areas in New South Wales where there are what are called "ghost wards". This is where there are operating theatres and hospital beds where there are no medical staff, and the Government is unable to provide health services to those and to patients who want to be there, so in fact they are empty. Have you heard similar stories?

Ms THOMPSON: Yes, I have heard similar stories. I guess one of the current ones that pertains to our area is the visiting medical officers that are not available at the hospitals for surgical cover or things like that. For example, a birthing mother may have pre-booked to birth at one of the local, smaller hospitals and presentation might occur on the weekend, but because there is no theatre coverage she is then moved to a tertiary hospital for that to take place. I am aware of beds being available in multi-purpose services in rural areas where if you have got pneumonia or an acute illness you are unable to be admitted because there is no VMO coverage into that. I have also heard, anecdotally, stories from all around. We hear the stories all the time, but they are just two specific examples that I can give you.

The Hon. WALT SECORD: Can I ask you for a comment on this? It has been put to me that poor health services in rural and regional areas are actually discouraging young people from looking at farming as a vocation. Have you received feedback to that effect?

Ms THOMPSON: I think that if someone is going to go into farming that normally requires a passion beyond service availability of connectivity or health provision or education. I think the difficulty we see constantly is the ability to attract workforce or attract human capital to the communities that serve our farming businesses. I also know that for many people with young families that might be considering coming, they are the three key things that will cause them to do some more research. Our ageing population very frequently will withdraw from our smaller rural and remote communities because they fear that their health needs will not be met in them.

The Hon. WALT SECORD: With the indulgence of the Committee, I will rephrase my question and I will be very quick. Because of more health and medical services in rural and regional areas, would you agree that it makes it more difficult to attract labour and workforce to farms?

Ms THOMPSON: Yes.

The Hon. WALT SECORD: Thank you.

The Hon. EMMA HURST: Ms Henry, you talked a little bit, both in your opening statement and your submission, about how Australia is falling well behind other countries in regards to the collection and publication of health data, particularly death rates in hospitals. I am just wondering if you are able to point the Committee to other countries that do have a better system for collecting and publishing data.

Ms HENRY: I think we can learn a lot from the way it is done in the UK. I note that I often look at the way in which the type of law that I practice is practised in the UK. They have a much more developed community sector than I think we do. I would draw you to the work that is done by a national charitable organisation called Action Against Medical Accidents, which is a very useful resource. They have a great website. They do a lot of

very good work and very good policy work. The UK is the—I think we could learn a lot from the way in which they manage their health data, and emulate a similar system in this country.

The Hon. EMMA HURST: Your submission also highlighted the over-reliance on temporary locums to fill gaps in rural areas. You said that a lack of continuity of care can be a risk management issue. As lawyers working on medical neglect cases, do you see often that it is actually that lack of continuity of care that is leading to some of those adverse outcomes?

Ms HENRY: That is just but one reason. What I can say is almost exclusively the reason for medical negligence litigation is the high incidence of systemic issues in our public hospitals in particular. Most of the work done by my peers at my firm is litigation against publicly funded hospitals, where staffing is not as it should be, where communication is not as it should be, where junior doctors are not supervised properly. Almost every case that I have ever seen involving an avoidable medical accident has arisen from a systemic issue of some type.

The Hon. EMMA HURST: Just moving on, I have one question for Ms Rankin. A recommendation that you made in your submission is:

> That an audit of medical equipment available in remote areas be conducted determine gaps and enable appropriate resource allocation to increase locally delivered health interventions and preventative services …

Can you talk a little bit more about this recommendation and what kind of equipment you are concerned is lacking in remote areas? Or can you give any examples?

Ms RANKIN: Certainly. I will make an attempt to. Our concern is that often the leading-edge technology and resources tend to be placed within high population density areas, such as metropolitan areas. Too often we find that the technology and the equipment in regional areas tends to be low prioritised in terms of replacement and repair. Without having specific data, we feel that an audit of what is available in regional hospitals to either confirm or debunk that assumption is really important. That would also then lead to a better identification of how resourcing for the purchase, maintenance and improvement of those materials could be made available.

Ms CATE FAEHRMANN: I will just go to the NSW Farmers representatives first with this question, and maybe Ms Henry as well. This is a question around health promotion and disease prevention. All throughout the inquiry, of course, we have heard of the greater health inequities in regional New South Wales. What more could be done in regional, rural and remote New South Wales, specifically in the area of health promotion and disease prevention?

Ms HENRY: I think maybe that question is not something I—

The CHAIR: You may take it on notice if you wish.

Ms HENRY: Yes, I might take it on notice. Health promotion—I know that it is not my area of expertise.

Ms CATE FAEHRMANN: That is okay. Sorry, just to jump in, I think Ms Thompson or Ms Rankin from NSW Farmers had something in relation to this in their submission. Ms Rankin, is that something you care to address?

Ms RANKIN: Yes, I am happy for Ms Thompson to respond to that. But I will make the first comment that farmers tend to be more remote, even though they live in remote or regional settings. They tend to be a little bit isolated, and they tend to trust peer-to-peer information. Anything that helps to equip farmers to talk to their peers and their families about these issues is really important. Anything in a clear plain English setting is really important. Sarah, you might like to add some more.

Ms THOMPSON: I think that the communication with the cohort, as Ms Rankin said, peer to peer, is something that works well. If we look at what services are available in, for example, community health, where do you go to get access about that? Finding that accurately presented on websites I think is problematic. Being involved in palliative care as a consumer and previously as a clinician, you go to Cancer Council, for example, and there is a whole heap of pamphlets that say what is available and what it is and what you can get from where. That is not readily available in communities for people to be able to find out. In rural communities when you are going into public places it is quite good to have brochures to pick up and read what is available in your local community health centres. I think that is also perhaps not widely available.

There is a program at the moment that is a peer support program. It is called farmgate. It is meant to be able to—well, it does support low-level mental health early intervention. That model of care works really well as it provides someone with lived experience to give a gateway to conversation, and it overcomes the cultural barriers. But how do people know that it is out there? How do they know who to contact? At the moment, it is the clinician that is working in our region that is actually just—she is the one doing the research, saying, "Here is a group. Can I come and talk to you? I am here." We have just had floods and she is the one who has driven out to

the community and then talked to the community here to say, "What can I do for you? Where can I go?" That is not coming from anyone else other than her. How do you know it is there?

Farmers also access health information through their context through the Local Land Services [LLS]. Are there brochures at the LLS? I talk to brochures a lot because often it is that incidental pick-up of information that provides some insight into what is there. I do not think that the promotion of health services is well publicised. Equally, I would think that as a clinician I put my clinical hat on to publicise the service that I offer—or that I did offer because I am retired—which would then bring more people into that service and create a stress point that is not met because there is not the staff to do that. You can list what the palliative care services are in the community that I live in, for example. There are two full-time equivalent palliative care nurses to cover 11½ square kilometres promote the service.

The CHAIR: Sorry to interrupt, there was a break in transmission of about three or four seconds on the numbers you were speaking of. Could you please go back and repeat those?

Ms THOMPSON: Was that regarding the palliative care nursing numbers I was talking about?

The CHAIR: The numbers, yes. We just missed that. Thank you.

Ms THOMPSON: Speaking personally, two full-time equivalent palliative care nurses providing clinical support cover the Upper Hunter shire and the Muswellbrook shire, which is 11½ thousand square kilometres. Therefore, there is no after-hours and there is no weekend coverage because that is impossible to manage. You publicise what palliative care support is and you put it out there, but maybe you cannot meet the expectations of the community because you do not have the staffing numbers to do that. You would need three full-time equivalents to be able to cover after-hours or weekend work. Promotion of health—I am just trying to say there is a conundrum there as well.

The CHAIR: Yes, it is appreciated, thank you.

Ms HENRY: Can I just step in and draw the Committee's attention, and just continuing on from what Ms Thompson has just said about access to brochures, access to information, that there was a particularly good resource available to those in regional New South Wales, an initiative of the New South Wales Department of Primary Industries. It had a very good website and it used to produce really good material, a hard-copy publication that went out to women, admittedly—so half the population—called *The Country Web*. Because of their lack of funding—I don't know whether either Ms Rankin or Ms Thompson know about the existence of this good resource. It was an excellent resource specifically for women living in regional and rural New South Wales and a source of information to me as a health lawyer about what was of interest and current concern. So yes, I think there are lots of opportunities for communication within networks, community networks—I am often talking to them—in regional New South Wales and I think there is a lot of dissemination of that.

Ms CATE FAEHRMANN: Thank you. My last question specifically for Ms Henry. You have recommendations in the excellent submission you pulled together, and thank you for that. I wanted you to expand on recommendation No. 22, if you could, which is an amendment to the Mental Health Act "to permit suitable remote facilities to operate safe assessment rooms for mental health patients on the basis that three-hourly reviews of patients may be undertaken by a senior nurse or psychiatrist over video link." Could you expand upon the need for that?

Ms HENRY: I mentioned in my opening statement that I have been involved in a case which has come before the Mental Health Review Tribunal on three occasions during the course of a month, which is highly unusual, and that it is apparent to me through the mental health advocacy work that I have done and also having been a legal member of the Mental Health Review Tribunal that the resourcing of mental health services in regional New South Wales—and I am talking here exclusively about the Hunter—is far from what it should be. I have been contacted by people at the ABC who refer to the fact that Hunter New England has a disproportionate number of adverse outcomes in the mental health setting. There was a much-publicised case of a tragic suicide of a young woman called Ahlia Raftery. There was an inquest concerning the circumstances of her death and then subsequent disciplinary proceedings, as a result of which the nursing staff, two of them, were taken off the register; one received some sort of disciplinary sanctions—I think it was a reprimand.

Anyway, the point was that the staffing is such in mental health facilities that those who would need to be on 15-minute obs, half-hour obs, one-hour obs, often do not get those opportunities because the staff are just run off their feet. They were the circumstances that led to this tragic death of Ahlia Raftery. This was just one that received publicity through the inquest process but there are others, and it has come to the attention of those who report on cases and look at this area of health practice that why is it that Hunter New England—the Presland decision, the McKenna decision—we do not see involuntary patients, they are locked away, and there is a lack of

resourcing for advocacy of those patients. We need psychiatrists, we need better surveillance and it is an area that needs reform.

The Hon. WALT SECORD: Ms Henry, I would like to jump in on a last question. You mentioned in your opening statement that it was tens of millions of dollars and then you changed it to hundreds of millions of dollars that the State Government pays in medical negligence cases. How are these settlements and these figures reached? I guess I would like to get to how it actually occurs—the settlement, the amounts paid. How does that actually work?

Ms HENRY: There is a system for assessing the monetary value of a claim that is well entrenched. One case that I have just recently been involved in resolving involved the avoidable onset of bacterial meningitis. I referred to that case in the submission, so I guess it is within the last 12 months. Her case, that particular case generated a settlement of in excess of—and I am not able to say too much but, you know, north of $10 million. If you want to look at the way in which these cases are quantified and particularised and how we get to the end result and how the damages are calculated, I would refer you to a decision in a mental negligence case against an obstetrician, Diamond, and the plaintiff's name in that case. There are very few, in fact hardly any of these cases are reported publicly in the case reports because we have developed to a culture of mediation. So a lot of these cases are resolved behind—in fact almost all cases now are resolved behind closed doors. But Calandre Simpson's case, which is in the public domain, resulted in a verdict of $14 million.

So it does not take many cases—a person who has received catastrophic injuries, as my meningitis client did; she had some very mild developmental issues before she received this substandard care. Now she is unable to walk, talk and be educated and requires 24-hour care. So that is why these results—some of the cases that I referred to in the submission, money will never compensate a person for the loss of their life, effectively the loss of their life when they have been the victim of a catastrophic injury. But it is the system we have and the cases often result in outcomes—well, not often but can result in multimillion-dollar verdicts.

The Hon. WALT SECORD: You mentioned that the Hunter New England Local Health District had a disproportionate number of negligence cases involving mental health. Is that still the case?

Ms HENRY: Correct.

The Hon. WALT SECORD: Is that still the case in that local health district?

Ms HENRY: I was approached for comment by a journalist from the Radio National program *Background Briefing*. It had come to their attention that Hunter New England had a disproportionate number. As I said at the early part of my presentation, when you are at the coalface, running these cases one by one on an individual basis, you might make the observation, "Gee, that is the sixth case involving poor mental health services that we have run this year", but because, again, we do not have the stats and the cases are resolving behind closed doors as a result of mediations or settlement conferences, we do not know, there is not that sort of interaction and provision of information that allows you to discern trends. But yes, it has been talked about. I can say that it has been talked about within the medico-legal fraternity. I think the fact that the ABC are onto it as a story that is deserving of investigative journalism, which is what that program does, indicates that it is a problem. The publicised cases, if you look at the last 10 years of medical negligence cases that arose in psychiatric facilities, they have all, I think, involved Hunter New England.

The Hon. TREVOR KHAN: I thank NSW Farmers for the quality of their submission; it will be very useful to the Committee. I do not need to ask any questions.

The CHAIR: I concur with the Hon. Trevor Khan and deputy president that the evidence today from both the Australian Lawyers Alliance and the NSW Farmers Association has been very high quality and has left us much to reflect on. On behalf of the Committee, I thank both organisations very much. This material, as you know, stands as oral evidence to the inquiry, which will all blend nicely with the detailed content of your submissions. Thank you very much. It will certainly be important in informing us in terms of the deliberations over our report and recommendations. Once again, on behalf of the Committee, thank you both very much.

(The witnesses withdrew.)

EDWARD JOHNSON, President, Services for Australian Rural and Remote Allied Health, before the Committee via videoconference, affirmed and examined

CATHERINE MALONEY, Chief Executive Officer, Services for Australian Rural and Remote Allied Health, before the Committee via videoconference, affirmed and examined

LEANNE EVANS, Senior Policy and Relations Adviser, Exercise & Sports Science Australia, before the Committee via videoconference, affirmed and examined

JOHN STEVENS, NSW State Chapter Co-chair, Exercise & Sports Science Australia, before the Committee via videoconference, affirmed and examined

The CHAIR: On behalf of the Committee, I thank you all very much for making time to be available. We know you have very pressing demands and are very busy. We appreciate you carving out the time to make yourselves available this morning. Welcome to you all. Before we commence, I acknowledge and thank both organisations for the making of submissions to the inquiry. With respect to Services for Australian Rural and Remote Allied Health, your submission has been received and processed. It now stands as submission No. 473 to the inquiry and has been uploaded onto the inquiry's webpage. With respect to Exercise and Sports Science Australia [ESSA], equally, thank you for your submission. It has been received and processed and it stands as submission No. 456 to the inquiry. It has also been uploaded onto the inquiry's webpage. I invite opening statements now from both organisations. We will start, first of all, with Services for Australian Rural and Remote Allied Health. Who would like to make the opening statement or who has been delegated to do so?

Ms MALONEY: I have been delegated, thank you, Chair.

The CHAIR: Thanks, Ms Maloney.

Ms MALONEY: We will proceed. We were planning this to be after the ESSA's statement, but that is fine. It will still work the same. So we will get underway.

The CHAIR: We are flexible. The opening statement normally sets up the questioning.

Ms MALONEY: It will be fine, thank you. I acknowledge the traditional custodians of Ngunnawal and Ngambri people from whose lands I am speaking today and those of the Wiradjuri people on whose lands my colleague Ed Johnson joins the meeting. I also acknowledge the traditional custodians of the lands, seas and waters throughout Australia and pay my respects to Elders past, present and future.

Thank you for inviting us to contribute to this important inquiry. I am Catherine Maloney, CEO of Services for Australian Rural and Remote Allied Health, or SARRAH. I am a physiotherapist by background and have worked in both public and private sectors as a director of allied health and senior allied health manager in rural New South Wales local health districts, served as a member of a New South Wales rural primary health network board, managed a remote Aboriginal community controlled health organisation—but not in New South Wales—and held other service roles. I am joined by Ed Johnson, President of SARRAH, a speech pathologist who lives in Blayney and has extensive experience practising across New South Wales. Dr Johnson has been a member of the Clinical Council at the Western New South Wales Primary Health Network, has a PhD researching online therapy in rural and remote settings, and lectures for the School of Health Sciences at Western Sydney University. We both have extensive clinical experience working in and with the New South Wales health system.

SARRAH is the peak body representing rural and remote allied health professionals. Our members live and work across regional, rural and remote Australia, in public, private and community sectors, health, aged care, disability and other settings. Our New South Wales membership includes at least 16 distinct health professions. We are informed by the breadth of our members' experience within and across service systems. Our submission focuses on allied health. We acknowledge the vital roles of our nursing and medical colleagues but note that the relative lack of allied health workforce and service capacity, especially in rural and remote New South Wales, is a major systemic shortfall that contributes to the poor health outcomes experienced by people living in rural and remote New South Wales.

We understand that the inquiry is primarily about New South Wales public health services, but the allied health workforce and service systems frequently span other settings, primarily health, aged and disability services. Where access to allied health services is lacking, it puts extra demand on public health resources, resulting in higher, avoidable hospitalisations and readmission rates, for example. As a result, where few allied health services are provided through the Commonwealth Medicare Benefits Schedule in rural and remote New South Wales, when NDIS participants cannot access allied health services and NDIS funding goes unspent, and when older Australians miss out on home-care services to keep them well and independent, it all has an impact and the consequences are often felt at the local hospital.

But even within the local health district, the allied health workforce and capacity to deliver the services is often not available, unsupported or overstretched; yet having access to allied health services will address the health needs of rural communities, where we see higher rates of chronic disease, an older population, lower incomes on average and higher rates of preventable hospitalisations. Operational management, reporting structures and clinical governance within rural hospital services need to facilitate increased involvement by allied health in order to improve access to services that will help people to manage their own health and prevent unnecessary hospitalisations. We need to see a greater number of allied health professionals filling operational management positions with responsibility for allied health service delivery and developing innovative, integrated models of care.

The practice of not budgeting for the backfill of allied health positions needs to stop, as this has a direct impact on service continuity and, in some cases, has led to the loss of substantive positions over time. Greater flexibility is needed to enable multidisciplinary and cross-sector models of care that make use of the available workforce capacity in rural communities. The extreme short supply of these resources means that they must be drawn on wherever they are available. There are successful examples of public-private partnerships, such as those that operate now in the Murrumbidgee Local Health District, providing allied health services to hospital inpatients, aged-care recipients and outpatients in rural and regional townships. SARRAH would be happy to help embed more of these innovative service models. Thank you.

The CHAIR: Thank you very much, Ms Maloney. Moving on now to Exercise & Sports Science Australia, who would like to make the opening statement?

Ms EVANS: That is me. Thank you, Chair. I acknowledge the traditional custodians of the lands, seas and waters throughout Australia, especially the Yugambeh language people, where I am speaking to you from today. I pay my respects to Elders past, present and future. My colleague John Stevens is speaking to you from the lands of the Biripi people. I also acknowledge any Aboriginal and Torres Strait Islander people who might be involved in the inquiry and/or listening today. Thank you for the opportunity to speak to you today. My name is Leanne Evans and I work for Exercise & Sports Science Australia in government relations and policy. ESSA is the peak professional and accrediting body for Accredited Exercise Physiologists, who use exercise therapy to treat people with chronic conditions and injuries, and for exercise scientists, who often work as allied health assistants and in the NDIS. John Stevens is an Accredited Exercise Physiologist [AEP] and business owner, with seven rural and regional clinics.

Treatments that AEPs deliver offer good value for money, especially in regard to type 2 diabetes, with an estimated health system saving of just over $5,000 per person per year. AEPs can help patients reverse and manage diabetes through improving blood glucose levels. AEPs can also help prevent hospital admissions and readmissions. Despite allied health comprising the second-largest clinical workforce, after nursing and midwifery, it is often the forgotten grouping in health care. As a smaller, newer, self-regulated health profession, there is limited consumer and professional awareness of exercise physiologists' roles. Reporting structures and clinical governance of AEPs and allied health staff needs to be improved. Not all staff are operationally and professionally managed by allied health staff. Many are managed by nurse unit managers, but no allied health staff manage nurses. There are not always positions for allied health professionals on local clinical councils.

When allied health staff go on annual leave, their positions are not automatically backfilled, like nurses' positions are. Exercise physiology services mostly cease when AEPs take annual leave, and there are no AEPs recruited in most local health district casual pools to help fill vacancies. As at June 2019, there are almost 60 per cent more AEPs working in the Victorian public system compared with New South Wales. In New South Wales, exercise physiologists are more widely employed in inpatient cardiac rehab, mainly in larger urban locations. Changing workforce practices and introducing more efficient and effective multidisciplinary models would see more AEPs in teams in mental health, cancer, renal and diabetes units, and in reconditioning hospital patients and older people in the community. Public-private partnerships could be strengthened with an exemption from the sessional contracting rates in rural areas with big gaps in service delivery. We encourage fewer short-term contracts and project funding and more permanent roles.

Many AEPs are employed in lower graded positions or are not working to their full scope or direct scopes of practice. Greater flexibility for reallocating budgets and making some roles 'physical therapy' roles across exercise physiology, occupational therapy and physiotherapy would better support clinical needs. We ask that you support our campaign to remove GST from exercise physiology and talk to the Federal Government about extending the Workforce Incentive Program to allow allied health businesses to employ allied health staff, supported by subsidies currently only available for general practices. Two NSW Health staff, Nicola Clemens and Andrew Davison, need to be congratulated for their work in New South Wales becoming the first and only State to allow allied health professionals, including exercise physiologists, to administer COVID-19 vaccines in State-run clinics. Thank you.

The CHAIR: Thank you. We will move now to questioning from the groups around the table, starting with the Opposition and the Hon. Walt Secord.

The Hon. WALT SECORD: Thank you, Mr Chair. Thank you for your opening statements. Dr Johnson, you indicated that you are a speech therapist. Is that correct?

Dr JOHNSON: That is correct.

The Hon. WALT SECORD: Thank you. Your practice is in Blayney. Is that correct?

Dr JOHNSON: My practice is based online, so we service people across Australia. I am physically based in Blayney and I see clients and patients across the Central West of New South Wales.

The Hon. WALT SECORD: What is the wait to see you? If someone wanted to book an appointment to see you today, when would they be able to get in to your practice, or get online, or get your services?

Dr JOHNSON: We are a relatively new practice, so it is significantly shorter for us; it is only a couple of months for us. But generally speaking, if you want to see—

The Hon. WALT SECORD: That is short? I'm sorry, everything is context. There was a response here when you said that a short time is two months. What is a long time to wait?

Dr JOHNSON: Generally the average wait time is 18 months to two years, and that includes for early intervention. Kids who are referred to speech pathology through general practice, through the NDIS or through any means at preschool age are still looking at 18 months to two years for the vast majority of speech therapy services.

The Hon. WALT SECORD: It has been a long time since I have studied education and child development, and it has been 30 years since I have had a small child, but isn't two years a long time in the development of a child if the child has speech problems, autism and problems in that area?

Dr JOHNSON: It is an incredibly long time. If we are not getting to kids before they are five years old, a lot of the issues that they have are incredibly difficult to remediate. It is incredibly difficult to teach them new skills, so those kids are already behind by the time they get to school. In terms of speech pathology, they are then having trouble with reading and socialising. That has kick-ons in terms of being able to engage socially in class and being able to pay attention in class. We are seeing when those kids get older, because of those long waiting lists, that those kids are disengaging, even as early as mid-primary school. They are not attending school. They are getting involved in the criminal justice system. There are mental health implications as well. A lot of those kids, unfortunately, are kids who are ending up in jail. The amount of people and young people especially who end up in the criminal justice system are people with speech and language disorders which could have been prevented.

The Hon. WALT SECORD: Are there certain parts of New South Wales, certain parts of the State where there are no allied health workers, particularly speech therapists, available at all?

Dr JOHNSON: Yes. To my knowledge, particularly in north-west New South Wales, the problem is particularly bad, especially around towns like Bourke, Brewarrina, Walgett. There are minimal visiting services. But there are not community health services. There is a huge gap between someone who is accepted into the NDIS and kids who have hearing difficulties, kids who have speech and language and developmental concerns, that will not qualify for NDIS. They currently cannot be seen by public health services. Even if they are, it is usually a matter of six half-an-hour visits and then a break from therapy for quite some time. I think, if I can put that into a meaningful context again, to have a therapist see you six times for half an hour—if you go to six half-an-hour piano lessons, you are not going to come out playing like Beethoven. You are going to have a very difficult time, even getting up the scales. That is the offering in many community health settings at the moment, if there is one. There is not in towns like Brewarrina. It is often a sort of lip service almost. Families are left disengaged then because they do not see progress, they do not see continued support. If they are offered assistance a second time, they often decline because they do not see it as being in any way meaningful or effective.

The Hon. WALT SECORD: But this is just not limited to speech therapy. Would you provide similar evidence to podiatry, nutrition, things like that?

Dr JOHNSON: I could not speak—

The Hon. WALT SECORD: But you are the association.

Dr JOHNSON: I could not speak specifically to podiatry. I know there are very similar waitlists for occupational therapy. That is almost the same situation as we are seeing for speech pathology. Ms Maloney may have particular thoughts on other disciplines.

The Hon. WALT SECORD: Could I get a snapshot from her, please?

The CHAIR: Could you please unmute?

Ms MALONEY: Sorry, my apologies. I have here workforce data for New South Wales on podiatry and a range of other disciplines. In terms of workforce distribution, there is a substantial drop-off in the numbers of podiatrists available once you leave Modified Monash zone 3, which are your large- to medium-sized townships. Those that are present in Modified Monash 5 zones is around 2 per cent of the entire workforce. Podiatry is not a large workforce. So you are probably talking about a handful of podiatrists there. The numbers drop off again, to 0.2 per cent in Modified Monash 6 and 7 zones.

The Hon. WALT SECORD: Could you identify some of the towns in those areas? We do not know the jurisdictions you are referring to by that description.

Ms MALONEY: I do not have this data by township. But you would be talking about places like Hillston, Ivanhoe, further west, very small townships. The implication being that lack of access to the podiatry services has a direct impact on amputation rates. Where you have a high prevalence of diabetes, for example, and high-risk feet, the lack of podiatry services means that these people cannot be managed effectively in the community, which leads to a higher rate of amputation.

The Hon. WALT SECORD: We make recommendations to the Government as part of our findings. What would you like to see occur or recommended to increase access or facilitate more allied health workers in rural and regional areas?

Ms MALONEY: There is no quick fix to this. To an extent, the State governments have done some work towards workforce development and in New South Wales, notably, the work to improve the numbers of allied health assistants. But that in itself is insufficient. There are very few controls in place to support allied health workforce development at pretty much every stage of the workforce development pipeline. So we would like to see, for example, quotas for students from a rural background entering into the allied health professions to study. Because the evidence tells us that if you are from a rural background to begin with [audio malfunction] come back and practice in rural and remote areas after graduation.

We also need to see further development of the pathways into the professions. I have mentioned allied health assistants. While this is an important career in itself and often is a fantastic opportunity for growth in jobs in regional areas, it is also an important pathway into the profession. If you have got somebody who has got a background of working as an allied health assistant already, these potential workers have great potential to become allied health professionals in the future, as long as there are flexible delivery options, flexible education offerings for them, so that they do not have to leave home to study. Which leads to my third point, which is about flexible delivery options by universities to ensure that people do not have to leave rural communities for a substantial period of time to obtain their degree. Because again the evidence tells us that once you move to the city to study and you become embedded with your social circles there, often the capacity to come back and work in rural becomes less over time.

We need to see more supports for the early career allied health professional working in rural and remote areas to make sure they can have a successful and positive experience working rurally. So what we would like to see New South Wales take on is a statewide approach to the allied health rural generalist pathway, which is something that has been established in other jurisdictions. We would like to see a formal and statewide approach taken by NSW Health to implement the allied health rural generalist pathway in local health districts and, finally—I will let my colleagues at ESSA speak in a moment—just more closer links with academic institutions, so that we have got increased capacity to undertake and build the evidence base in rural and remote communities. NSW Health does run some great programs along those lines. We need better access for allied health professionals to participate in those programs. Thank you.

The CHAIR: Thank you very much. We will move now to the questions from our crossbench members. Deputy Chair Emma Hurst?

The Hon. EMMA HURST: Thank you, Chair. I just want to start with a couple of questions either for Ms Evans or Mr John Stevens. One of your recommendations is that the New South Wales Health Minister commit to spending at least 5 per cent of the New South Wales health budget and each local health district budget on public health initiatives. Could you unpack this a bit for us? I am trying to get an understanding of where you got that figure of 5 per cent from and also what effect that would have on the ground if that were to take place.

Ms EVANS: Thank you. Just a few comments. That 5 per cent figure is a figure that has been adopted already by the Western Australia Government. It did a review of health expenditure a couple of years ago and the findings of that review were if health expenditure patterns continue health budgets are becoming more and more

unsustainable. The 5 per cent figure is a well thought out, considered figure in terms of investing in prevention, with a view that greater investment in prevention will prevent a lot higher expenditure at the tail end in terms of dealing with people with chronic conditions. That figure, for example, is a priority widely acknowledged in public health circles. Mr Stevens may like to speak briefly in terms of the impact of treating people early in the progression in terms of a chronic disease.

Mr STEVENS: If I may, it is quite well established that end-of-life care is where a considerable amount of health budgets are spent and, unfortunately, when we lack the funds or the incentives within schemes for early intervention, or even secondary prevention therapies to be implemented, we see inevitably costs escalate as patients continue through an unregulated disease progression process. We know pretty robustly that non-pharmaceutical management via dietitians and exercise physiologists can reduce a diabetic's risk of further escalation on par with medication, but we do not see incentives or funding commensurate with the resources that allied health professionals can provide compared with, say the resources assigned to the Pharmaceutical Benefits Scheme.

We know that we can diminish rates of hospitalisation and exacerbation in patients with chronic respiratory conditions but we routinely see in rural and regional communities funding for pulmonary rehabilitation and pulmonary maintenance programs, which are well supported by organisations like the Lung Foundation and not supported by funding in order to help people often experiencing disadvantage, either by rural or geographical or socio-economic means, from accessing services that would otherwise help them. I guess the evidence is there for us to see. The relevant modelling would not be hard to attain but the will to implement these changes is what appears to have failed us to this point.

The Hon. EMMA HURST: Do you think that NSW Health and local health districts can better integrate and support your work to ensure greater access in rural and regional areas beyond funding as well?

Ms EVANS: Most definitely. There are issues in terms of the interface of patients who come into the public system and then referrals into the private sector, and we are aware of current policies which disallow public practitioners from providing referral pathways for patients. There are interface issues there. There are also issues in relation to the sharing of patient data and we draw your attention to 'The Viewer', which is a model established by the Queensland Health Department which enables the sharing of public patient hospital data with, at the moment, private GPs, but there are moves underway to change the regulations to allow private allied health professionals to have access to public health patient data. My colleagues may have other points to add on that.

Ms CATE FAEHRMANN: Thank you all for appearing today and for your submissions. There are a lot of excellent recommendations in the submissions and a fair few of my questions have been answered in your responses to previous questions. It really is frustrating recognising that in some ways the answer and the solution is so simple in terms of spending more on wellness and exercise, as you are also talking about. Within NSW Health specifically, are you working or advocating for greater funding within NSW Health or with the Minister? Has there been any progress? I see recommendation 1 of Exercise and Sports Science Australia's submission is that at least 5 per cent of the NSW Health budget and each local health district be spent on public health initiatives. I am assuming there has been some advocacy over several years to try to get an increase. I am keen to hear what the response is like or if there is any traction within government already on this?

Ms EVANS: We work closely with the New South Wales Chief Allied Health Officer, Andrew Davison, and his colleague, Nicola, the Manager of Allied Health Workforce. Yes, it is fair to say we have been pushing for that for a number of years. At this point, it is fair to say we have not had a lot of traction. It is a completely different way of looking at health budgets and from our perspective it is probably fair to say that people within the hospital system have a lot greater authority and clout probably to ensure that the status quo prevails. It is a difficult process. But we are not the only organisation that is asking for that target to be set. The Public Health Association of Australia, for example, is leading the charge in respect to its policy priorities. Yes, we are aware of a number of chronic disease or health promotion charities that also have that target as one of their priorities.

Ms CATE FAEHRMANN: The 5 per cent—what is it at the moment, do you know?

Ms EVANS: On the figures that I have done nationally, it is around 1 per cent. We are well down the OECD list, so any increase, and to be fair to the Western Australia Government, they have made a commitment to achieve that 5 per cent over a four- or five-year period. It is not something that they are moving to in a single financial year.

Ms CATE FAEHRMANN: No. I am interested in the exercise medicine training. Who does the exercise medicine at the moment?

Ms EVANS: That is an Exercise & Sports Science Australia supported program, in conjunction with a number of stakeholders. That is offered free online to any health professional across Australia and it is also

accredited by the Royal Australian College of General Practitioners and the peak professional body for primary care health nurses. That is something that we promote on an ongoing basis as a means to increase the level of health literacy around the value of prescribing exercise.

Ms CATE FAEHRMANN: At the moment that is voluntary. What is the take-up at the moment? Do you have statistics on how many physicians or allied health professionals do that?

Ms EVANS: I can take that on notice and come back to you with the figures for New South Wales.

Ms CATE FAEHRMANN: Sorry, I just realised that the recommendation is about the Rural Adversity Mental Health Program coordinators. That is obviously drawing a link between exercise and mental health there.

Ms EVANS: Yes, but equally the value of Exercise is Medicine [EIM] can be applied to any health professional, including nursing as well as medical practitioners.

The Hon. WES FANG: Ms Evans, I have had the opportunity to chat with you previously and I noted from our conversation you were able to provide some examples around the difficulty in getting the training that is required for exercise physiologists in rural and regional settings because we know that if we train medical professionals of any type, whether they be doctors or allied health, that they are more likely to stay if they have exposure to rural and regional areas. Do you think you could provide the Committee with some examples of how that difficulty occurs and what you think we might be able to do around fixing it?

Ms EVANS: Thank you, Mr Fang. I bring to the attention of the Committee an early career graduate that I spoke to from Wagga. She basically quit her job after two years. She was the sole exercise physiologist in the local health district and, as a consequence of that, had no local mentoring or professional clinical support. So that is one example. In terms of some of the solutions, one is the capacity. The senior allied health staff that are already in the New South Wales health system are working to capacity. That was an issue that we are conscious of. It is not necessarily that they do not want to supervise students. It is just in many cases they are simply working to their absolute limit and do not have any capacity to supervise staff. The other issue is that there is just a lack of senior clinical roles in exercise physiology across the State generally. Part of the solution to that is that senior staff in other health districts can provide cross-district clinical supervision, and we have seen examples of that. But, again, that is inconsistent. We would love that to be more of a consistent policy across all local health districts.

The Hon. WES FANG: I think Ms Maloney had raised her hand on the videoconference system. Ms Maloney, are you able to provide some further insights?

Ms MALONEY: [Audio malfunction.]

The Hon. WES FANG: I think you are on mute again, Ms Maloney. I have always wanted to say that. I have never had the opportunity to tell someone they are on mute, so thank you for that.

The CHAIR: We actually like to say to the Hon. Wes Fang that he should be on mute but we do not get to say that. I am only joking.

Ms MALONEY: Thank you. I was glad that I was able to provide that opportunity for you. I can speak from experience as a former director of allied health within a rural local health district. I empathise with that former employee, the exercise physiologist, who was not able to access direct supervision. While there are some governance supports and resources in place within each local health district, there is usually very little funding made available to allied health professionals to enable adequate access to supervision and support. Even where you see a need where there is a sole practitioner who needs to be networked with other professionals of their discipline, you often do not have the resources to actually do much about that. You are relying on the goodwill of your existing employees to provide—whether it is within discipline or cross-discipline—supervision and support to sole practitioners across rural health services. As my colleague at ESSA said, these people are already working to capacity and are stretched. There is no capacity within the system to enable adequate supervision and support for allied health professionals. This is why they often burn out and leave the health service.

The Hon. WES FANG: It seems to me that there is often a reliance on a level of goodwill provided by colleagues and supervisors to provide that collegiate support, whether it be to trainees or newly minted people that are coming into the sector. If they perhaps have not got that collegiate support, particularly in a remote or rural area, it makes it very difficult. Is that a fair assumption as to the problems?

Ms MALONEY: Yes, absolutely. That is part of it. We see this with our membership both within health services and in the private sector because there is such an overwhelming unmet need for allied health services in the community. The allied health professionals feel under pressure to continue to provide those services and take very little time out for themselves to develop themselves professionally and to undertake those self-care functions that we know are so important to maintain their own health and wellbeing. So it is partially a demand issue. It is

partially that there is no resource set aside specifically to support allied health professionals. I mentioned in my opening statement the fact that there is no budgeting for backfill for allied health professionals so that when they go on leave, an entire service can fall over for that period of time, which again places increased pressure.

The Hon. WES FANG: Ms Evans addressed that point to me earlier as well, which I found very interesting. I know my time is up but I am going to sneak one more question in while I have got you. I am doing a Walt Secord and just sneaking one more in. Is it fair to say, do you think, that instead of recruiting the newest, youngest graduates from the program into a rural and regional area because they perhaps are available and they may not be experienced enough to, say, get a high-profile job in a metropolitan area, what we really need to do is have a targeted recruitment campaign around very senior, experienced people that can actually kick off the start of what would be a mentoring role where we then get those younger people to come in? They are mentored. They then stay, allowing the other, more experienced people to retire. Then we have got that sort of continuity. They can then mentor the next generation. Is that the circuit breaker that we need to fix that? Ms Maloney, I can see you actually raising your hand now. I am not sure if you are on mute but by all means you have got the call.

Ms MALONEY: I think I am not on mute, so thank you. Simply put, that is a great strategy but those senior clinicians do not exist. I will give you an example of where we did implement a trial of the allied health rural generalist pathway in the Murrumbidgee Local Health District, which was addressing this issue about how we support junior allied health professionals into some of these sole practitioner roles. We cobbled some positions together to create a senior position whose sole job was to support three junior physiotherapists in this instance and to recruit for three very chronic vacancies within three different locations across the Murrumbidgee. That was successful in that within a few months all of those positions were filled.

The senior position was a novel position within NSW Health in that their sole job was to provide supervision and support and service delivery support to these junior allied health professionals. The funding did not continue though. So now they are, my understanding is, still in contact with those local allied health professionals but that program has not continued and those vacancies have arisen again. What we need to see is that ongoing support made to allied health professionals to build that experience and seniority. Apart from the fact—I will just add that there is a tendency that as a position becomes vacant to revert it to the lowest level of pay. As a director allied health myself, I had to fight to maintain that level three sole practitioner rating in some of these positions. There is this constant tension between what can be filled—because we only have access to early career allied health professionals in general—and the need for seniority and experience in these positions.

The Hon. WES FANG: Thank you very much. I really appreciate it.

Dr JOHNSON: Very quickly, it also becomes a clinical quality issue when we cannot have supervision. We cannot get adequate clinical supervision for our junior clinicians, who then feel obliged, because they are seen as fully formed clinicians once they graduate, that is it, that is all you learn. We know from nursing and medicine that training goes on for many years throughout your career, but this does not seem to happen in allied health and there is not that recognition. Non-allied health managers of those junior clinicians then often put pressure on those clinicians to work in areas of clinical competency which they simply do not have.

The Hon. WES FANG: Thank you very much.

The CHAIR: On behalf of all Committee members, thank you very much. That was a very, very worthwhile session, rich with detail and information that adds very nicely to the detailed content of your submissions. That will obviously inform our deliberations in regards to the preparation of the report and the recommendations that we will be producing. Once again, thank you all very much for carving out some time during your busy day. We appreciate that very much. That brings us to the luncheon adjournment. The Committee will resume at 1.10 p.m.

(The witnesses withdrew.)

(Luncheon adjournment)

MICHAEL JONAS, President, Australian Dental Association—NSW Branch, affirmed and examined

SARAH RAPHAEL, Advisory and Engagement Executive, Australian Dental Association—NSW Branch, sworn and examined

KRISTIN BELL, Head of Department, Ophthalmology Department, Royal Hobart Hospital, and Chair, QEC Regional Training Network, The Royal Australian and New Zealand College of Ophthalmologists, Chair and Equity Coordinator, Specialist Training Program Committee, before the Committee via videoconference, affirmed and examined

ASHISH AGAR, Member, Outback Eye Service in western New South Wales, Chair, Reconciliation Action Plan Working Group, The Royal Australian and New Zealand College of Ophthalmologists, before the Committee via videoconference, affirmed and examined

The CHAIR: We normally provide each of the groups an opportunity to make an opening statement through one of their witnesses. If you decide to split the opening statement between yourselves, that is okay with us; we just need to know that in advance. Once that is completed, we will move to questioning from Committee members, if that is agreeable, for the allocation of times. Are we happy with that outline for this afternoon? Thank you very much. We will commence with the Australian Dental Association and their opening statement.

Dr JONAS: Thank you for the opportunity to address this important New South Wales parliamentary inquiry. As I just said, my name is Michael Jonas and I am President of the Australian Dental Association—New South Wales Branch. We are the peak body representing the dental profession in New South Wales and the ACT. Our membership comprises over 70 per cent of the registered dentists in that area. For over 30 years I was a private practitioner in Gunnedah, so I know only too well the oral health issues our rural and remote communities face. I could tell you pretty much to the minute when a patient sat down in my chair whether they had been exposed to and had been drinking fluoridated tap water as distinct from tank water: It was almost day and night. Currently practising in Tamworth, I see improvements to access to fluoridated water and oral health services offered, but there is still a long way to go.

Currently in New South Wales there are over 85,000 adults on the public waiting list, and about 30,000 of these are in regional, rural and remote areas. These communities struggle with the lack of specialist oral health services, long public waiting oral health lists, as well as longer travel times and limited transport options. Many remote communities rely solely on the Royal Flying Doctor Service for dental treatment, and while they do an incredible job, they cannot offer any continuity of care that so many city folk enjoy. The more remote you get, the less chance you have to access clean, fluoridated drinking water, fresh healthy foods and oral hygiene products; and the patient-to-dentist ratio nearly triples. Good oral health is fundamental to overall health and wellbeing. Tooth decay and gum disease cost of billions of health dollars each year and this is without accounting for the wider health consequences of poor oral health on chronic diseases including diabetes, cardiovascular disease, lung conditions, adverse pregnancy outcomes—and the list goes on.

What does good oral health actually look like? The expectations can vary widely depending on a person's circumstances, but what is undeniable is that every Australian deserves the ability to smile, speak and eat without pain. After all, no-one expects a child to just put up with an earache, so why should they put up with similar conditions in the mouth? To improve oral health for rural and remote residents there are a number of existing programs and schemes that ADANSW recommends Government build on. These include addressing workforce issues, facilitating tele-dentistry where appropriate and promoting the Child Dental Benefits Schedule to improve the current uptake from only 37 per cent. This would see our rural and remote children get off to a much better start. The picture of oral health that I have described is not a luxury but it is a basic human right that cannot be overlooked. ADANSW pledges to support the much-needed improvements and will work with policymakers, healthcare administrators and our profession to continue to advocate for a better deal for people in these communities.

The CHAIR: Thank you very much, Dr Jonas. I should have mentioned at the start the two very helpful submissions that have been made to this inquiry. RANZCO's submission is No. 271 and the Australian Dental Association—NSW Branch's submission is No. 714. Both submissions have been received, processed and now stand as submissions to the inquiry and have been uploaded to the inquiry's website. Thank you for those. Today's testimony builds on top of the content of your submissions. I will now pass to RANZCO for an opening statement.

Dr BELL: I will start the statement and then we will switch over to Associate Professor Ashish Agar, if that is okay.

The CHAIR: Certainly.

Dr BELL: RANZCO thanks you for the opportunity to appear before this parliamentary inquiry. We note that timely access to eye health prevents 80 per cent of permanent visual loss. We tabled *The Lancet Global Health Commission on Global Eye Health: vision beyond 2020*, which notes that vision impairment exacerbates dementia, increases falls, car crashes, the need for social care, and mortality, and finds:

> Eye health is an essential component of universal health coverage; it must be included in planning, resourcing, and delivery of health care.

We tabled the true cost of hidden waiting times for cataract surgery in Australia, which documents inequitable access and long waits, and we recommend NSW Health funds equitable access to public cataract surgery, noting that that can save money. But cataract surgery only comprises 20 per cent of eye health, the other 80 per cent being delivered in an eye clinic and essential to prevent blindness. NSW Health mostly does not deliver eye clinic services in regional New South Wales, despite these services being attributable to public hospital funding. Timely access to outpatient services adds value by preventing hospital admissions. RANZCO recommends mandating eye outpatient delivery in all districts and public reporting of this data. RANZCO also recommends NSW Health develops an essentially administered e-referrals portal.

New South Wales public ophthalmology full-time equivalent [FTE] is insufficient, with stagnant growth causing inadequate service capacity and threatening workforce stability. RANZCO recommends NSW Health develops key performance indicators [KPIs] and increases funding for the public ophthalmology workforce. We tabled the proposal brief RANZCO Regionally Enhanced Training Network and appendices, which has Federal funding but requires State investment to actualise, which we request.

Associate Professor AGAR: There is even more that we can do to try to fix this problem. Some of these are really quite simple solutions. For example, if we were able to list Indigeneity as a comorbidity when wait-listing someone for cataract surgery, we would actually help our First Nations communities access surgery in a more effective manner. Another proposal is for an agency for telehealth inreach/outreach services. This would enable the regional workforce—whether it is an emergency doctor, a GP or a colleague of ours in the regions—to be able to be supported. There are other measures that are more longer term. We tabled the *National Health Reform Agreement (NHRA) – Long-term Health Reforms – Roadmap*, which provides a framework for NSW Health to be able to map and detail the existing services. That would allow us to then plan for the future. We are not talking about a year in, year out plan but four to five years' worth of planning, which could address these gaps. There are existing services to areas where there is no ophthalmology present. We have outreach services already, and these need to be funded by NSW Health.

We recognise, though, that all these plans need to have clinician involvement up-front at the design stage, not at the end, without which these plans invariably fail. I have had the honour and the privilege of working in outback New South Wales for 20 years now, and it is easily the best part of my job. But you will forgive me, honourable members, if there is a sense of deja vu and, dare I say it, scepticism about yet another inquiry. We have seen and heard all these messages before and we are still having to ask the same questions. So RANZCO asks, with the greatest respect, whether this inquiry will be any different. Will the Government commit to meaningful and real change that will enable our community to keep seeing? We welcome the establishment of a parliamentary champion for eye health, but I think we really need to join forces and address this because, without this, the right to sight will be lost in rural New South Wales.

The CHAIR: I appreciate the comments you made about another inquiry. We are determined, as best as we possibly can, to utilise what has been a lot of evidence that we have collected to produce this report over the Christmas-new year period and into January and February with some strong recommendations back to government. We sincerely hope that government will look at those, examine them closely and hopefully adopt them. We will go to questioning and move between Opposition, crossbench and Government members of the Committee. There will be roughly 10 minutes for each grouping.

The Hon. WALT SECORD: I thank the witnesses for their submissions and their opening statements. Dr Jonas and Dr Raphael, I want to make sure I get this correct: You said 85,000 people are on the waiting list for dental. What is the length of time on the waiting list? Is it months? Is it years? Can you give me a bit of context?

Dr RAPHAEL: Sure. It is very variable from one LHD to another. Generally, adult waiting lists are very long. Then, again, it gets split between some emergency care waiting lists versus sort of comprehensive care waiting lists. But there are many cases where people are on waiting lists for up to two to three years.

The Hon. WALT SECORD: To get on a dental waiting list, do you have to have major problems?

Dr RAPHAEL: No, you need to be an eligible adult. All children up to 18 are eligible, but you need to be an eligible adult, so you need to hold a healthcare card or a pension card of some description. But, no, if you have got pain of varying severity, it will place you on a waiting list of a certain length of time. If it is intractable

pain and facial swelling, you need to be seen within 24 hours. If it is pain not quite that bad, it will be a longer period of time. But for comprehensive—if you just want a check-up and you are an eligible adult, you could be waiting three years for that check-up.

The Hon. WALT SECORD: About 40 per cent of those people on the waiting lists are in rural and regional areas.

Dr JONAS: Yes.

Dr RAPHAEL: Where there are much fewer services.

The Hon. WALT SECORD: I was going to get to that. Those 30,000 people are on the list because there are fewer dentists in rural and regional areas. So you would not be able to get them through on procedures because there would not be enough dentists in those areas. Is that correct or am I misunderstanding the situation?

Dr JONAS: That is close to the point. However, if the workload was spread across the available practitioners, that would be alleviated a lot. The government schemes that address emergency treatments like the Oral Health Fee For Service Scheme—which operates quite successfully for emergency care in collaboration with private practitioners, for instance—get those waiting lists significantly decreasing. But, at the moment, all patients present to a public clinic, which is usually associated with a local hospital, and then they are sequenced from there—so it slows down.

The Hon. WALT SECORD: The 30,000 people in rural and regional areas who are waiting for dental treatment, are they people who are waiting with more complex or greater problems than people in Sydney, Wollongong and Newcastle?

Dr JONAS: I would say it is much the same.

The Hon. WALT SECORD: The 30,000 people who are waiting are not spread across the State. Are there local government areas or sections of the State where there are no dentists whatsoever?

Dr RAPHAEL: Yes.

Dr JONAS: As in public dental facilities?

The Hon. WALT SECORD: Yes.

Dr RAPHAEL: Yes.

Dr JONAS: I can talk about my own situation in Gunnedah.

The Hon. WALT SECORD: You are from Tamworth, aren't you?

Dr JONAS: I am in Tamworth now, which has got a fantastic facility. I had the joy of having a look it about three months ago and it is quite something. It is really something to be proud of. But in Gunnedah, where I worked for 30 years, there is a clinic and it gets manned one day a week and it gets manned by a dentist who comes over from Tamworth, depending on workload. Gunnedah is a town of 10,000 or 11,000 people and serves 15,000 people.

The Hon. WALT SECORD: It is quite large. So there would be enough work there?

Dr JONAS: For someone full-time it would be maybe stretching it a bit, but you could easily have that split with Gunnedah. There are a number of out clinics too; there is one in Narrabri. There are a lot of them around the place but they are not staffed adequately.

The Hon. WALT SECORD: If you had a magic wand, are there enough dentists in New South Wales to staff the areas of need?

Dr RAPHAEL: Yes, absolutely.

The Hon. WALT SECORD: There are?

Dr RAPHAEL: It is a maldistribution; it is not a workforce shortage. It is about finding the right incentives for people to go and work in these areas.

The Hon. WALT SECORD: When you are talking about incentives, you mean people who want to work in the public system—is that what you are saying?

Dr RAPHAEL: Public or private. It is equally as difficult to find a private dentist in some of these areas as a public one. Dr Jonas alluded to the Oral Health Fee For Service voucher system. If there was some assurity for practitioners that they would be given a certain amount of their work time doing work through the voucher

system then it might make practices in some of these regions sustainable and it might be an incentive that gets people to move to the bush, basically.

The Hon. WALT SECORD: Do you find that because of the lack of dental treatment in rural and regional areas, people are not doing restorative or preventative work—they are simply pulling teeth? Or am I oversimplifying it?

Dr JONAS: No. The treatments are usually episodic, as you described. But a huge cohort of those people end up at their GP, who is overworked anyway. They get a GP diagnosis, which is fair enough, they get antibiotics, they get painkillers, they leave and two days later they are feeling a lot better, until they don't and they go back through the cycle again. You will find these people do go through and we finally get to see them. This process could have been going on for 18 months to two years before it got to that intractable situation. So there is an economic argument almost to decrease the amount of treatments as a result of having people there.

The Hon. WALT SECORD: In your opening statement you made reference to fluoride.

Dr JONAS: Yes.

The Hon. WALT SECORD: Do you know how many communities in New South Wales could have fluoride in the water supply but do not have fluoride in the water?

Dr RAPHAEL: Not exactly, but we know of several councils that have now approved and it has been gazetted with NSW Health. But the process then of implementation and staff training to implement the fluoridation plant is very long and protracted. For example, in Molong in New South Wales that process is over 10 years, and they still have not got fluoride flowing through their water system.

The Hon. WALT SECORD: Is it hard to put fluoride in the waters? Isn't it just a matter of putting it in?

Dr RAPHAEL: It requires the water system to be upgraded, which NSW Health pay for. So that bit is done. But usually the stumbling block in many of these small areas is that they cannot get qualified people to do the monitoring and the dosing—

The Hon. WALT SECORD: Oh, I see. Sorry, I am just mindful of the time. If the State Government was to invest in support systems to improve fluoride in country towns that need water, would that in fact help dentists, help prevent bad teeth happening and improve general health?

Dr JONAS: I think the general statement can be said that the best form of dentistry is prevention, and that would be perhaps the biggest step forward in prevention without a doubt. We get fluoride from lots of other areas—working in Gunnedah, it still has not fluoridated. It is to be done, but it still has not been done.

The Hon. WALT SECORD: Gunnedah does not have fluoride in the water?

Dr JONAS: Not yet. It has already been gazetted—it is going to happen—but they still have not built the plant. There are lots of things happening, but it is there. We have had the battle, which was a very interesting thing to take part in. Yes, it would certainly help a lot, but not all communities are really of a size big enough—or am I wrong, Dr Raphael?—to do that.

Dr RAPHAEL: Yes. Also, we are at the point where approximately 95 per cent of New South Wales people have access to fluoridated water. It is quite a small number, but that 95 per cent would take in the ones that are gazetted but it has not happened yet, if that makes sense.

The Hon. WALT SECORD: Can I ask one more question? I am sorry, but other members will have to ask the eye questions. I have just realised I have run out of time.

The CHAIR: It is alright. We will cycle around the members again.

The Hon. WALT SECORD: Okay. Back to the waiting lists, what is the best thing that the Committee could recommend to the Government to cut the waiting lists in rural and regional areas? Is it more vouchers to get people into private dentists? What is the best approach?

Dr JONAS: That certainly would—I do not know about more vouchers, but a more equitable and collaborative approach. But I can tell you from my experience that I had 12 months working in Gunnedah, where we had a system like that operating with a budget to work for—and it worked brilliantly. They just trusted the practitioners to do the right thing. There is a huge element of trust in this, of course. That would certainly work. Just getting people to use the child dental benefit schedule will make a huge effect. The uptake is 37 per cent. It is just silly.

The Hon. WALT SECORD: How do you feel, as a dentist, when you see children under the age of five coming in with rotten teeth?

Dr JONAS: I can tell you, I spoke to one of my colleagues yesterday and she did a general anaesthetic list. One of the children had eight teeth removed; the child was about eight or nine years old. This young person had about 60 per cent or 70 per cent of the remaining teeth removed. They were deciduous baby teeth, but being that as it may it is quite often a preventable situation. It is very traumatic and very painful. Going through the process to get there and getting general anaesthetic services is another story altogether.

Dr RAPHAEL: And that was in Wagga Wagga.

Dr JONAS: Yes, that was in Wagga.

The Hon. WALT SECORD: In a major town?

Dr RAPHAEL: Yes.

Dr JONAS: Yes.

The Hon. WALT SECORD: Wow. Thank you. My time has expired.

The Hon. EMMA HURST: I might start with Dr Bell and Associate Professor Agar. I am still wanting to talk about those long waiting times. Obviously with eye issues, they often need to be looked at quickly and deterioration can be quite fast. Do you see long waiting times to see ophthalmologists, and what does that mean when you finally get to see a patient? Is their condition often a lot worse, or more difficult or expensive to treat, than it could have been?

Dr BELL: Yes—

Associate Professor AGAR: Yes. Dr Bell?

Dr BELL: Yes. In fact, even though you think about cataract surgery when you think about ophthalmology it is only, as I said, 20 per cent. We are dealing with some chronic diseases—glaucoma, macular degeneration and diabetic retinopathy. If they are not treated in a timely manner you get a permanent loss. You cannot get it back. It also results in very high-cost treatments being needed. It is, quite frankly, a disaster for the patient and the community as well—all the flow-on costs for looking after somebody who is vision impaired.

We do not even have outpatient services in regional New South Wales, with very few exceptions, so we do not even get to see a waiting list. If you cannot afford the private care or there is no private care then you need to go into the city. If you end up waitlisted for surgery in the city then you also have to travel there for surgery, and the waitlists for cataract surgery in the city are very long. You are talking three-plus years just to get onto the clinic—the wait for the wait to get into the clinic—and then once you are on the inpatient waitlist it is another year or so, in some areas. It is a huge problem. We do not even have outpatient eye clinics in Wollongong; in Nepean, we do not have them; in Gosford; and we do not have a decent one at John Hunter Hospital. Most of our public outpatient clinics are centred in central Sydney. It is a huge problem, with huge waits.

The Hon. EMMA HURST: You were talking about the fact that obviously a lot of these people are having to then transport to Sydney. Obviously, when we are talking about people with vision issues that transport is an even bigger issue. On top of the fact that they are already having to travel, how do we deal with the situation that some of these people might be vision impaired and not be able to transport themselves?

Dr BELL: It is another huge issue. We do not have great public transport. The patient transport scheme does not cover people that are for non-acute at the moment, as far as I am understanding. Community transports cost money. There are huge issues. Carers have to take time off. That results in economic losses to the community when people have to travel in and spend money elsewhere than regional Australia. But really, we do have regional ophthalmologists in many areas. They will work for short and they do bulk-bill a lot of patients, but one of the problems is that with the Medicare Benefits Schedule not being indexed the actual value of the Medicare benefits has dropped. It is about 40 per cent of what it was in 1984. It is like patients are in a bit of a, I guess, no-man's-land if they are socio-economically disadvantaged. They are dependent on a practitioner bulk-billing them—if there is workforce in the area. There are no public hospital services, in terms of outpatient clinics. There is really nowhere for them to go, so then they need to wait for long waits and go into the city for their care if they cannot access it in the community. It is a public health disaster, really, with huge flow-on effects to the community and cost burdens.

The Hon. EMMA HURST: Why do you think that ophthalmology is being overlooked as an essential health service?

Dr BELL: There seems to be this almost "bunker" mentality when it comes to outpatient services that we have observed, where if you can just stop them coming in the front door and just delay them getting into the outpatient clinic then you can control your inpatient waitlist. Certainly I have heard that from business managers in numerous jurisdictions. Probably the irony of the whole thing is that when you do that—when you delay access to the essential services, the outpatient services—you actually end up causing cost. People fall over. Elderly people fall and they end up in nursing homes and care. There are morbidities and mortality just from breaking your hip. They have car crashes. It is not just eyes, of course; it is right across the other medical specialties. If COVID taught us anything, it has taught us that if you do not see your doctor regularly you will end up increasing the inpatient admissions. We have seen that flow-on effect around the world and in Australia. When people do not get their regular care for their chronic conditions—and one in six Australians has a chronic condition—then they will end up increasing the inpatient admissions, which is where the huge costs are.

Ms CATE FAEHRMANN: Dr Bell, your submission states:

> Aboriginality is the single biggest risk factor for vision impairment and blindness in regional NSW. Mechanisms to expedite services for patients identifying as Aboriginal and/or Torres Strait Islander should be considered.

It is quite extraordinary to hear that there aren't already any mechanisms to expedite services for First Nations patients. Is that the situation?

Dr BELL: From a NSW Health side of things, there is not. Back in 2012, the then Chief Medical Officer of Australia, following some engagement from Indigenous Eye Health, agreed that access to cataract surgery for Indigenous people should be prioritised. That was taken around all of the various States. Queensland took it up and has used Indigeneity as a clinical modifier for categorisation purposes on waitlists. There are a number of barriers to that. What you have got, with this LHD system—which is great because care should be on the local level—is there is not a lot of governance over the waitlists. You have an issue where you have patients on multiple waitlists. You cannot really see what is happening with the waitlists outside that local health district.

Having a mechanism where you could have central oversight of waitlists, with a central ePortal, to actually deliver a cohesive health information system that would assist managers and allow oversight of the LHDs to see what they are delivering in each LHD—at the moment we have the National Health Reform Agreement. One of the key things that it says it wants to do is give equity of access to care. Despite that being a key objective, it is really left up to each LHD to decide what services will be delivered within the area. It is an ad hoc approach to delivering equitable services. What we need is a central process and wider engagement. Let us work out what should be delivered in each area. Let us calibrate it for geography and calibrate it for demographics, provide LHDs with a detailed map of outpatient and inpatient services which should be delivered in the area and then observe if they do it—so organise it.

Ms CATE FAEHRMANN: Are you aware of any outreach services that specifically go to some of the remote communities in far western New South Wales?

Dr BELL: We have a great one. I am going to hand you over to Associate Professor Agar, who is going to tell you all about it.

Associate Professor AGAR: I am part of what is called the Outback Eye Service, which is based at the Prince of Wales Hospital. This is the legacy of Fred. Not many people are recognised by one name, but Fred is. Professor Hollows really took the bull by the horns and started this program in the 1970s. We have, under our current leader, Professor Coroneo, expanded this to cover almost two-thirds of New South Wales. West of Dubbo, we are the only public ophthalmology provider for the State. It has been tough. It is something that we are constantly having to fight to justify our existence. But I can say with confidence that, for a large part of the State, we are able to meet a lot of these needs. We talked before about what happens when there is no public service. By maintaining a public ophthalmology presence in these areas, we are actually able to prevent people going blind.

As a counterpoint to some of the problems, it is important to see what happens when a system works. In the places where I work—even somewhere like Broken Hill—when you have good engagement, when the executive works with you and when administration is working with you, which they do with us there, we are able to achieve incredible things. Over the COVID pandemic, the eye service was the only specialist medical service that was uninterrupted. Through the first wave, the second wave and the Delta wave, we managed to keep people from going blind in the bush. That was because one of the big obstacles to a public service was actually ameliorated by having really good engagement and an executive and administration that listened to us. These services are amazing, but they are not funded by NSW Health. They are on year-to-year agreements. We could fall over tomorrow, and we would have patients from Bourke to Brewarrina to Broken Hill to Lightning Ridge who would have nothing left. Even we are precarious, despite going for almost five decades.

Ms CATE FAEHRMANN: I just want to quickly follow up on the funding—

The Hon. TREVOR KHAN: Don't feel the need to rush.

Dr BELL: Can we table the report as well?

Ms CATE FAEHRMANN: Yes. We have got a few—

Associate Professor AGAR: There is a report on the Outback Eye Service.

Dr BELL: We table the Outback Eye Service report as an example.

Ms CATE FAEHRMANN: There it is. I was going to ask about the year-by-year funding. Are you saying that it is funded largely through the Fred Hollows Foundation? No?

Associate Professor AGAR: No. Through the Commonwealth.

Ms CATE FAEHRMANN: But it is year to year. And is it a contract with the Commonwealth or with NSW Health? With the Commonwealth, yes.

Associate Professor AGAR: The Commonwealth.

Ms CATE FAEHRMANN: Nothing from New South Wales?

Associate Professor AGAR: And there is no certainty that the next year it will even exist. We are in a battle just to stay alive, despite looking after two-thirds of the State.

Ms CATE FAEHRMANN: Is the contract—are the figures in here able to be shared?

Associate Professor AGAR: To cover the whole service—and I have to stress this is comprehensive. We are not just talking about one type of disease; it is every specialty within ophthalmology. It is about half a million a year to cover two-thirds of the State. It is not a lot of money.

The Hon. WES FANG: Thank you to all the witnesses for appearing today and for your comprehensive submissions. It is appreciated. I declare that I know Professor Coroneo. I have had a connection with him for some time, so I very much appreciate the work that happens with the Fred Hollows Foundation. You said that it is predominantly funded through the Commonwealth. Is that correct? And the contributions that the Commonwealth makes, they are renewed every year. How much warning do you get that the Commonwealth is going to reaffirm the commitment for the next year?

Associate Professor AGAR: It is funny you ask that. As anyone who works in any area of public health, education, research or anything that is based on a year-to-year commitment knows, you spend half a year trying to get the money for the next year. You have notice, but essentially we are writing reports and having to justify our existence every 12 months.

The Hon. WES FANG: In relation to the area that you cover, you have said two-thirds of the far west of New South Wales. Do you cover areas past the border into other States as well?

Associate Professor AGAR: That is a really good question. We have clinics up in Bourke. We will see overflow from Queensland—places like Goondiwindi. These places that straddle the border will feed into us—less so in Broken Hill. Of course there has been a whole bunch of issues with that with the border closures. It is not limited to the State lines. We will see all comers.

The Hon. WES FANG: In effect, what you are doing is providing a remote service from the metropolitan area, but it really is spanning across the border and picking up a lot of those remote communities, acting as a magnet to the service. Is there a similar program that is operating in other States that is being implemented by, say, the Northern Territory or South Australia? Or is this really unique to Australia?

Associate Professor AGAR: It is not unique. It is the first one, so it has been going the longest. Our colleagues in Western Australia and in central Australia run similar programs. The idea is what is called a hub-and-spoke model. For us, Broken Hill and Bourke are our hubs, and the spokes are the smaller regional towns. Australia kind of leads the field in this. We have been doing this for a long time, but they are different for different areas. They are fragmented and the funding is very random. It is a model that we kind of pioneered, but it is still struggling to keep afloat.

The Hon. WES FANG: Which almost leads me perfectly—

Dr BELL: The Northern Territory ones are public funded from the State, from Royal Darwin Hospital and from Alice Springs Hospital. The one in Western Australia, which encompasses most of the State, also receives State funding. New South Wales is the one that does not.

The Hon. WES FANG: Which was the question I was about to ask. With the other services that are being provided, do you know the percentage of how much is funded by the State versus the Commonwealth?

Associate Professor AGAR: I think the vast majority is State funded, almost completely.

The Hon. WES FANG: I am just going to move now to the dentistry aspect. I am not sure how much time we have left, five more minutes. Mr Khan, do you have anything to add?

The Hon. TREVOR KHAN: I am very relaxed listening to and absorbing it all.

The Hon. WES FANG: The Hon. Trevor Khan is like a sponge.

The Hon. TREVOR KHAN: I have been called many other things but rarely a sponge.

The Hon. EMMA HURST: You will take that one.

The Hon. WES FANG: I meant that in a good way.

The CHAIR: Do you visit your dentist every 12 months, Mr Khan? That is the question.

The Hon. WES FANG: Despite Mr Khan's dental issues, what I wanted to ask you is, I was listening to your earlier testimony about the voucher scheme. Can you expand a little more on how access to that might assist in attracting more dentists to those remote areas of the State, where obviously provision of services is an issue?

Dr RAPHAEL: If there could be better collaboration in a public-private sense, it would incentivise practitioners to go out there knowing that they can make a certain income from public patients through the voucher system and then knowing that they could also see private patients at the same time. That is not something that is well utilised out in the rural remote areas because the voucher system is basically spread out on more of a per capita rate. As your population is smaller, there are going to be many less vouchers out there. Whereas in the metropolitan area, where we have got good oral health services in the public system already, they have got many more of the voucher dollars.

The Hon. WES FANG: How does a patient access the voucher? Is it through a GP where they would actually get a referral to the system or is it through a hospital where they have recognised that there is an issue where the patient needs to have certain dentistry work done?

Dr RAPHAEL: No, it is through the public dental services. Basically, you go on the waitlist and once you get to the top of the waitlist, if the oral health service cannot provide that treatment or wants to farm some of that treatment out to the private service, they will give the voucher for the specific items of service that they would ask a private practitioner who is participating to carry out. It is not done through GPs or hospitals. It is not facilitated that way at all.

The Hon. WES FANG: I would assume then that means rural and regional people probably find it slightly harder to access the voucher system because accessing that scheme in itself is made more difficult through remoteness. Is that correct?

Dr JONAS: We can give you examples of people driving at least two to three hours to attend a public dental clinic only to find that it is not manned and then going home with the same problem and coming another day still in acute pain, getting a voucher and then having to find a dentist to actually do whatever therapy has been given, and then they go home. For two or three days out of their life, the economic cost to everyone, I do not think we have ever actually calculated it, but it is a very cumbersome scheme at the moment.

The Hon. WES FANG: It would be enormous. Projecting that forward, it is really, I would say, a Commonwealth scheme, much like the Medicare system. Is that—

Dr RAPHAEL: No, it is—

The Hon. WES FANG: Sorry, I meant it is federally administered like the Medicare system, is it not?

Dr RAPHAEL: No, it is a NSW Health system.

The Hon. WES FANG: So NSW Health are providing that service and they are providing the vouchers for access of services, but then the patient cannot get into a dentist because the dentist is either booked up or is too far away. The way to actually attract dentists out there is to expand that voucher service. Does the dentist need to have an accreditation in order to provide the service to receive the voucher?

Dr RAPHAEL: They need to be signed up to the voucher scheme. It is not accreditation as such.

The Hon. WES FANG: Are there many dentists that are actually part of that scheme at the moment?

Dr RAPHAEL: Yes, there are a significant number of private dentists and our members that would do that scheme.

The Hon. WES FANG: In that instance where the dentist is signed up, NSW Health has got the voucher that is pushed out . Is it just the fact that the dentists are not out in the areas? When you say that accessing the voucher scheme is part of the holding back of dentists distributing further out, what changes need to be made in order to see those dentists move out to those regional areas to access those schemes?

Dr RAPHAEL: There is not enough money. If we talk to the head of the Centre for Oral Health Strategy NSW, he will tell you that on the funding that they have got, there is no way that they can provide comprehensive oral health services to everybody eligible. In fact, data shows us that about 20 per cent of those people who are eligible access the public dental services. It largely comes down to funding. As everybody in the room is aware, Medicare does not cover dentistry. It is the only part of the body that is not covered in any way. When you are starting on that footing, it is very difficult to provide anything comprehensive, let alone anything preventive and giving people a good start because there is no basis on which to build. It is schemes like that that are already in existence that we would propose additional funding will alleviate some of the issues, especially for rural and remote dwellers.

Dr JONAS: I would also add to that, as you no doubt have been told in the past, there is a fair amount of hidden poverty in rural areas. It is well disguised, but it is certainly there. My own personal experience is people turning up in a very bad way needing dental care and you just do it. It is just part of what we do. But it certainly could be altered a lot to make it more attractive to other practitioners to come and make it part of their life.

The Hon. WES FANG: If I were to summarise, in order to get more dentists out there using the voucher scheme, we need more vouchers.

Dr RAPHAEL: Yes, and we are forgetting a whole other sector. We are not just dentists. We have got oral health therapists, hygienists and dental therapists as well, who are soon to be getting their own provider numbers. That is providing a greater workforce. It is about working out ways to get all of these different types of dental practitioners out there and incentivising them and making their practices sustainable.

The Hon. WALT SECORD: May I be indulged with a simple question on Indigenous ophthalmologists and Indigenous dentists?

The CHAIR: These last questions are always the simplest ones. Please proceed.

The Hon. WALT SECORD: Indigenous dentists and Indigenous ophthalmologists, Dr Jonas?

Dr JONAS: We are at this very minute helping Indigenous dentists set up their own independent organisation. They claim their numbers at the moment are about 50 nationwide. That would include dentists and people in the oral health field. They are hoping to get up to 100 by about 2030, or something like that. So, yes, we actively engage with them. We only had a meeting with them last week. We are keen as mustard to get this thing going.

The Hon. WALT SECORD: And ophthalmologists, Ms Bell?

Dr BELL: We have one in Queensland who identifies as Indigenous. We have two who have just joined training programs—one in Western Australia and one in Victoria who identify as Indigenous. With all of our national selection, we now have eight out of 100 points for indigeneity and a guaranteed interview, at least at the RANZCO level. We are taking a number of measures to actively drive that. We are also looking at the regionally enhanced training network. We know that training people on country is a great way to go if you are Indigenous. We have got a top end pathway looking at if we can attract some Aboriginal Torres Strait Islander doctors to commit to training in the Northern Territory and northern Western Australia. Also, we are aware that if you want to get people to go regionally and stay regionally, the split model training where you train more than 50 per cent of your specialist training in regional areas is five times more likely to make them stay there when they actually graduate as a specialist. That is why we have put together this Regionally Enhanced Training Network, hopefully which will also increase the number of Indigenous trainees.

The Hon. WALT SECORD: Thank you.

The CHAIR: On behalf of the Committee members, I thank all four witnesses. It has been great to have you with us this afternoon. It has provided rich insights in terms of detailed information that I am sure we will be able to use in our deliberations for the preparation of our report recommendations. I also acknowledge and thank the two organisations for the thoughtful and strategic work you are doing in your areas of respective health, taking us forward and looking at new ways of dealing with clearly serious issues that are there and have been there for

some time. Hopefully we can make some progress over time with respect to dealing with them. Thank you very much for your great work.

(The witnesses withdrew.)

CATHERINE LOUREY, Commissioner, Mental Health Commission of NSW, before the Committee via videoconference, affirmed and examined

JUSTINE HOEY-THOMPSON, Member, The Royal Australian and New Zealand College of Psychiatrists, before the Committee via videoconference, affirmed and examined

DAVID PERKINS, Director and Professor of Rural Health Research, Centre for Rural and Remote Mental Health, before the Committee via teleconference, sworn and examined

HAZEL DALTON, Research Leader and Senior Research Fellow, Centre for Rural and Remote Mental Health, before the Committee via videoconference, affirmed and examined

The CHAIR: Our last session for this afternoon is now underway and we welcome our next witnesses. On behalf of the Committee, I thank you all for joining us for this session. I acknowledge and thank the respective organisations for their submissions to this inquiry. The submission from the Mental Health Commission of NSW is submission No. 476 to the inquiry; the submission from the Royal Australian and New Zealand College of Psychiatrists is submission No. 272; and the submission from the Centre for Rural and Remote Mental Health is submission No. 454. All of those have been received, processed and stand as submissions to the inquiry and have been uploaded to the inquiry's webpage. Of course, this afternoon is an opportunity to add to that evidence your organisations have provided by your providing oral testimony. I will proceed through the three organisations and invite an opening statement from each and then we will move to questioning from the Committee members present at the table. Ms Lourey, we will commence with you to make your opening statement.

Ms LOUREY: Thank you for the opportunity to speak with the Committee today. The commission's submission focuses on the wellbeing and mental health aspects of people who live in rural, regional and remote New South Wales and their relative access to mental health services and wellbeing supports. In responding to a number of the terms of reference of the inquiry, we highlighted that all rural and remote local health districts [LHDs] have higher than average rates of high or very high psychological distress in adults. We also know that suicide rates tend to increase with remoteness. Intentional self-harm hospitalisations are much higher in regional and remote local health districts compared to metropolitan local health districts.

We know that data shows that a lower proportion of the population access Medicare-funded mental health items in regional and remote areas than in metropolitan areas. There are lower levels of mental health prescriptions in remote and very remote communities. However, there are wide variations in patient experiences and timeliness of care across New South Wales LHDs but overall patient experiences are more positive in rural areas. The prevalence of mental health professionals increases with remoteness and the average hours of work increases with remoteness. The specialist workforces are important to responding to the needs of particular communities. We know that the health workforce must support and respond to the social and emotional wellbeing of Aboriginal people, which is that broader concept of health alone, and that we need to overcome barriers to seeking help for mental health concerns raised by culturally and linguistically diverse communities.

Additionally, rural, regional and remote communities have faced compounding disaster events—drought, bushfire, floods, mouse plagues and, of course, COVID. The long-term consequences of these compounding events on mental health in regional and remote communities are still being explored. We know over half of regional and remote communities were impacted by the drought, at 57 per cent, and half of regional and remote communities were impacted by the Black Summer bushfires, of which 16 per cent reported that more than half of the local area was burnt in the fires. In February 2020, flood and storms impacted most of New South Wales and 94 per cent of regional and remote postcodes were declared by the Insurance Council of Australia to be in the February catastrophe event. These indicate the impacts that overall the communities in these areas experience on their mental health and their wellbeing and the subsequent need to provide services appropriately and in a timely fashion.

COVID-19 has also had an impact on the wellbeing of rural communities. In 2020 the commission surveyed New South Wales residents about the impact of COVID-19 on their mental health and wellbeing. One in 20 regional residents were diagnosed with a new mental health issue in 2020 compared to one in 10 among their Greater Sydney counterparts. However, in 2021, I have been advised that NSW Health data shows there have been, unfortunately, an increase in suspected or confirmed suicide deaths in rural and remote New South Wales compared to the same period in 2020, and an increase in self-harm and suicide ideation presentations in emergency departments in almost all regional and rural local health districts. The commission is now conducting a second survey to understand the mental health impacts of COVID-19 on wellbeing and mental health during 2021.

Over the development of the Living Well in Focus New South Wales strategic plan to 2024, we visited over 60 communities around New South Wales, and 20 of these in regional and remote areas of New South Wales.

These consultations highlighted five consistent themes in the consideration of mental health service delivery in regional and remote New South Wales. The first theme was access to services, that is, the desire for services to be available where people are, easy navigation of the system including better pathways between services, and service delivery through community hubs. The second theme was funding, security and challenges. Financial barriers have increased the cost of services and, with the reduction of bulk-billing, impact community access. The impost upon smaller organisations of competitive tendering and short-term funding cycles means they may not be in the best position to secure funding for their local communities.

The third theme was the mental health peer workforce: increasing the numbers of peer-led services and lived experience peer workers were seen as essential to grow local services and supports from their own community. The fourth theme was staffing and workforce: availability of staff, availability of training, barriers to professional development, and recruitment and training challenges are the result of ongoing challenges overall in recruitment and training in rural and regional areas. The last theme was the impact of social determinants. This is housing, education opportunities, drug addiction and financial assistance, employment opportunities and transport.

There was really an overall picture in saying this, but community strength and resourcing the community in early intervention and supporting wellbeing as well as mental health, that was key in these areas. Having local responses, the local people are part of designing those responses. Living Well in Focus has three strategic priorities that really highlights and resonates with those: strengthening community recovery and wellbeing; strategically investing in community wellbeing and mental health; and ensuring the right workforce for the future. I will leave my opening comments at that and I welcome any questions on our submission. Thank you.

The CHAIR: Thank you very much, Commissioner. Can we now move to Dr Hoey-Thompson please?

Dr HOEY-THOMPSON: Thank you. I agree with everything Catherine Lourey had to say and there will be a similar overlap with what I have to say on behalf of the college. The New South Wales branch of the Royal Australian and New Zealand College of Psychiatrists, who I am here to represent, thanks you for the opportunity to provide a submission and to appear before this parliamentary inquiry. The college is a membership organisation that trains doctors to be psychiatrists as medical specialists; it supports and enhances clinical practice; advocates for people affected by mental illness; and advises governments on mental health. The New South Wales branch represents more than 1,200 fellows and around 400 trainees.

According to the 2016 census, about two million people live rurally, regionally and remotely in New South Wales and about one in five, or 400,000 of those, a year will have a mental illness. Some 55 per cent of First Nations people in New South Wales live in these areas. They are twice as likely, as Catherine Lourey said, to have experienced high or very high levels of distress, are three times more likely to be hospitalised for intentional self-harm, and have double the rates of suicide—up to three times the rate in the 15- to 24-year-old age group. Health inequities for these people are unfair and largely unavailable. They are primarily from isolation, socio-economic disadvantage, lack of healthcare providers and barriers to service access.

One of the reasons for lower engagement in health care is a lack of access, which requires targeted funding. The basis of the New South Wales branch recommendations comes from the belief that people living rurally deserve equitable access to services to meet their needs in an affordable way and continuity of care. In fact, I think that is a human right. The care should be as close to home as possible. This may involve innovation such as telehealth, specialist supports at local services, solutions to facilitate access, and addressing transport and digital barriers. First Nations people need to be provided with culturally safe and appropriate mental health care to address the intrinsic disadvantage.

As far as the terms of reference: comparisons for patient outcomes, we mentioned the higher rates of suicide, self-harm and psychological distress, despite the prevalence of mental illness being similar to those in the cities, is exacerbated by poor access to acute and primary care; as Ms Lourey said, reduced bulk-billing; the limited number of mental health services and professionals; and also the distance, the travel and cost for people who are already struggling can be significant. Alcohol and other drug issues in all populations are often comorbid with mental health issues and harder to access help for in rural, regional and remote communities. There is more risky smoking, more risky drinking, more use of illicit substances including methamphetamines. And child and adolescent services have seen an escalation of presentations, particularly in the COVID times, to emergency departments, with eating disorders, self-harm, suicide and psychotic illnesses.

As far as access to health and hospital services, there is reduced access compared to people in the city. There are fewer health professionals and services might not be appropriate for the care of young people or older people. Telehealth services may be difficult to access, particularly in areas with poor connectivity and data speeds. Fly-in fly-out specialists can fill gaps in the service but they deliver care at limited times, and we have heard that there are some areas such as western New South Wales, southern New South Wales and the Murrumbidgee areas

that primarily depend on fly-in fly-out psychiatrists. So rural communities have a chronic shortage of services and health professionals to staff them.

As far as patient experiences and wait times, there is frequently a lack of 24-hour support and care for acute presentations at night. Many people have to stay overnight in really noisy, bright, distressing emergency departments so that they can access care. The first recommendation of the college is the development of a rural and remote mental health strategy which targets those at risk of harm—ageing people, children and adolescents, people with drug and alcohol issues—targeted funding for suicide prevention and continuity of care; funding support for telepsychiatry and upgrades to technology; expanding treatments for drug and alcohol; and the whole array of prevention, early intervention. As far as planning systems for NSW Health, the branch recommends the Government's rural mental health strategy consider population growth and the care needs of the community to be met with a reliable and sustainable workforce.

As far as recurrent expenditure, expenditure on mental services per capita decreases significantly more in rural areas, and so it is grossly unequal and inequitable. In fact, there can be a 700 per cent disparity between mental health spending in the city compared to a remote area. Services, in fact, might be even more expensive to run remotely because of the distances travelled. So the third recommendation is funding reform that is equitable across rural LHD services, it acknowledges the population growth, and also the significance of and shows economic disadvantage.

The final aspect I would like to comment on is the staffing challenges in these areas. The distribution of mental health professionals rapidly decreases with remoteness. Psychiatrists are six times less prevalent, psychologists five times less prevalent remotely and mental health nurses three times. The issues are complex of why this is so, but one of the reasons is the lack of flexibility of the New South Wales Government awards, with no capacity to provide financial incentives in large recruit areas like growth areas. So there is a need for the consideration of the lack of flexibility in the award.

Just as a final comment from myself, the shortages in workforce are not just—I heard yesterday that Walgett hospital has lost different workforces. It is also in rural and regional areas. Today I heard of someone in a rural emergency department with a mental health illness who has been there for 96 hours, waiting for a bed. Meantime, there are 16 beds that are not being used in our health district because they cannot be staffed. I think that is a great disappointment and it leads to a lot of suffering that is unnecessary. Thank you.

The CHAIR: Thank you. That was a very comprehensive opening statement for and on behalf of the college. I am sure that will lead to some questions from members shortly. Moving now to Professor Perkins. Can I invite you to make an opening statement? Was that the plan or is it going to be Dr Dalton? Or both?

Dr DALTON: It is the plan.

The CHAIR: Okay. Thank you.

Professor PERKINS: Thank you, very much, Chair and I apologise for being on the phone. It is an example of rural internet difficulties. I would like to start by saying that I strongly support the comments that have been made by my two colleagues. There has been a significant change since we submitted our evidence. Since we submitted the evidence that you have before you, the New South Wales Government decided not to continue to fund the Centre for Rural and Remote Mental Health in New South Wales. So we are no longer funded by the New South Wales Government and, after 20 years, the physical office will be closing on 17 December. A small team of about seven will work remotely to complete externally funded research projects, such as the impact of the pandemic on rural and remote mental health, which is being undertaken for the National Mental Health Commission. We can provide information about—

The CHAIR: Professor, sorry to interrupt. How long had that been operating for?

Professor PERKINS: For 20 years.

The CHAIR: Thank you.

Professor PERKINS: Based in Orange. We can provide further information on any of the points we make. In broad terms, the prevalence of mental health problems in rural and remote New South Wales is similar to that of the large cities, but we do have a series of stressors such as fire, flood, drought, mice, to a much greater extent than takes place in cities. We can see this as a form of rural adversity which is sequential, which is cumulative, and which overlays the adversity of normal life that individuals contend with such as a cancer diagnosis, a child with a learning disability, an accident, all of those sorts of things. We know that, over very many years, rural and remote suicide rates have been consistently higher by up to 50 per cent than those in the cities, and we know that self-harm rates are also elevated, particularly amongst young people and that COVID has—as the commissioner told us—led to some increases in New South Wales.

We know that most available data is provided out of health service data and it implies that people have managed to access services. Community data, such as the 2007 National Survey of Mental Health and Wellbeing, or the Australian Rural Mental Health Study, is crucially important because we need to include those people who are not currently receiving services, as well as those people who actually manage to find their way to the front door. We know that access to mental health services is a problem. In rural areas such as Orange or Dubbo, there is a shortage of specialists, of psychiatrists and clinical psychologists. When you get to remote areas, there is also a shortage of resident generalists, of GPs, of nurses. So it is really very difficult for those in remote parts of New South Wales. We know that access to mental health services declines with remoteness. Less money is spent on those people from the Medicare Benefits Schedule [MBS] and Pharmaceutical Benefits Scheme [PBS] systems, and it is a major equity issue.

We know that rural communities are highly variable and that one service model will not fit all. The model for Wilcannia will not be the same as the model for Lismore. Services are made up of private, public, Aboriginal, NGO and philanthropic staff, supplemented by visiting clinicians and a wide range of mental telehealth programs and services. The key to effective rural services is the way in which these providers collaborate. Collaboration has a time and a resource cost, which must be accounted for and supported. This enables the ability to build trust and to build continuity. The constant cutting and changing of services is not good for trust. It is not good community capacity and it is not good for outcomes. We know there is a digital divide. Some rural residents are excluded from many of the teleservices by poor internet access, poor skills or capability to use those services, and sometimes they are trying to use services from a place that is not safe.

In our view, the most effective services are those that have been designed by local communities working with the full range of community members and service providers. These have been made to measure, as it were, for those communities. Over the COVID experience, we know that frontline responses—whether they are health service, police or any of the others who come to see people—have been suffering increased anxiety, increased depression, higher burnout scores and that many have announced an intention to leave and to find other employment. The pandemic has taken a significant toll on the people we wish to provide these services.

We believe, in conclusion, that it is critical that we focus on developing and supporting the workforce. This will require effective and sustained collaboration between governments, between training providers, between colleges and between service providers, and that this workforce that supports the system includes clinicians but it also includes other professionals, peer workers, managers and those in service planning, design, training, research and evaluation. It is these people working collaboratively that will make the system more effective or where the big holes will appear. Thank you very much.

The CHAIR: Thank you, Professor Perkins. That was, equally, a very comprehensive and detailed opening statement. Out of interest, just for my knowledge, where are you actually calling from, Professor Perkins? Where are you located?

The Hon. TREVOR KHAN: In a general sense.

Professor PERKINS: I am currently calling from Orange because my office has no internet working, so I am trying to operate from home.

The Hon. WALT SECORD: It was not a criticism.

The CHAIR: No, it is not a reflection on you. We are having these breakages and it is just out of interest, for me anyway, whereabouts people are located. I appreciate that. The Hon. Walt Secord?

The Hon. WALT SECORD: Professor Perkins, can you tell us a bit about the Centre for Rural and Remote Mental Health and why is it closing on 17 December?

Professor PERKINS: We were set up in about 2000 by Professor Beverley Raphael when she was the Director of Mental Health for New South Wales. The basic case was that, with the greatest respect, people sitting in the middle of Sydney do not see rural mental health problems in the same perspective as people who live and work in rural and remote New South Wales. We had a series of short-term contracts of three and five years for that 20-year period. Our last contract ran out at the end of December last year, December 2020. We have been through six-month and three-month extensions, but the previous contract was to have a centre for rural and remote mental health. What was left were two service contracts. And so, essentially, we are in the physical process of closing the building. The library has been dispersed and a lot of the staff have moved to other jobs and other industries.

The Hon. WALT SECORD: How many people were there providing services?

Professor PERKINS: There were around 20, and we are now down to seven. I am stepping down on the seventeenth. Dr Dalton and a small group will be completing activities through to 30 June next year.

The Hon. WALT SECORD: What will happen to the people who are accessing your services or getting support and the programs? What will happen to them?

Professor PERKINS: What will happen will be that there will still be rural adversity mental health workers, who will be out in rural and remote New South Wales and employed by health districts. What will be lost will be two things. One will be the development, coordination and training of those people, which we have been doing. The second will be the independent or quasi-independent research, which is about trying to understand the key issues of rural adversity and the impact of fire, flood, drought and those things; secondly, the issue of rural suicide; thirdly, the issue of rural services; and fourthly, the issue of community development and addressing the social determinants of mental ill health and suicide.

The Hon. WALT SECORD: Professor Perkins, it could not have come at a worse time, could it?

Professor PERKINS: No, and it has been a slow burn. My staff have been working on trying to address the funding issue since the beginning of 2020. It has been a long period of uncertainty and loss and stress.

The Hon. WALT SECORD: Thank you very much. Dr Hoey-Thompson, you mentioned in your opening statement a patient waiting 96 hours for a bed. Which hospital was that?

Dr HOEY-THOMPSON: Lismore.

The Hon. WALT SECORD: Was that a recent development? When did that occur?

Dr HOEY-THOMPSON: That is now. It is today.

The Hon. WALT SECORD: Today? A person is waiting 96 hours in Lismore hospital as we speak? Why is that? I am not blaming you; I am just asking the question. Why is that occurring?

Dr HOEY-THOMPSON: I think there are 85 adult mental health beds in the LHD. Sixteen of those are unavailable because they cannot be staffed by doctors, nurses and allied health. They are not available for use. They are not in use.

The Hon. WALT SECORD: So what is happening to the patient? Is the patient just sitting on a chair in the emergency department?

Dr HOEY-THOMPSON: I do not work in that particular hospital anymore. I assume that they are either in a room by themselves or have a bed, but I do not know the precise details of that. I cannot comment too much on individual people.

The Hon. WALT SECORD: No, I understand that. Mental health commissioner Catherine Lourey, you mentioned that you have done consultations around the State. I think you mentioned, from memory, 60 consultations around New South Wales. Is that correct?

Ms LOUREY: That's correct.

The Hon. WALT SECORD: How many in rural and regional areas?

Ms LOUREY: [Audio malfunction.]

The Hon. WALT SECORD: Sorry, you're muted.

Ms CATE FAEHRMANN: Or very faint.

Ms LOUREY: Sorry, I will speak louder. Twenty-one.

The CHAIR: Yes, come a little bit closer to the microphone, please.

The Hon. WALT SECORD: Sorry, what was the answer?

Ms LOUREY: Twenty-one.

The Hon. WALT SECORD: Ms Lourey, do you remember some time ago—I think it was several years ago—when you were appointed mental health commissioner? Have you met the new Premier?

Ms LOUREY: Yes, I have.

The Hon. WALT SECORD: Oh, you have? When did you meet the new Premier?

Ms LOUREY: I met him when there was an announcement of mental health funding four weeks ago. I can get back to you with the exact date.

The Hon. WALT SECORD: Could you take that on notice? I would like to know. When you met the Premier, did you raise with him concerns about the Centre for Rural and Remote Mental Health closing on 17 December?

Ms LOUREY: No, I did not.

The Hon. WALT SECORD: Have you raised it with the health Minister?

Ms LOUREY: No. I have only been recently apprised of the closure of the centre.

The Hon. WALT SECORD: Do you support the closure of the centre?

Ms LOUREY: I would say that we have had a really good working relationship with the centre. The commission has not been involved in the procurement process that ended up in a different tendering outcome for the service. The commission is really interested in establishing new relationships with the new provider, but we hold the centre and its employees in high esteem and we have worked productively with them.

The Hon. WALT SECORD: I am sure you hold them in high esteem. What about the people receiving the services and receiving the training? What steps have you taken to ensure that they are not going to be disadvantaged?

Ms LOUREY: The commission does not have a role in providing services. That is really the Ministry of Health.

The Hon. WALT SECORD: I was not asking about providing services; I meant supporting those who are providing the services. I would assume that you would have an interest in the Centre for Rural and Remote Mental Health continuing to operate.

Ms LOUREY: I absolutely have an interest in having those services continued. I do not know the details of the new procurement, so I am not in a position to understand what services are being transferred. I have asked for some advice on that.

The Hon. WALT SECORD: It has been put to me—I was the shadow Minister for Health for seven years, five of that in mental health—that having access to a psychiatrist in New South Wales, particularly outside of Sydney, Wollongong and Newcastle, is a luxury. What do you say to that?

Ms LOUREY: I think we know from the evidence previously from the college rep that, absolutely, access to psychiatrists outside metropolitan Sydney is difficult. Even if we look at telehealth, telehealth modalities do not always suit individuals. So how can we get local services that can support people, and support people to become more familiar with telehealth? It is not only about psychiatrists, of course; it is about the team and the mental health team that are also there on the ground in towns to support individuals in their recovery and their mental health journey.

The Hon. WALT SECORD: We have had evidence from people from the Indigenous First Nations community who are concerned about and very uncomfortable with telehealth. How do you grapple with First Nations people who are uncomfortable with telehealth in general and then layer that on top with having to deal with mental health problems? How do you grapple with that?

Ms LOUREY: When the commission did its consultations, we had a particular stream where we sat with Aboriginal people and asked them what they would want. It was about having Aboriginal psychiatrists and Aboriginal trained mental health workers working with them—on country, preferably. I think something in the recommendation that the college made about having a rural mental health plan is looking at how we can grow the Aboriginal workforce.

The Hon. WALT SECORD: No, I understand that. In fact, I think there is one New South Wales Aboriginal psychiatrist, and I know him. I think there is one in New South Wales. Can I take you to the issue of seclusion? As a KPI indicator, the use of seclusion involving mental health treatment in New South Wales—what is seclusion?

Ms LOUREY: The definition of "seclusion"?

The Hon. WALT SECORD: I sort of know what it is, but I want you to say what it is.

Ms LOUREY: Oh, okay. Seclusion is the placing of a person in a room or a location where they have no access or egress from that, so they have no ability to leave that space.

The Hon. WALT SECORD: No freedom of exit?

Ms LOUREY: Exactly.

The Hon. WALT SECORD: Are you concerned that the top 10 hospitals in New South Wales that use seclusion as a response to people suffering from mental illness episodes—Broken Hill, Maitland, Lismore, Port Macquarie and Wyong. I put Wyong in there, but that is actually the Central Coast. I will drop Wyong off. Is it because of a lack of workers, a lack of staff and workforce issues that seclusion is now becoming an issue in rural and regional hospitals?

Ms LOUREY: I would say that I totally support the decline of the use of seclusion to eliminating seclusion. Seclusion should not be tolerated. I think there needs to be in parallel other opportunities that are about providing alternative locations of care, to have improved education and training of staff, to have improved availability of training and to have peer workers appropriate to that community, referring to your earlier question about having Aboriginal peer workers who can be in emergency departments or in other crisis environments to support people so that they do not need seclusion but also to support the mental health team around that person.

The Hon. WALT SECORD: My last question, 10.7 per cent of mental health patients in the Broken Hill Hospital are subjected to this treatment, are subjected to being locked in a room alone as treatment. Is that acceptable?

Ms LOUREY: Seclusion is not acceptable. Seclusion especially for people who may be in that case, at that hospital—I have been to that hospital; I have been to that inpatient unit. Especially with Aboriginal people, we need to have very culturally appropriate responses. We need to have teams that understand and embed responses that are early, when people are feeling distressed. I think there is a national commitment to that. But in rural locations, where we have already heard about staffing difficulties, we need to have a focus on that. Because it is not only about seclusion; it is about the re-traumatisation of people. We want people to approach mental health services not being fearful that they may be further traumatised by seclusion. I think that is a really important point.

The Hon. WALT SECORD: Thank you, Mr Chair. I would love to have another session on mental health. I think we should consider that.

The CHAIR: Thank you, commissioner. We will now move to crossbench questions. The Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: Thank you all for coming today. I might throw to either Professor Perkins or Dr Dalton. In the submission you make the point that having a good, stable GP in the community is essential and that people in rural areas are missing out on potential mental health diagnoses because they do not have that regular access to GPs or might not even have a regular GP at all. Can you expand on the effect of that in regards to mental health services. I also just want to put the question forward, whether you think that the situation is going to get worse with the close-down of the centre.

Professor PERKINS: Dr Dalton, do you want to answer?

Dr DALTON: I can do it, Professor Perkins, thank you. In terms of general practitioners, in resident communities GPs are the heart of health. They are the gateway to access to specialists. They provide mental health care themselves. So having a delay in access to general practitioner is a delay in access to care. It potentially leads to the exacerbation of the condition, and it reduces cost. If you are going to see a psychologist, you see a GP, you get a referral, you get an MBS subsidy to see that psychologist. Obviously if you need to see a psychiatrist more, you will definitely need to see the GP. So I think what it does is it adds delay and it can lead to a lack of continuity of care. So mostly what you run the risk of is an escalation in the intensity of the illness and delay in terms of getting treatment. In terms of how the centre impacts it, our opportunities have been around researching what the good models of care are, where the successes are and being able to share that with other rural communities, where we know care works effectively—integrated care models like out in Mudgee—slow, quiet work that gives the models that work in the country, as opposed to the city models getting rolled out.

Professor PERKINS: Can I make one other comment there.

The Hon. EMMA HURST: Please.

Professor PERKINS: That is very often physical and mental health problems come together and the GP is actually able to address both sides of the problem, which is critically important.

The Hon. EMMA HURST: Definitely. In your submission you also pointed out that the telehealth should be an adjunct to, not a replacement of, local primary care and mental health services. Do you feel that there is a tendency for telehealth to become a replacement for face-to-face mental health services? Or is there concern that that is where we are moving?

Dr DALTON: There is a [audio malfunction] important. I think telehealth is essential component to the system. One of the risks is in how we do it and what it does to resident services. If it comes in without regulation or consideration to the resident workforce, you can have a situation wherein the resident workforce may not have enough work to be a sustainable business. If you are a psychologist, you have to run on hours and you have got time imposts and there are a lot of things that go on. If we eviscerate the rural workforce by supplanting with telehealth, you end up with no resident support. So it is important to consider how telehealth is used and deployed. There are some really great models where the specialists are brought in with Community Mental Health and things like that. There are ways that it is an absolute boon and an enhancement. I guess the other thing that comes into play as a risk with telehealth is who is providing the support. If you are visiting a psychologist who is resident and knows your area, they are quite familiar with the general challenges of being out in the country, what someone might be contending with, and there is a resident continuity with your experience. That might be another aspect in terms of best practice and care and understanding.

The Hon. EMMA HURST: In your submission you also talk about that there is a missing middle in rural and regional areas where patients' needs are too serious for a GP but not quite at the point of requiring the State mental health care services. Can you help us unpack this a bit more to understand what services are needed in this middle group to prevent conditions getting worse?

Dr DALTON: I can speak somewhat to it. I guess it is probably not strictly just rural and remote, but it is one of the things in rural and remote where workforce is an issue and servicing becomes a challenge. But what you have is people with potentially serious but episodic mental illness who are not in acute phase and the thing around what is support whilst they are well to stay well. That is one aspect. There is also when someone has a moderate to serious mental illness but may not need to be an inpatient. And [audio malfunction] work funded to [inaudible] people can, services can declare them too acute or too serious for their model-of-care parameters. Then when you go to the LHD, Community Mental Health or Mental Health, they say, "You're not serious enough to be in hospital. We don't have anything for you." It is that gap in care around who is holding whom and how do we get the responsibility so that there is actually overlap as opposed to a gap. It is about encouraging the responsibilities to extend into a proper handover and cover over as opposed to, "You're not difficult enough for me", or, "You're too much for my service". So that collaborative care and actually good collaboration between services so they actually make sure people do not fall in the gaps.

The Hon. EMMA HURST: Thank you.

Ms CATE FAEHRMANN: My first question is to Ms Lourey. This morning we heard from Just Reinvest, who brought to the Committee the really unacceptable link between undiagnosed, unaddressed and untreated cognitive impairment, mental ill health and trauma amongst young Aboriginal people going through the Youth Justice system. I asked the witness for Just Reinvest about whether there was any statewide programs to try to address this issue with vulnerable young Aboriginal people. Is there a statewide program in terms of mental health, particularly for the most vulnerable, to try to address that issue before they enter the criminal justice system? Are there any statewide programs you are aware of?

Ms LOUREY: I am not aware of those. I could find out. But that would either be from the Justice and Communities cluster or from the Justice and Forensic Mental Health Network.

Ms CATE FAEHRMANN: Do you think this is an issue that needs to have a lot more consideration and attention given to it then?

Ms LOUREY: I think that when we look at the over-representation of young Aboriginal people in our custodial system and in our forensic system, I think it is absolutely a priority.

Ms CATE FAEHRMANN: Do any of the witnesses from the Centre for Rural and Remote Mental Health have anything to contribute in that regard in terms of particularly young Aboriginal people and mental health issues—whether anything can be addressed at a level or extent before they enter the criminal justice system, whether there are any recommendations around programs or whether there have been any successful trials, or what have you, that you have any knowledge of.

Professor PERKINS: I am not an expert here but I think it would be worth looking seriously at the Justice Reinvestment projects in Bourke, the broad idea being that we spend an enormous amount of money incarcerating people and if we could use some of that money to provide them with care and with educational and employment and support opportunities, it would be a much better situation.

The Hon. TREVOR KHAN: Hear, hear!

Ms CATE FAEHRMANN: There is obviously an enormous gap. The statistics suggest it is horrendous. The rate of mental health issues for young Aboriginal people who enter the criminal justice system is just

extraordinary. The witnesses that we have asked just do not seem to—there is nothing in that space. it is just so obvious the connection, what is happening here. But no, there is nothing. Maybe we could make a recommendation on that.

Dr DALTON: Justice Reinvestment project, which Professor Perkins referred to and the team who presented, did work in both Bourke and Cowra. I think the approach they have taken is really about addressing the social and emotional determinants of mental health and wellbeing, so taking a holistic approach with their Aboriginal youth, and they have got good data on how well it has worked.

Ms CATE FAEHRMANN: That would be good. Maybe we will find out a little bit more about that for this inquiry. Thank you. Again, with the Centre for Rural and Remote Mental Health in terms of your submission, you have a particular criticism of market-driven responses for rural areas, particularly the significant fragmentation and duplication of rural mental health services. We have heard a fair bit about that, in fact, but not just mental health services. Could you explain to the Committee a little bit more about why you wanted to draw our attention to that?

Professor PERKINS: Yes. I think because the whole issue of fee for services in this area imply that, on the one hand, there is a demand sufficient to enable a psychiatrist or a psychologist or occupational therapist to make a living and it implies that it is possible to have a range of providers. What is clear is that that works to some extent in the cities, but that really does not work in small, rural places where there is not a sufficiently sized population to pay for specialist services, and that goes right across the board. It is why you do not have barristers living and working in these places; that is why they visit.

So we have, as it were, thin service systems, and that does also bring the point that Dr Dalton made earlier, namely that a city-based telehealth service may actually take away—particularly if it is provided free—the market for a resident psychologist, occupational therapist, who lives in a rural area. We have to look at it from the perspective of the consumer and the patient, and we have to look at it particularly from those who cannot afford to pay market rates for these services, because they are on Newstart or they are disabled, whatever it might be.

Ms CATE FAEHRMANN: Professor Perkins, one last question. I understand you lost a contract; is that correct? Ms Lourey referred to that, that the services being provided by yourselves have actually been contracted out to another organisation.

Professor PERKINS: There was a change in contract. We were contracted to run a physical centre for rural and remote mental health. What happened was that after a long period of uncertainty; two contracts for support services were let and those contracts were awarded to groups based in Wollongong. We can provide more information if that would help.

The Hon. TREVOR KHAN: No, you are now cutting into my time.

Ms CATE FAEHRMANN: I am just saying thank you.

Dr DALTON: It was just an open, competitive tender for two different—one was to manage the Rural Adversity Mental Health Program, which we formerly developed and managed. And the other was for a rural mental health research partnership, which is distinctly different from what we had formerly been funded to do. Whilst there is an investment going forward, it is not the same as it was before, and financially it is less as well. We did not get it. It went to The Peregrine Centre at Wollongong.

The Hon. TREVOR KHAN: That last answer in part answers the question. It is the case, is it not, Professor Perkins, that the rural mental health research partnership tender went to The Peregrine Centre, which is based essentially around the University of Wollongong? That is correct, is it not?

Professor PERKINS: Yes, absolutely.

The Hon. TREVOR KHAN: And the other part of the contract was with regards to the management and coordination of the Rural Adversity Mental Health Program [RAMHP] coordinators, and that was awarded to Grand Pacific Health.

The Hon. WALT SECORD: A private provider.

Professor PERKINS: Yes.

The Hon. TREVOR KHAN: That is correct?

Dr DALTON: Yes.

The Hon. TREVOR KHAN: And the 19.5 RAMHP coordinators continued on in employment, now under the control of Grand Pacific Health. That is correct, is it not?

Professor PERKINS: No. They are under the control now of health districts.

The Hon. TREVOR KHAN: I tried to be careful who their employment might be with, but their management and coordination is through Grand Pacific Health; correct?

Professor PERKINS: Yes.

Dr DALTON: Yes, in partnership with-—

Professor PERKINS: That is a contentious—

The CHAIR: That is 19.5 full-time equivalent; is that what you meant?

The Hon. TREVOR KHAN: Yes. It might be contentious for you, Professor Perkins, but that is the case, is it not? The 19.5 that existed before still exists and you are aware that they are funded through until June 2026, is that not right?

Professor PERKINS: Absolutely.

Dr DALTON: Yes.

The Hon. TREVOR KHAN: So in effect there is no impact on that area of services at all, irrespective of your involvement in it or not; correct?

Professor PERKINS: That remains to be seen. The resource levels may be the same, but the impact will remain to be seen.

The Hon. TREVOR KHAN: I can understand as an unsuccessful tenderer you are not going to be particularly happy about it, but it was a tender process that was overseen by O'Connor Marsden & Associates, was it not?

Professor PERKINS: As we understand, yes.

The Hon. TREVOR KHAN: And there was an independent probity adviser as well.

Dr DALTON: Totally, do not have [audio malfunction].

The CHAIR: Sorry, I did not hear that last answer.

Dr DALTON: Yes.

The Hon. TREVOR KHAN: I did not quite hear that last observation.

Dr DALTON: Yes.

Professor PERKINS: There was a tender. That is correct, yes.

The Hon. TREVOR KHAN: I think it has just been important to make quite clear that it has not simply been an exercise of closing down and there being nothing. There has been a different strategy that has been adopted and unfortunately you were the unsuccessful tenderer in the process.

Professor PERKINS: Yes, but I guess the point I was trying to make was that the previous contract was to provide a physical centre for rural and remote mental health. The current contract, there are two contracts for services and those are—that is quite different.

The Hon. TREVOR KHAN: One is a contract for research and the other is a contract for services, is it not? Yes?

Professor PERKINS: Yes, sure.

The Hon. TREVOR KHAN: I do not have much more but if I could go to—

The Hon. WALT SECORD: How about Lismore? Why don't you clean up Lismore?

The Hon. TREVOR KHAN: I would love to, but I can't tell you that yet. Doctor Hoey-Thompson, I am wondering what the college has done with regards to the issue of—what do we describe it as? Training?

The Hon. WALT SECORD: Seclusion.

The Hon. WES FANG: The testing.

The Hon. TREVOR KHAN: The testing of—

The Hon. WES FANG: Final graduates.

The Hon. TREVOR KHAN: Of trainees.

The Hon. WALT SECORD: I thought you were dealing with seclusion.

The Hon. TREVOR KHAN: There has been a problem in terms of those seeking to become fellows completing their accreditation process. Would that be correct?

Dr HOEY-THOMPSON: There was a whole cohort of senior psychiatry trainees who were sitting a particular exam and the digital technology failed. They were all prepared and were unable to complete that exam. Actually, I am not sure where the college is at. I work as a clinician in a rural area, not in the centre of the college—

The Hon. TREVOR KHAN: This is not a criticism of you or the college.

Dr HOEY-THOMPSON: No, that is okay. I think they are trying to find other ways to permit those trainees to progress. They know that there is extreme need for those trainees to get on with their lives. There is also a lot of unmet need for people to see psychiatrists and we need more. They are looking at that now. But I do not know the actual answer, sorry.

The Hon. TREVOR KHAN: Could you take that on notice and see if we can find out or get some sort of schedule as to when we might see an end to the problem?

Dr HOEY-THOMPSON: Certainly.

The Hon. WES FANG: I wanted to take up the first part of the Hon. Trevor Khan's questioning when he talked about the two contracts. Professor Perkins, the research that you were conducting into mental health was predominantly based around the Orange region. Is that correct?

Professor PERKINS: No. That covered the whole of the State. We, for instance, have done work over many years focused right across the State, ranging from work in the bushfires in the south, to Lismore in the north, to the west and Far West. So, yes.

The Hon. WES FANG: So did you have employed researchers in areas across the State? Is that how you operated?

Professor PERKINS: No, we did not. We largely had researchers employed in Orange, who travelled on the basis that research these days is usually done with teams and it requires getting together a team with a set of skills that you can conduct serious research with. The lone researcher is a very unusual beast these days.

The Hon. WES FANG: No, I understand that. Is it your contention that the research contract will vary at all from what you were providing to what is currently being adopted now?

Professor PERKINS: I think we will see how having a small group and building a new group operates. My view on this would be that it takes five to 10 years to build good, effective research groups based in rural areas, and that groups based in Wollongong have various opportunities of size and scale that are not available to the same extent in rural areas.

The Hon. WES FANG: Can I just clarify then—you are not saying that you think that there is going to be a detrimental impact in the research component under the new contract?

Professor PERKINS: I do not know. What I am saying is that it was for less money, that there is no physical centre and that a 20-year mental health library has now been dispersed. I felt that it was important for the Committee to know that when we gave written evidence that was the state of affairs, the state of affairs has changed. From my perspective, it is clearly disappointing to essentially see a team of about 20 basically going off and joining other industries, given the challenges and problems we have in rural mental health.

The Hon. WES FANG: But it is true, is it not, that your research is rural—based in Orange—whereas the new contract has a number of research positions located all across the State in order to do that research? Is that correct?

Professor PERKINS: I have not seen the new research contract because, obviously, it was a tender process.

Dr DALTON: There is a call for distributed part-time workers at eight to 12 hours per week.

The Hon. WES FANG: So when you say Wollongong, are you aware that a lot of the researchers are actually employed in places like Griffith, Abercrombie, the Far West, Scone and Katoomba and not just in Wollongong?

Professor PERKINS: Are they actually employed there?

The Hon. WES FANG: Yes, they actually are.

The CHAIR: Listen. I think I understand the line of questioning, but I think the Hon. Wes Fang has got the advantage of having some document with detail in it about where people are working.

The Hon. WES FANG: I know and I am sharing it with you and the witness.

The CHAIR: Hang on. I do not think it is reasonable and fair. This is not the way in which we deal with witnesses, with the greatest of respect. Information—if you have got a document, give it to them.

The Hon. WES FANG: They are not getting my documents.

The CHAIR: Order! The professor has said he has not seen the details. You are playing a bit of game, the Hon. Wes Fang. I do not think it is fair to treat witnesses like this. That is the point I am making.

The Hon. WES FANG: It is not my role, Chair.

The CHAIR: Well, I think you are. I think we always treat witnesses with respect and fairness. You are obviously playing a bit of a game. I do not think it is reasonable.

The Hon. WES FANG: I would reject that, Chair.

The CHAIR: If you have got a document to share with them, share it with them.

The Hon. WES FANG: No, it is my document. I do my own research.

The CHAIR: Do not play a game of ping-pong with them.

The Hon. WES FANG: I do my own research. I am asking the question because I want to make sure that—

The CHAIR: I will continue on and raise issue with the way in which you are going about doing this. There are ways—like the Hon. Trevor Khan pursued, by asking questions and going back and forth.

The Hon. WES FANG: But Trevor is much more professional than I am, Chair.

The CHAIR: Well, you will be damned by your own words. That is what you just said, okay.

The Hon. WES FANG: That is fair.

The CHAIR: If you have got a document to share with the witnesses, let us do it and do it fairly and let the questioning go back and forth. That is my only point.

The Hon. TREVOR KHAN: Could I say, Chair, the observation that has been made by the Hon. Walt Secord is correct. I anticipate in the further hearings there will be an opportunity for some matters to be further explored. Clearly how the Peregrine Centre operates is going to be of interest to the Committee and I think it is quite reasonable—

The Hon. WALT SECORD: Yes, I was going to move that in the deliberative.

The Hon. TREVOR KHAN: Yes. I think it is quite reasonable that we look at how that works at that time. I think we will have the opportunity to flesh it out there.

The CHAIR: I have no difficulties, but as you would appreciate—I hope that was not the point I was suggesting.

The Hon. TREVOR KHAN: No, I do agree.

The CHAIR: That brings us to the conclusion of this afternoon's final session. I thank all the witnesses very much. I think there probably are going to be some questions on notice or supplementary questions arising from this afternoon's questioning. They will be provided to you and the secretariat will liaise with you accordingly. Once again, thank you all very much for your participation, both through the submissions and the oral testimonies this afternoon. Thanks very much to anyone who has been joining us on the internet. That concludes our public hearings for this year. We will be back on 1 and 2 February next year.

(The witnesses withdrew.)

The Committee adjourned at 15:07.