REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Macquarie Room, Parliament House, Sydney, on Friday 22 September 2023

The Committee met at 11:00.

PRESENT

Dr Amanda Cohn (Chair)

The Hon. Mark Buttigieg
The Hon. Susan Carter (Deputy Chair
The Hon. Greg Donnelly
The Hon. Emily Suvaal
The Hon. Bronnie Taylor

PRESENT VIA VIDEOCONFERENCE

Ms Cate Faehrmann

The CHAIR: Welcome to the first hearing of the Committee's inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales. I acknowledge the Gadigal people of the Eora nation, the traditional custodians of the lands on which we are meeting today. I pay my respects to Elders past and present, and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respects to any Aboriginal and Torres Strait Islander people joining us today.

My name is Dr Amanda Cohn; I am Chair of the Committee. Everyone in the room should turn their mobile phone to silent. Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside of the hearing. I urge witnesses to be careful about making comments to the media or to others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage Committee members and witnesses to be mindful of these procedures.

Ms PRISCILLA BICE, CEO, BEING, affirmed and examined

Dr PETER SCHMIEDGEN, Policy Lead, BEING, affirmed and examined

Ms KATIE THORBURN, Policy Manager, Mental Health Carers NSW, affirmed and examined

Ms RACHEL LAIDLER, Policy Officer, Mental Health Carers NSW, affirmed and examined

The CHAIR: Welcome, and thank you for making the time to provide us with your evidence today. I now invite you, if you would like, to make a short opening statement.

PRISCILLA BICE: BEING Mental Health Consumers represents consumers of public mental health services across New South Wales. Our goals are to understand consumer experience and to advocate for systemic change in New South Wales government-funded mental health services. We would like to use our opening comments to amplify recommendations 10, 11, 12 and 13 of our submission. These recommendations focus on the inadequacy of the current arrangements for police involvement in mental health crisis response in New South Wales. We believe that too many people have been injured or have lost their lives as a result of conduct with police during mental health crises, and we would like to see change. So-called "welfare checks" should not be associated with the possible death of the consumer. Any adequate change process will need to include people with lived experience as core participants. Such weighty matters should not be transacted behind closed doors without the involvement of key community stakeholders.

The very recent passing of Krista Kach as a result of a "non-lethal" beanbag round underlies the need for timely change in this area. We know that only yesterday Minister Jackson advised that she and the Ministry of Health are starting to explore alternatives. We also note that these changes will only be possible if appropriate funding is made available to allow new alternatives to be developed. Our preferred model would be that police reinstate the substantial training they had for officers up until 2019 and that plain-clothes teams respond to mental health crises rather than police. The ACT utilises such a model, as do SPOT teams in New South Wales.

KATIE THORBURN: Mental Health Carers NSW's recommendations and responses at this hearing are underpinned by this quote from the executive summary of our submission:

> … there is inadequate access to an inadequate mental health 'system' that lacks the scale to deal with the scope of the population's need for mental health services in the community. The fragmented system is hard to navigate, tracks needs and delivers support poorly across settings, relying excessively on medication and coercive and emergency responses due to the inadequate planning and resources for follow-up and coordination. This leaves overburdened service providers hard pressed to deliver adequate, empathic support, let alone time to identify, engage and support families and carers in their caring role and in looking after their own wellbeing.

As the State peak representative and advocacy organisation for mental health carers, the issues escalated to us constantly reflect a mental health system driven by sane-ist discrimination, coercion and risk prediction fallacies. These, thought to be relics of the past, allowed for asylum-era practices seen as a historical blight on the decision-makers at the time. We see this parliamentary inquiry as an opportunity to reset the direction of community services toward developing robust systems of support which can prevent crisis, facilitate recovery and foster wellbeing. Choosing instead to resource trauma-informed, personal-recovery-focused community alternatives on principles of choice can generate a new culture in communities that upholds human rights and inclusion. Building strong and vibrant communities which fully address the social determinants of health is, we believe, the best preventative and responsive approach to reducing distress which presents as mental health crisis in the community. Services that support this will support carers to support loved ones.

The CHAIR: I'd like to start by acknowledging the incredible amount of work that both of your organisations have put into your submissions. They're extremely comprehensive. You've obviously done broad consultation and included the experiences of a large number of people, and we really appreciate those written submissions. I will start with my own question for BEING. You've chosen to focus your opening statement on the role of police in responding to mental health emergencies. It's obviously really topical at the moment; it's been in the news. This Committee's terms of reference are specifically interested in what the alternatives are. We're really looking for solutions, and you mentioned the ACT model and the SPOT model in your opening statement. I was hoping you could speak to the experiences of your members in those alternative systems and what difference that could make to consumers.

PRISCILLA BICE: I guess our view is that we've seen four deaths in as many months at the hands of police. I know that police didn't go into those mental health situations wanting to kill, but that was the outcome. We're seeing that consumers are becoming more scared of the outcome that they might experience if police are called. In terms of alternatives, we really like the SPOT team model at the moment. SPOT is an acronym for suicidal—

KATIE THORBURN: Suicide Prevention Outreach Team.

PRISCILLA BICE: Thanks, colleagues. It's not specifically for responding to all emergencies, just suicidal emergencies, crises. The benefit of that model is that there's a clinician and a peer worker working side by side together to respond, which has some advantages in that the peer worker has possibly been in the situation before or something similar. They are able to support the consumer with empathy and the clinician comes with their clinician training, so as a team that is a really strong team. They also go in plain clothes. Part of the issue we have with police response is they're going in fully kitted up with their uniform and their gun and their taser, and that in and of itself is a possible trigger for a trauma response in a consumer.

In addition to the SPOT team, we know that in the ACT they have a model a little bit like that. I believe it's a police officer, a clinician and a paramedic. We would probably want to see something slightly different: inclusive of a peer worker perhaps rather than a paramedic, to add that extra lived experience and empathy element to the response. Ultimately, though, I think we really do need to have a discussion with both Police and Health because I don't know how they are going to feel about these particular models. I'm sure they will all want to negotiate the ultimate outcome, but we would like to be included in all those conversations.

The Hon. EMILY SUVAAL: Where is the SPOT model currently in place? Is it currently in place?

PRISCILLA BICE: Yes, it's in place across New South Wales. I don't know how many SPOT teams there are across New South Wales. It's part of the Towards Zero Suicides program.

The Hon. EMILY SUVAAL: So it's a Federal-funded initiative?

PRISCILLA BICE: State. I believe it's State.

KATIE THORBURN: They're embedded in Health. They're within community mental health teams. They'll be at community centres—another team alongside that.

The Hon. EMILY SUVAAL: Thank you. Sorry, I just hadn't heard of it before.

The CHAIR: To the carers, I saw you nodding along with the response. I would invite you to answer the same question, if you'd like, or we can move to other questions.

KATIE THORBURN: Thank you. Absolutely. As a carer, for our members and the people we represent, the scariest thing and the worst thing that could possibly happen is the death of a loved one when seeking help or when a response is put out inappropriately to a mental health situation. We're hearing that carers are afraid to call for help because of the inappropriate responses going out. Very similar, we really support being in this call. The situation needs to be assessed by people who understand mental health, who understand the people who are experiencing that, and are peer support workers who have the empathy and understanding through lived experience, past experience, extensive training, alongside support with mental health clinicians to then be making the decisions and navigating that support and making sure that it's actually a support response and not that a person is treated punitively or as a threat, unless it is deemed so by someone who actually understands the situation, in which case of course they can call upon the police. What we're seeing is people who aren't trained appropriately and don't understand mental health.

PETER SCHMIEDGEN: I was going to say, I suppose the thing we think is that building and maintaining trust with consumers should be core business for the mental health service system, and I think that's the issue. If you see too many situations where violence occurs, carers don't want to reach out but also consumers don't. That's already an issue anyway with some consumers. It's not just because they're experiencing mental health issues; it's sometimes because they've been traumatised by the system in the past. So they don't necessarily feel the trust that you would hope would cause them to go and reach out for further help in the future. It's tied up a bit with this as well. I think, from a broader societal perspective, the more police are involved, the more at a societal level we tend to see people with mental health issues as inherently dangerous. This is often reinforced often certainly by the mainstream media, and I'm thinking of television news, for example. Often there's this reference made when crimes occur to the mental health status of the person who committed the crime. But it's not clear whether that's relevant or not, so I think it reinforces that as well. That's a broader societal impact that this has.

The Hon. EMILY SUVAAL: Thanks so much for making the time to appear here today. It is very valuable for our inquiry. My question is to all of you. Is there a centralised pathway that is integrated with both State and federally funded services that enables people to access the care they need at the time they want it?

PETER SCHMIEDGEN: Who wants this first?

KATIE THORBURN: You're welcome to.

PETER SCHMIEDGEN: I'll say no.

The Hon. EMILY SUVAAL: It is a bit of a Dixer.

PETER SCHMIEDGEN: If you think of the first point where people would enter mental health services, it could be emergency, which would mean it would be State services. You might be in a situation where you feel suicidal, or your carer or support has taken you down to emergency because you are so depressed. That might be one point. That would be State. Another point could be your GP. If you're okay but not completely okay, often people will go to their GP as their first point of call, and the GP will give them a referral to a therapist in some cases or to a psychiatrist in other cases. Those are federally funded services. So you have both a State and a federally funded initial point of access. If you have been in the system for a period of time, you may well also start to get services from a not-for-profit organisation like Flourish that provides very individualised things like daily living supports or additional supports that just help people cope if their mental health issues are quite significant.

It's quite a messy system, and the reason that we emphasise in our submission that navigation is required is that we always hear, and still hear, that certainly at the first point of contact, navigating the system is very hard. Part of the issue is that it is stigmatising anyway. Even going to a GP is not comfortable. It's a difficult thing for most people to go to their GP and say, "I think I'm not doing so well mentally." It's much harder than saying, "I think I've sprained my finger or I've broken my arm." There's not a stigma around that in the way there is around mental health. Those would probably be your main entry points within New South Wales. Obviously, if you're homeless, for example, it might also be things like homelessness services. I can imagine, for example, if someone is going to Wayside Chapel or something like that, there may be connection points there into mental health services. But those two I've just mentioned are probably the most common ones.

The Hon. EMILY SUVAAL: ED and GP?

PETER SCHMIEDGEN: Yes.

The Hon. EMILY SUVAAL: In terms of the presentation to ED, are there challenges or failures that exist when someone is either admitted for a short stay or, in fact, not admitted when they present to ED, particularly in the context of self-harm or suicidal ideation? And what linkage then occurs for community services? Rachel?

PETER SCHMIEDGEN: Do you want to talk or will I? I could say more.

KATIE THORBURN: Absolutely. EDs are really ill-placed to be the site of a mental health crisis or situation. EDs have the bright lights and the physical traumas happening, and it's not well resourced. There are not enough beds. There are not enough spaces. There are not appropriate spaces. You will have people in intense emotional, psychological distress and their loved ones waiting in ED waiting rooms for 17 hours or overnight. And then you can have people jammed up in the system and waiting in a space like resus—taking up a resus bed, which is costing a lot of money taxpayer-wise—when they aren't actually in a state of physical harm, just because they're waiting for a bed in a psychiatric facility. ED is really ill-placed to be handling that and being the space for that triage. Also, because mental health emergencies are constantly being put down the line as to what is the most pressing issue to be dealing with, people are constantly waiting for a very long time.

The Hon. EMILY SUVAAL: What's the alternative? I couldn't agree with you more; EDs are very ill-placed. How do we ensure that people are seen and then linked in assertively as an outpatient?

PRISCILLA BICE: Head to Health would probably be my answer, together with a safe haven. That is another area where Commonwealth and State services meet in some areas. I can give the example of Penrith. The Penrith Head to Health houses the safe haven. It's run by Neami. It actually relies on the CMO, who has been contracted to run the services—

The Hon. EMILY SUVAAL: The CLO is—

PRISCILLA BICE: CMO. Community-managed organisation. Sorry, I know there's too many acronyms.

The Hon. EMILY SUVAAL: So that's not always the case? The Head to Health doesn't always run the safe haven?

PRISCILLA BICE: Correct. It's actually unusual.

KATIE THORBURN: For example, the safe haven can exist within Health. For example, in the South Eastern Sydney Local Health District, the safe haven is co-located with the recovery college. It's a really beautiful space. I encourage you all to go out and look at that. But also, the safe haven model is not funded enough. It's not open all the time. It's not a seven-day-a-week service, and it might only operate between 5.00 and 9.00 p.m., for example. It would be great to have longer hours of service and be open more so people could go there instead of the ED.

PRISCILLA BICE: Can I just add to that? There are 19 safe havens around New South Wales. Only two of them are open seven days a week. As a mental health consumer, I can't predict when I'm going to experience a mental health crisis, so that is not good enough. They need more funding. The reason that the safe haven in Penrith is co-located with the Head to Health, in my understanding, is because Neami has decided to set it up in that way because they found that it would be more efficient. But it's not always the case in every area where a safe haven is located that they can locate with a Head to Health or a different service in that area. It's just not always possible.

The other thing I would say about safe havens is that sometimes they can be used for people who are experiencing suicidality as a waiting room for ED. Basically, if you're experiencing suicidal thoughts and you decide to go to a safe haven and the staff there feel that you need to go to ED, they can ring the ED—provided it's not that far away, of course. It's probably different in an urban area to a regional or rural area. They can ring ahead and say, "We have this person who we think needs to be admitted. When do you think you can find space for them?" And then that person can stay in the safe haven, where it's much more calm and they're with peer workers. Safe havens are run entirely by peer workers, so they get the compassionate support as well. But some of them—like in Penrith, where it is co-located—they have access to clinicians. That's the other thing I would say. It is a nicer place to wait and a more calm place to wait, for people who are feeling upset or in crisis, than in an ED.

The Hon. SUSAN CARTER: If I could jump in with one question relating to the ED. I believe there is at least one hospital in the Greater Sydney area where there is a specialised two-bed psychiatric ED, so that if somebody presents at ED there are two beds put aside for no longer than a two- or three-day stay. Given that ED is often the place that people will go or be taken if it is a time of crisis, would some sort of specialised place within ED be an appropriate model?

PETER SCHMIEDGEN: I think a number of hospitals have what they call PEC units. They are psychiatric emergency care units, which it sounds like you are referring to. But, again, you won't really get into even those units—they are kind of like a side sort of area of an emergency department—unless you have been judged to be experiencing severe enough symptoms, basically. You can say that, of the people who go into emergency for mental health issues, some will stay maybe for five, six, seven or eight hours, and then they will be told, "Oh, no, I think you are okay now. Off you go." Some will go into PEC for a day or two, and some will go into inpatient. That's that kind of transition.

The Hon. SUSAN CARTER: You still have to jump the triage hoops.

PETER SCHMIEDGEN: That's right. I think, in a way, it seems to me that the people who get told, "You are okay; you can go home now," are the ones who you worry most about because you think, "Gosh, they should be connected up somehow with some other service." Say, for example, you presented in emergency experiencing suicidality. Obviously there is something not going quite right in your life and you probably would benefit from a little bit of support. Maybe it's not a psychologist; maybe it's a social worker. It's this sense that there is a need for better connection so that people go, "Okay. Well, that's your problem. We can't deal with that, but this service over here will."

It would be good to see, really, better referrals and connections between, say, emergency and other services. I mean, not to go on about suicidality, but also I suppose suicidality is a complex thing. Sometimes it's something you experience because of social factors—"I've lost my house," "My wife has dumped me," these kinds of things—and other times it's not. Other times it's because you are really struggling with depression, or you are really struggling with a personality issue. It's kind of an odd thing. Sometimes it's not always a psychologist or a psychiatrist who is the best one to treat.

The Hon. MARK BUTTIGIEG: So you will have an external sort of shock, for want of a better word, or something that's endemic.

PETER SCHMIEDGEN: That's right.

The Hon. MARK BUTTIGIEG: You're saying that you need to differentiate between those two things.

PETER SCHMIEDGEN: I think it's important to recognise both can be causes. Suicidality isn't—it's a mental health issue in some cases, or a symptom of underlying mental health issues in some cases, but in other cases it's more a symptom of the fact that you're struggling in other ways. And it can be things like losing a job, losing a house or having a relationship breakdown.

KATIE THORBURN: If I may, the treatment here or the prevention is not just mental health care as it looks but also ensuring that we have housing, education, services and the ability for people to live good and happy lives. That is something that the New South Wales Government needs to do across the board, not just in terms of a really obvious mental health approach, as well.

The Hon. MARK BUTTIGIEG: If we just cut to the chase in terms of the evidence, I think what we are hearing is that mental health is being treated as a second-class citizen in terms of resourcing and funding—

KATIE THORBURN: Absolutely.

The Hon. MARK BUTTIGIEG: —as a by-product of the overall physical health system, for want of a better word. What needs to happen is there need to be dedicated, trained and qualified people, like Safe Haven, who are resourced to look at this as a specialist care, rather than just flicking them off to ED in the hope that it will go away. That's pretty much the evidence, isn't it?

PRISCILLA BICE: Yes, 100 per cent.

KATIE THORBURN: Yes.

PETER SCHMIEDGEN: I mean, a lot of ED staff aren't very well trained in terms of mental health either.

The Hon. MARK BUTTIGIEG: No, it's not their—

PETER SCHMIEDGEN: Of course, they have psychiatric registrars—and they are trained—but a lot of the staff won't be. They are not necessarily the best placed.

The Hon. EMILY SUVAAL: In regional places, they won't have a psychiatric registrar, in fact.

PETER SCHMIEDGEN: That's right. Clearly, that's right. Definitely.

The Hon. SUSAN CARTER: I just wanted to go back to that issue of suicidality, and I understand if you don't feel that you are able to make a comment on this. There is a group of people who will present and they will be able to say, "I feel that I may take my life." But I wonder about that other group of people who are feeling that way but are not able to reach out and express that. Is there anything that can be done to support that group of people who don't present at ED or don't turn up at a Safe Haven? How can we identify and, I suppose, empower those people to reach out?

PRISCILLA BICE: Can I jump in here? Safe Havens have not been very well advertised or promoted in the community. Not many people know about them. I'm still surprised when I hear that people have only just heard about Safe Havens. In part, to be fair, they have only been around for, I think, a couple of years, but I think a better job needs to be done so that people know that they exist and then can use that service.

The Hon. SUSAN CARTER: Do you think that would help people who don't feel they can articulate their suicidal ideation?

PRISCILLA BICE: I think consumers need to access support of their own—they have to choose to access support.

KATIE THORBURN: It's also about information and access. It seems that a lot of the time people rock up to ED or make the 000 call because a situation has escalated so much, because they didn't have any other service they knew about or support mechanisms to prevent that. Really, a lot of hospital presentations are preventable if people get the care earlier on. It is also about systems being coordinated. We are seeing so much siloing, where people rock up and then ED isn't referring on. But it is also the people who aren't necessarily going to ED or, as you say, articulating their suicidality. They don't know about where to go for help, but also because that doesn't exist. Or they exist, like Safe Haven, and they're not in the area, they're not well-resourced and they're not promoted.

RACHEL LAIDLER: I would also like to speak about the silos beyond just the mental health system. You have people from all walks of life going through traumas, especially following the pandemic, who are, for the first time, becoming homeless, people who are experiencing domestic violence—something that is extremely traumatic and impactful in their lives—who don't have the mental health language, who lack the access and information, but they're interacting with other government services that should have the capacity and the ability to recognise these issues and start connecting people. You know, the social determinants of health across the board are all in government services and we could be doing more to recognise mental health in all of those spaces.

The CHAIR: Something you have all mentioned in your responses to other questions is the role of a huge range of different types of clinicians like psychiatrists, psychiatric registrars, GPs, social workers, counsellors, nurses and peer workers. In the submission from the carers, I specifically noted the wrong-door problem where, because you have already got care, in a binary sense—because one clinician is already involved in someone's care—another service will say, "No, we can't support you." Can you speak to the different parts of care that can be provided by those different sorts of professionals or the need to actually have different members of that team involved?

KATIE THORBURN: Take, for instance, a rural location which is in part serviced by maybe State and CMO services, but because the State-based services don't include, say, a dietician, but the community-managed service does, the person and their family are rocking up to the community-managed organisation. But because they are linked into the State, the CMO has gone, "No, you stay over there," but the nearest dietician is 200 kilometres away. So there is not this coordination. It speaks a lot to the under-resourcing of the care coordinators. They are stretched. They don't have enough resources to talk to outside services to build those relationships and connections. We want these strong, vibrant communities that have all these services that are very accessible, but there seem to be these blockages. If you're linked into the public sector, you can't go private, even if it was something that would actually match up.

RACHEL LAIDLER: The other big one that we saw was NDIS. People who were previously or currently linked in with community mental health services—any State-based services that provide clinical care—as soon as they receive an NDIS package the State-based services, who do not have the funding and the resources to see every client who comes through their doors, immediately say, "Okay, well you have got support elsewhere. We're going to have to take you off our books and let somebody else in." But the NDIS was never designed that way. It's not designed to deliver clinical services. It is designed to sit alongside State-based mental health services, and that's just not how it's worked out. That's not what carers and consumers are experiencing.

PETER SCHMIEDGEN: I think the sense with State-based services for mental health is that they're generally structured around crisis management. That's kind of what they do. Their focus is providing acute care in hospitals—and PEC is acute care as well, but much shorter term—and providing community mental health services that usually are provided, by and large, to people who have just left inpatient and who either need to rebuild their daily living skills or are likely to go back into inpatient if they don't have more support. And as Katie was saying, they're very thin on the ground. It generally tends to be a risk calculation: "Okay, well, this person is going to end up back in inpatient if we don't help them. Gosh, we'd better help them."

I don't think it's because they don't have goodwill. That's not what I'm suggesting. But they just don't have the funds to have resources to expand enough. That's the thing that I see often driving very much State-based mental health services. Then as soon as you're seen as not needing acute services, you go towards services which are more federally funded, like getting your 10 to 20 therapy sessions, for example, on the basis of a mental health care plan. But there is a real lack of attention, I think, to prevention in State-based services.

RACHEL LAIDLER: We at Mental Health Carers call that "the missing middle to deep end"—that you can either be experiencing acute crisis and admitted into State-based mental health services or you can be living fairly well in the community, needing limited supports, and you're supported by federally based services. But that missing middle that is not acute but needs more ongoing support—it's missing, it's clear.

The Hon. MARK BUTTIGIEG: I suppose what interests me—there are two pieces here. There is the overall quantum of funding, whether it is Federal or State-based, as a proportion to the relative damage that mental health does to society. For example, this morning we were talking to some people who said that the mental health budget for the State is—what was it, Em?

The Hon. EMILY SUVAAL: It was $2.7 billion.

The Hon. MARK BUTTIGIEG: That is $2.7 billion out of a total budget of $33 billion. So you are talking about less than 10 per cent and whether or not that's an adequate reflection of the proportion of the problem. I see by your expressions that it's clearly not. And then you have got the issue of misallocation and waste of whatever funding there is and whether that's the result of overlaps and misallocation between Federal and State funding or just pure misallocation as well. I'm just interested to hear your views on that because obviously, under the current funding envelope, the first thing would be to use the current funding more effectively and then, over a longer term period, try and get that proportionality up.

PRISCILLA BICE: Can you describe a little bit more by what you mean by misallocation?

The Hon. MARK BUTTIGIEG: If there is funding going to particular areas of mental health that are not being used effectively, for example, in early intervention. If we had the funding allocated towards early intervention and that would save us a whole lot more down the track, then governments should know about that because it's a waste of money.

PRISCILLA BICE: Got it. We are, of course, pro-early intervention and prevention. I don't think we've got a comment on misallocation though. We don't really talk about it in those terms. The way we do talk about it is that there's not enough supports earlier, which would hopefully and therefore save money for the acute services. It would save people the heartache of having to go through some mental health issues because they would be caught early.

The Hon. MARK BUTTIGIEG: We are not going to be able to increase the budget right here today. In the short term, what would be an example of where we could reallocate funds from, say, the back end of an issue with mental health that was dealt with too late down the track that could have been—

KATIE THORBURN: I think I can give an example for this. However, I think this is something that requires a really in-depth gap analysis and understanding of the landscape and what's going on. Take, for instance, what I said earlier about people ending up in a resuscitation bed overnight in a non-physically harmed way. Yes, that requires some thought, consideration, preparation and navigation prior to that to make sure that they are in a better service. I think that is something that—we need to look at all the services mapped up.

The Hon. MARK BUTTIGIEG: Yes, there needs to be a mapping exercise and a study done, unless it's already been done.

PRISCILLA BICE: There are several gap analyses underway right now. They are all looking at slightly different aspects of the mental health system. I don't know whether any of them are going to talk to this particular issue that you are raising right now though. Certainly, we are looking at the lack of staff across all disciplines, including peer workers and clinicians, and also the missing middle. I think it was Katie who talked to that a little bit earlier, where there is the gap in the middle between acute and very early intervention. I think a lot of work would need to be done to actually answer your question, I'm sorry. I can't answer it today.

PETER SCHMIEDGEN: I'll say something. I don't think I would use the word "misallocation", but you do see a general tendency to provide much more funding for biomedical kinds of treatment, and that's not necessarily a bad thing. That is for psychiatrists, in other words. You can access many sessions if you are judged to be unwell enough with a psychiatrist. On the other hand, when it comes to therapy—for example, talk therapy—it's much harder to access. Some funds have been allocated in very specific areas, like, for example, eating disorders, but it's not true across the board. So it would probably benefit people who are living with complex trauma as well, for example, to be able to have much more talk therapy. The reality is that for some people—probably not for most—it would be good to have supportive therapy once a week forever. I'm not saying everyone needs that, but there is definitely a lack of balance in the commitment of those funds. Psychiatry is much easier to access than non-psychiatric treatments, I think, in terms of funding.

The Hon. MARK BUTTIGIEG: That's a good example.

PETER SCHMIEDGEN: That means that there are certain models that are emphasised as well. And that will be good for some people but not for everyone because biomedical ways of treating mental health don't work for everyone so well. They might work quite well if you are living with bipolar or you are living with someone with symptoms of schizophrenia but not necessarily everyone, particularly trauma. It's very complex—

The Hon. GREG DONNELLY: Returning to the matter of PACER and SPOT and these particular points, where there is a matter to be dealt with—forgive me if I have this description incorrect. There is an event happening somewhere and a phone call gets made. I'm not sure where all the phone calls are typically being made; they are perhaps to multiple locations. But there is a call being made that there is something happening and there is concern about where this is going to end up. It could be the individual themselves ringing, who is going through an experience, or someone with them making an observation and thinking there is need for some immediate attention. The call gets made. In terms of the determination of how to deal with understanding what the substance of the call is, and making that judgement or intending to discern, what is the best response? I'll come to who is in that response group. But making that judgement—could you comment on how that's being dealt with and how that's being managed typically here in New South Wales?

PRISCILLA BICE: Are you talking about 000 calls or calls to PACER? They are two different things.

The Hon. GREG DONNELLY: I'm trying to tease it all out because this is part of the issue. Who do people call? Most people have embedded in their mind if there is an emergency situation to ring 000. That's typically a response I think many people have. I think if you walked out on George Street and asked people what PACER is, you would probably struggle to find anyone. The question is the management of these emergency situations and trying to work out how they are best done at a macro level. The first point being is there a single point, and then the judgement made about what is allocated to deal with it?

PRISCILLA BICE: I think I understand your question. I think generally from the public's point of view, 000 is still the place to call. PACER is specific to police. It is a collaboration between health and police whereby, to my understanding at least, a clinician sits in a police station, for want of a better term. If someone calls 000 and it is identified that it could be a police issue, police will turn up, look at the scene, look at what is happening, minimise any risks that might be apparent, and then they call PACER. PACER isn't available to the public to call. Effectively, when they are calling PACER, they are calling the clinician that is sitting in their police station for advice so they know how to deal with the situation at hand. But that's only after they have assessed the risks. That's the issue that we are seeing right now, where police don't have any mental health training of note. It might be a few hours but it is not substantial enough, turning up to emergency situations—a mental health crisis—without mental health training and having to deal with a situation before calling PACER. They don't actually have access to the clinician until they have assessed the risks and dealt with the risks. That's why these problems are happening.

The Hon. GREG DONNELLY: Yes, that's as I understood it. But to obviate the situation, then, if there are these calls to 000 that get to the police and the police respond, is the proposition that we need to somehow make a judgement—I'm working out in my mind how this judgement is made—that we either send the police in under the current model to make that assessment, and then PACER, and then it follows that way, or alternatively there should be an ability to get a team in which doesn't have that authoritative presence and concerns for an individual and have it dealt with that way quicker? The PACER step obviously has an extra step in the whole process, doesn't it?

PRISCILLA BICE: Yes.

The Hon. GREG DONNELLY: I would presume you would agree that to get someone in quicker, or get a team in quicker, would be a preferred situation. The question is can that be done without having that intermediate step?

PRISCILLA BICE: I think what we would like to see would be, in addition to police, ambulance and fire as the places that generally would go out to different types of emergencies, a fourth team added which is a mental health crisis team.

The Hon. GREG DONNELLY: What would be the decision-making process for determining whether they go out? I'm trying to work out what's to going be the threshold crossed over to make that determination.

KATIE THORBURN: By the example you've given, someone has called 000. At the moment, someone calls 000, you've got the three options. The thing is, though, these calls to 000 are going to not necessarily be made by someone who has an understanding of what mental health looks like, presents, and has that understanding. One, it's going to be the training and the support and well-resourcing of the 000 call centre to be able to assess the situation better of who needs to be sent out. It's not my area of expertise, of course, in my line of work but I am familiar with that service needing to be better resourced, and more support and training there.

The Hon. GREG DONNELLY: Sorry to interrupt, but someone has to make that decision—

KATIE THORBURN: Absolutely.

The Hon. GREG DONNELLY: —about whether it's the cops or the cops and someone else.

KATIE THORBURN: Thank you. The decision, I'm saying, of course is going to be done by that 000 responder on the end of the phone but they need to be able to have the training to understand what information they're being given to make that call as to who to get sent out. The suggestion by Priscilla of a fourth team of a mental health crisis team, it's more the case of: Where are police most responsible to go to in a situation? It's not always the situation that you want a police officer rocking up to a fire first; you want the fire department. In the case where it might be a vulnerable person who is perceived by the public or someone who doesn't have mental health understanding, that's that time that the more PACER clinical person and peer support worker go out and assess the situation first. Then, if it's deemed to be a threatening situation, involve police.

The CHAIR: I'm going to ask a question that's on a very different topic, but in finishing this up I would note to members that I'm hoping and looking forward to hearing from representatives from other jurisdictions where those emergency calls are handled in a completely different manner. Some of those other jurisdictions will be making submissions to our inquiry, so we'll have the opportunity to pursue that line of questioning further. I want to ask a question to both of you—it was raised in the submission from the carers—about community treatment orders under the Mental Health Act. There's a recommendation in particular that ensuring involuntary treatment in the community is supported by counselling, therapy, rehabilitation and other services. I think it would be shocking to most members of the public to understand that that's not currently the case, and I was hoping you could expand on that.

RACHEL LAIDLER: There are a lot of issues sort of interconnecting that cause what we've seen and what we've heard from carers. Part of it is simply the under-resourcing of community mental health services taking on CTOs. Predominantly what appears to be offered is a biomedical response, so simply medication in response, because they are not resourced to deliver all of the things that they are allowed to deliver under a CTO. Some of the other issues that are happening is that carers do not have access to the treatment plans of their person, so they can't check up if the treatment that is listed under the CTO is actually being offered because they don't understand what's in the CTO terribly well. There are quite a lot of things going into this particular issue. Would you want to add to that?

KATIE THORBURN: Yes. First of all, we're really calling for the section of the Mental Health Act that governs CTOs in particular to be brought in line with a more modern understanding of mental health and for it to be seen as the actual need for support and a more choice-based, rather than coercive, mechanism. Often it is the case that CTOs are used as a first response or are overused population-wise because systems aren't better resourced to be able to have these conversations with people and allow them to choose ways that they can be in charge and be able to have the mental health support that they want. There is also a huge issue that we see—on our looking at the section, there are a lot of gaps where there is not enough accountability of the CTOs when it accounts to the community centres that are overseeing CTOs. This means that there is the potential for human rights to not be as upheld. We wish to see that community treatment orders are given a full review as to the principles that underpin them, the reasons and situations in which they are used and then how they are used as a mechanism.

PRISCILLA BICE: We didn't add CTOs in our submission, not because we don't care about CTOs, but because BEING is extremely underfunded—you're seeing our entire policy team right in front of you—across the whole State and across every mental health issue. What we will say, though, is that we do think there needs to be a review process of CTOs with consumers. Consumers need to be centred in that. We want to see CTOs to be trauma informed, and that process to be trauma informed from start to finish.

The CHAIR: It was certainly alarming, from my point of view, to see an increase in the number of people both being considered for CTOs and being granted CTOs. This is a wonderful opportunity, through the process of this inquiry, to explore why that might be happening. Thank you to the carers for addressing that in quite a lot of detail in your submissions.

The Hon. SUSAN CARTER: One last question, if I may, just to take you back to the discussion about the hole in the middle of care—the early intervention and the acute. Are there other jurisdictions, are there other places, of which you are aware that do a better job of addressing the hole in the middle that we were talking about? If there is no answer, is there somewhere else we can look that might be useful? That's all.

KATIE THORBURN: Yes, I fully understand trying to understand the comparisons and where else is doing it well to be able to borrow from them. It's not necessarily a geographical jurisdiction, but the role and influence of lived experience, in particular in the academic realm of mad studies, is really important.

The Hon. GREG DONNELLY: Sorry, what does that mean?

KATIE THORBURN: Mad studies.

The Hon. GREG DONNELLY: Is it an acronym?

KATIE THORBURN: It is not an acronym; it stands for madness. So in the sense that we have saneism; that really influences a lot of mental health practices. I understand that we are wrapping up at the end of this hearing, but I implore everyone here to look into the area of mad studies and look at lived-experience academics who have written extensively in this area as to different viewpoints, to challenge some of the principles and issues that are underpinning policies, procedures and decisions that are being made.

The Hon. EMILY SUVAAL: In the Mental Health Carers' submission, you've mentioned shared care arrangements that have been piloted in various places such as the Central and Eastern Sydney Primary Health Network. Do you have any comments about why that is or has the potential to greatly increase the efficacy and what we should do about that?

RACHEL LAIDLER: I will try to be as brief as I can. For the 10 or so years I have been in the field, we have been talking a lot about care coordination and no wrong door. Carers and consumers tell us that that is not being actualised—that care coordination between Federal, State and community-managed organisations is not resourced to be delivered appropriately.

The Hon. EMILY SUVAAL: Yes, we've heard that a lot today.

RACHEL LAIDLER: Shared care arrangements are something that we are in support of that would connect community mental health teams with the primary care providers in the community—with the GPs, obviously—but it's something that needs to be actually resourced to have a quality standard across the State. It requires legal infrastructure; it requires technological infrastructure. It's the first and foremost important part of care coordination and, yes, it's going to require a lot of structural work. I'm hugely in support of it.

KATIE THORBURN: I'll just note that this is an integration model. We were talking before about the issues of that siloing and being able to navigate, so the integration. It's resource sharing; it's also upskilling general practitioners with more psychoeducation and ability to contact the psychiatrists and other things like that, so it's helpful.

The CHAIR: I thank all of you for the time you've taken, both today to share your evidence with us and on the substantial written submissions that you've made. If there were questions taken on notice today or if members have follow-up questions after the hearing, the secretariat will be in contact with you regarding those.

(The witnesses withdrew.)

Dr JANELLE WEISE, Senior Researcher, Department of Developmental Disability Neuropsychiatry, University of New South Wales, affirmed and examined

Ms ANNIE CROWE, Founder and Consultant, NeuroAccess, before the Committee via videoconference, sworn and examined

The CHAIR: I welcome our next witnesses, representing NeuroAccess and the Department of Developmental Disability Neuropsychiatry at UNSW. Would you like to start by making a brief opening statement?

JANELLE WEISE: Thank you so much for the consideration of people with intellectual disability in your inquiry into community mental health services. As some of you may be familiar, people with intellectual disability are two to three times more likely to experience a mental health problem compared with the general population. But we find that they face systemic neglect, as the Disability Royal Commission found, in accessing and participating in health care and, in particular, mental health care.

I guess we've been working since 2009 in our department to try to address this inequity and trying to meet these needs. We are excited to see a shift in New South Wales, and I think we are leading in this space, but much more needs to be done. For us the key, as your previous experts were giving witness to, is that involvement of people with intellectual disability. I apologise for not having someone with lived experience with me here today, but unfortunately, due to the short notice we were unable to bring them here. I guess what we would say is that there really is this need for continued growth and consideration for what kinds of reasonable adjustments can be made and expected of the system when meeting this need.

The CHAIR: Thank you. Ms Crowe, would you hike to make an opening statement as well?

ANNIE CROWE: Yes. I don't have my short opening statement. I said a lot in my submission, and I'm keen to get into questions that the Committee might have, given I'm quite a specific witness. But just from an equity, accessibility and cultural safety lens, there's a huge issue for the entire disabled community. But specifically, obviously, I'm here today to talk more about the autistic community, as an autistic woman myself and as someone who supports the community trying to access mental health services and also the NDIS, and the breakdown in those interactions and how complex they are.

The national autism strategy is currently in development. I'm actually a working group member on the economic inclusion working group, and that is obviously starting to address autistic health needs. But you really need State-based mental health services in the community, and outpatient, to also be accessible and meeting our requirements under the UN Human Rights Convention on people with disability. I'm here today to talk about all the barriers that my community face, including accessing, booking in and navigating the system; group therapy and how that's often quite unhelpful for my community, if not sometimes even harmful; the lack of neuro-affirming care and trauma-informed therapy; and the lack of accommodations for sensory needs, executive function and communication adjustments. More broadly, I think there's a topic here around that community mental health tends to be the first point of call for a lot of especially acute mental health crises. I think there's a real responsibility there for the community mental health sector to be aware of neurodiversity and what neurodivergence looks like—including autism, ADHD and other neurodivergent identities—so that they can assist in identifying and diagnosing these and maybe helping funnel them through other support channels, such as the NDIS, and working alongside that.

The CHAIR: Before we go to questions from the Committee, thank you for the time you've taken to be here today, particularly to speak to the needs of people with intellectual disability and people who are neurodiverse. The terms of reference of this inquiry are specifically looking at how we can ensure equitable access for particular priority groups, so this is really important evidence to help us understand that. My question is to both of you to start with. Dr Weise, in your opening statement you spoke about reasonable adjustments. Ms Crowe, in your opening statement you talked about neuro-informed care. Those are obviously umbrella terms for a whole variety of alternative ways of providing care or changes that can be made to the way that care is provided. I was hoping both of you could speak at a really practical level as to what that looks like. What does a mental health service that does those things right look like? How is that different to most care that is being provided?

JANELLE WEISE: Annie, you are very welcome to go first, if you would like.

ANNIE CROWE: I will happily go first. I appreciate it. Neurodiversity-affirming care is probably the catchword of the day. I prefer neuro-accessibility, specifically looking at a reasonable adjustments lens and a human rights angle. Essentially, in a nutshell, neurodiversity-affirming care means that you're giving traditional mental health care from a lens that affirms a neurodivergent identity. Rather than seeing a person who's autistic show up and innately thinking that they are disordered or need to change how their brain works, you're saying that it's okay to have a different brain, it's okay to have an autistic brain, and we're going to adjust our therapy to support that and build on your sense of self and identity and make sure that that's protected from a cultural lens as well, because we do have a cultural community of autistic people. Neuro-affirming care or neuro-informed care, whatever you want to use, is really doing that.

From a practical lens—and I mentioned this in my submission—the most popular evidence-based therapy used is still cognitive behaviour therapy. I think second to that would be probably DBT, dialectical behaviour therapy. Both of those, but specifically more so CBT, have been shown to be less effective for autistic people and sometimes even quite harmful. If you think about CBT, for those who aren't aware of the "change your thoughts, which changes your behaviour, which changes how you feel" circle of life, it can be quickly turned into, "You should change how you think." Autistic people think very differently to neurotypical or allistic—non-autistic—people, and that's not innately bad. The issue that we have in terms of why we have such high rates of poor mental health and suicidality is really that among society, we're not included, we're not accepted, and most of the time we don't have our disability access needs met in education, in health care and in employment.

Really, it's a matter of trying to look at therapy from a lens of—first of all, we need way more research on what does work for neurodivergent people. At the moment the key thing coming out is that therapy-based on self-compassion and self-acceptance seems to have the best outcomes for the autistic population, which makes sense because, again, that seems to be in line with that neuro-affirming care of recognising our neurodivergent identity and building on that and helping us navigate mental health challenges that are very prevalent for our population while also giving us that disability support and recognition. I hope that helps.

The CHAIR: Absolutely. Thank you.

The Hon. SUSAN CARTER: Could I ask one follow-up question? Excuse me, Ms Crowe. My name is Susan Carter. I have a question in relation to your comments about CBT and DBT for people who are neurodiverse. Do you have a comment about whether ACT is appropriate?

ANNIE CROWE: I'm not a therapist; I'm a lawyer. But I work with many people in our community and have experienced these therapies myself, and I am personally a big fan of ACT. I don't necessarily think CBT and DBT are off the table for autistic people. I do know certain autistic people whom this has helped. I just think, on a whole—and the evidence and research is supporting this—we need to be either adjusting CBT and DBT for autistic people or looking at other forms, such as ACT-based therapy, that seem to have better outcomes for this population.

JANELLE WEISE: Our recommendations would very much align with Annie and be of a similar flavour. In terms of people with intellectual disability, what we mean practically about reasonable adjustments is really true person-centred care and being responsive to that need. Obviously, intellectual disability is a spectrum, so one size won't fit all, but what we see commonly are things around communication and that ability to use non-verbal or augmentative forms of communication within mental health services. It also looks at environments that are suitable and appropriate—what is that for the person? Is the room with many other people in it the best place to be? A lot of it is around decision-making and consent, and we know that people with intellectual disability can face challenges when they intersect with healthcare centres around this. We strongly support supported decision-making, where we allow people to make all decisions possible.

Another reasonable adjustment that comes through time and time again is the role of the person's support network and allowing time and place for that to be there. That means that it's a fine line we tread between hearing the voice of the person and allowing their support network to be there and support them in a positive and not a negative way. Another key thing we think about is the types of treatments provided. I, too, am not a specialist clinician in this space, but we do see incorrect usage of psychotropic medications for non-mental health concerns, and that's something that people raise with us repeatedly.

The CHAIR: I had a follow-up question to that. You were talking about the inclusion of somebody's support network in decision-making. We had quite an interesting discussion this morning with carers of people with mental health conditions and discussed their experiences of inclusion or exclusion from that process. I was hoping you could speak to what best practice looks like for the inclusion of carers.

JANELLE WEISE: My personal opinion is that inclusion looks like being driven by the person and their preferences and will, unless there's a very strong reason to be against that. So person-centred care for me comes first and foremost but with acknowledgement of the role of the family and support network outside of that.

The Hon. GREG DONNELLY: Thank you very much for participating today. With respect to Dr Weise, thank you—that's a very helpful submission with some very rich content. Could I take you to page 5 going on to page 6, specifically going to the question of recommendations? The Committee, as I'm sure you appreciate, deliberates and receives submissions, oral evidence, answers to questions on notice and supplementary questions, and we analyse all of that, and then hopefully coming out of that is a set of recommendations. I will put it to you this way: If you had a top two or three recommendations—I know that's a pretty crude way of putting it. If this Committee could endorse your top two or three recommendations, what would you put forward? Be ambitious!

JANELLE WEISE: Wow! I've got the floor.

The Hon. GREG DONNELLY: For us to consider.

JANELLE WEISE: For us, when we went into community-based care and people moved out of institutions, there is was a big push to assume that mainstream services could meet the needs of people with intellectual disability. While they definitely have a role and we need to equip them, I think funding for specialist supports and people who specialise in this area, which can intersect and support both the person and the mainstream sector as we continue to build, would be one of my top recommendations. You will note that we have been involved in evaluating two different specialist services in New South Wales. They're showing great promise both in terms of for the person and their family when they interact but also for equipping the sector. They play a nice dual role. I'm definitely not arguing for specialist services only, because I don't agree with that, but they do have a place.

The Hon. GREG DONNELLY: Before you go on, would you like to nominate what those two were that you have just referred to?

JANELLE WEISE: Yes. There is the intellectual disability and mental health residual functions program. That was in the interim as we transitioned into the NDIS. Funding was given out to local health districts to design a localised solution to that transition. What we found in that was that those localised responses were exceptionally helpful. We note that we're a very diverse State and what the needs look like differs if you're based here in Sydney versus if you're out in the Far West. There were many lessons learned from that. The other one is around the two Statewide Intellectual Disability Mental Health Hubs. There is an adolescent, child and youth one and adult services. We're just wrapping up those findings at the moment, but they show great promise in terms of both access to community and a reduction in emergency department presentations, which builds on from what previous people were saying here this morning. That's what we're after, isn't it? We want people to stay well and be able to contribute in society.

The Hon. GREG DONNELLY: Ms Crowe, what are your top two or three recommendations, if I could be so bold as to ask?

ANNIE CROWE: That's a hard one. I would probably swing the other way and talk more about how we need more widespread education in the health system—not just mental health professionals but all health professionals. Mental and physical health do overlap very closely, and our society is barely starting to understand the complexity of that. I also believe that mental health is impacted in every aspect of health care, whether you're rocking up to a GP because you're feeling sick, going to hospital and having surgery or out in the community and in crisis. We really do need to be more broadly educating all health professionals on disability—all disability and neurodivergence—on what that looks like and what different access needs that means.

Equally, I would be talking about universal design principles, because a lot of the access adjustments that the autistic community needs would help many other communities. For example, for the deaf community, obviously it helps sometimes having Auslan or captions and alternative communication options. That also, a lot of the time, helps the autistic community. Many in my community with or without intellectual disability, as well as being autistic, struggle with communication or just communicate differently and need alternative means. And then when you're in a mental health crisis, communication can become that much harder. That's two.

The Hon. GREG DONNELLY: That's okay; I'm not putting the pressure on.

ANNIE CROWE: I would also add that I was listening to the conversation in the last session about the allocation of funding, or misallocation, and I wanted to comment on that. I don't believe we need to remove any funding from acute care right now. I don't think it's currently funded enough to begin with. But I also believe we desperately need increased funding in upstream suicide prevention and proactive mental health support. I hope to God we don't shift funding away from acute care into upstream in the hope that it prevents acute care. Until we can get that system working to the point where we get a reduction in acute care presentations of people in mental health crises, then that's quite negligent.

But I really do believe that there needs to be so much more focus on upstream mental health. By upstream, I mean preventative; downstream means in crisis, in a nutshell. Equally, for the broader New South Wales Government, I think going beyond just looking at specific mental health providers but going into—I've always found it odd that our schooling system doesn't include any mental health education. We used to have home economics a long time ago, which taught some home skills and life skills. That's mostly gone now as well.

We've just been through or are still going through a pandemic, and mental health is starting to become so much more understood, or at least acknowledged and recognised in society. One of the more positive things, I guess, of such an awful global pandemic is that people are no longer enabled to just sit back and ignore it. Many people who previously weren't affected by poor mental health have been, and I think that this is a perfect opportunity for us to look at the broader system of how our government helps support its citizens in positive mental health, which has huge ramifications for increased productivity, employment and education—things that will boost our economy and help everyone. This goes so much further beyond people in acute mental health crises. That's something that needs to be really remembered at the end of the day when we have these discussions.

The CHAIR: I have a very quick question that I'm sure will be a question on notice for Dr Weise—or Ms Weise.

JANELLE WEISE: You can call me Janelle. That's fine.

The CHAIR: Janelle, thank you. The two services that you mentioned that were very promising, it sounds like they're being either currently researched or currently evaluated. I was hoping you would be able to provide the Committee with those findings once they're available.

JANELLE WEISE: Yes, we can.

The CHAIR: Thank you.

ANNIE CROWE: I have a third point, if I may, to my top three.

The CHAIR: Sure.

ANNIE CROWE: The other thing that I would like to comment on is that it's great to see an increase in co-design of health services and mental health services with people with lived experience. But I also think that it needs to be said that beyond co-design—and really meaningful co-design, where lived experience is included in every step of the process—I think we need more lived experience leadership. What we're seeing in the autistic community is that the greatest impact any organisations are having on our community are led by autistic people. It makes sense, because having that lived experience means you truly understand what it's like to live in this world. It's like any other minority group. I think all marginalised identities would benefit from that kind of leadership, and I think that that needs to be focused on, especially in terms of the peer workforce and boosting community mental health more broadly and investing in those organisations.

The Hon. SUSAN CARTER: Dr Weise, perhaps you can help us with this. Dealing with people with intellectual disability, are there any issues of underdiagnosis of mental health issues or, I suppose, just not recognising that you can have multiple issues affecting the one person?

JANELLE WEISE: Thank you for raising this. Yes, it is a big problem. It's something that we call diagnostic overshadowing, whereby changes in the person are attributed to their disability rather than exploring what the cause is. If we see a change in behaviour, it's put as behavioural rather than looking into whether the person has either a physical or a mental health problem. If we think back historically too, there was kind of a thinking that people with intellectual disability can't experience a mental health issue. "That's not possible. How would we know that? How could we measure it?" We know that not to be true. Yes, there are high levels of undiagnosed and unmet need in the community.

The Hon. SUSAN CARTER: Do you think that is simply a matter of educating health workers, or are there ways that that could be best addressed?

JANELLE WEISE: Look, I think obviously mental health professionals do have a role, but also we've been working to develop a tool that also equips the person themselves and their support networks—be they family, carers or other social services—around what mental health might look like, or poor mental health might look like, in people with intellectual disability. We know that it's usually kind of late down in the process when you come in contact with a very well-trained mental health—your typical way of thinking about a mental health professional. We think it's essential that we equip all angles and all people so that they can identify those changes.

The Hon. SUSAN CARTER: Ms Crowe, can you point to any models that you would see as being effective to support neurodivergent people within the community healthcare space, other places, anywhere that we should look at, for something that you believe is working well?

ANNIE CROWE: Yes. There's actually an autistic physician in the US, in Vermont, Dr Mel Houser, who has started a not-for-profit over there called All Brains Belong. They run online brain club and community gatherings where half of it is based on connecting with your neurokin and the other half is focused on self-education and building those skills and self-awareness to help navigate all these complex systems. That's one that I'm seeing right now having really positive outcomes. We have some similar ones here with Yellow Ladybugs and Reframing Autism and the work both of those organisations do putting on events and producing books and writing that help our community. But we certainly could use a lot more. I hope that answers the question.

The Hon. SUSAN CARTER: Do those models that you have talked about deal with assisting people who are neurodivergent to understand themselves, or does it deal with the crossover between people who are neurodivergent and also have a mental health issue?

ANNIE CROWE: It's both. It really does go hand in hand. Most neurodivergent people have at least one or two mental health diagnoses before they even find out they're neurodivergent. As of 2022, 80 per cent of autistic women were not diagnosed at age 18, leaving school. And, for most of them, there is a lot of crossover of misdiagnosis and missed diagnoses, including a high prevalence of complex trauma, anxiety and depression in our community. So, really, education on neurodivergence and disability go hand in hand with mental health education and support.

The Hon. SUSAN CARTER: I have the same question for Dr Weise. Is anyone doing it better than us, and are there places we should look?

JANELLE WEISE: It's a great question. I think it's quite in its infancy, in terms of the emerging evidence about what does and doesn't work. I think what is showing up is that intersection between those specialist and mainstream models where you are working in a capacity-building sense.

The Hon. SUSAN CARTER: I note your comments before about what a diverse State we are. Do you think it's possible for us to develop models and roll them out into the regions, or do you think everything is best done if it's generated locally to deal with local conditions?

JANELLE WEISE: I think what we've shown is that, almost, like, the hub and spoke model can work, where you have that centralised support—noting we're talking about finite resources that we have available to us, but there is some capacity, if you have that centralised specialty, to reach out to communities. Obviously you're always weighing up the benefits of a very localised response versus something that you can scale and roll out at a government level.

The Hon. SUSAN CARTER: One last question, if I may: Are there particular issues in dealing with members of a community with intellectual disability using telehealth, when I imagine things like body language might be very important?

JANELLE WEISE: Yes, that's right. Out in western New South Wales they're currently running a project that is looking into virtual care and how we might be able to do it, noting the challenges that they face in distance in that region. But you are right. There are some challenges. For some people it works fine, but for others it is very difficult, particularly if they are using more non-verbal ways, for the other person to be able to read those subtleties and changes in their communication.

The CHAIR: Dr Weise, in your submission you mentioned something about the mental health information that's provided. You provided some examples that I understand were good examples, like Easy Read. How widespread is that kind of information provision? Where have you seen it, or where have you seen it missing?

JANELLE WEISE: A couple of years ago we were able to conduct an audit of the accessibility of the information in the mental health space across New South Wales public mental health services, and we found it to be largely inaccessible, even to the general population. So, in response, we looked at translating those into Easy Read. Sorry, there was a second part to your question then.

The CHAIR: It was about, I suppose, where is it done well or where is it missing.

JANELLE WEISE: At the moment it's very piecemeal and it's dependent on people understanding and having the ability to translate into it. I think New South Wales is one of the best places. We do have some information available but it by far does not cover all of the areas available. I think there is also emerging evidence—we're still not really sure if Easy Read is the best way. There's really a lack of research into the best ways of communication; it's the best we know for now. But we know that obviously people have varying communication needs, so something even more simplified may be required for the person.

The CHAIR: You mentioned that your audit showed that most of the information is actually inaccessible to the majority of the population. That's horrifying. Is that because of reading levels, literacy levels or linguistic differences? Could you expand on that?

JANELLE WEISE: We were looking at it primarily through the lens of intellectual disability, so we were looking at the complexity of the information provided and the reading age required, and it was very high. We know that low literacy exists in the general population. These adaptations that we talk about and the concept of "universal design"—if we can get these communications right, they would help people with intellectual disability but they'd also help a whole range of other people as well.

The CHAIR: My next question—Mrs Carter started asking this question. One of our terms of reference is to look at telehealth specifically. Obviously because of the COVID pandemic we've had a massive expansion of telehealth, video and phone services. We're looking at the risks and benefits of that more broadly. But I was hoping that you could both speak to whether or not you've seen telehealth being beneficial to those particular population groups or what reasonable adjustments we need to be making in a telehealth, video or phone service.

JANELLE WEISE: For people with intellectual disability, it's still out. We don't really know. In saying that, if telehealth is the only thing that is available to you versus no service at all it's better, isn't it? Something is better than nothing. We did see throughout COVID that those specialist services that are referred to did take advantage of phones and videoconferencing. What we found is people become—obviously there's an assumption that you have access to a telephone, you have access to the internet, you know how to use Zoom and you know how to navigate all that. What we found is that over the pandemic people became more and more comfortable with that because they were needing to do it in more and more parts of their life. But I think there are risks involved if you are not able to directly see or communicate as clearly as possible.

I think the thing that always strikes me is that in this area—I did a history project a few years ago where I talked to people who'd worked in this area for a really long time. They talked about how we live at a level of uncertainty. There's a lot of grey here for people; it's not black and white. We're often trying to make the best guess or best judgment we can make about someone's mental health state based on what they're able to tell us themselves but also what others around them are able to report back. I guess I wonder, through telehealth or virtual care—we know that there is a difference to when you're face to face with people.

The Hon. SUSAN CARTER: Could I ask a follow-up question?

ANNIE CROWE: Could I add to that?

The Hon. SUSAN CARTER: Sorry. Please, Ms Crowe.

ANNIE CROWE: I concur with what Janelle says regarding that it's not accessible to everyone, but at the same time there's a huge population in the disabled community that do not have intellectual disability or technology access issues who rely on telehealth, including regional and rural as well, to be able to access these services. From a universal design principle, I think it should always be an option available. From a physical disability angle, just getting out of the house sometimes is not possible, let alone often at all. From an autistic angle, leaving your house takes a lot of executive functioning, which is making decisions and choosing times and keeping track of everything, getting there on time, going the right way—it is a very complex executive function task to get anywhere. On top of that, the sensory overwhelm of leaving the house can be really debilitating for many autistic people, especially those who are experiencing mental health crises or even just any sort of mental health struggle.

But I don't want it to be missed in the conversation around telehealth that, yes, there are disadvantages around people who want to get on it or who can't get on it properly using the tech, or professionals wanting to have a more nuanced understanding of body language. But, at the same time, for many in my community, it's the only option. Without it, they won't seek mental health support and we're losing more and more lives. Additionally, I just wanted to mention that the rates of autistic people with a higher IQ are actually—the suicide rates are even higher than the broader autistic population. There is research emerging right now, but one of the theories that I think holds a bit of weight is that—if anyone doesn't know what masking is, masking is basically the ability to hide your autistic traits or neurodivergence. The higher IQ you have, generally the access to being able to mask is more prominent. It's seen as a privilege because, if you can mask your autistic traits, you're therefore less forced to deal with discrimination as much as if you weren't able to do that.

Masking is a double-edged sword because people who mask are at highest risk of burnout and suicidality and really complex mental health. It takes a very large toll on the population. I just wanted to mention that for anyone who was not aware because I think we're starting to understand intellectual disability and autism often gets put together with that, even though the majority of the autistic population does not have intellectual disability. At the same time, we need to recognise those who are both autistic with intellectual disability or any other disabilities that intersect. That's just something to also be aware of.

The Hon. SUSAN CARTER: I will ask a follow-up question to that, Ms Crowe. There was some discussion with some witnesses earlier about not just telehealth but actually communicating in ways perhaps where the person who was ill felt more control over the conversation—for example, the use of text or perhaps even email—so that there was time to process what had been said and then time to control what was sent back. Do you have any comments about the neurodiverse community in relation to using methods such as text lines rather than phone lines or email?

ANNIE CROWE: Absolutely. That's absolutely another accessibility issue that my community deals with because speech is not always a thing. Also, I think you mentioned control there. I think control and autonomy are two very important things that are often taken away from people struggling with mental health issues and crises. It's something that I think speaks to trying to use trauma-informed care as well. Specifically around communication, I think having options around emails and text based is incredible. Even if it was telehealth, having the option to use an AAC device, which is either text or image based, is another thing that can be really helpful.

The Hon. SUSAN CARTER: Could you tell me what an AAC (Augmented and Alternative Communication) device is?

ANNIE CROWE: I'm trying to think of what the acronym stands for.

The Hon. SUSAN CARTER: Just explain it to me.

ANNIE CROWE: Basically it can be on an iPad or it can be physical paper, and it can be images and pictures and you point to them, or it can be text, and you press buttons and it speaks for you. There are lots of different types of AAC devices but essentially it's a communication assistance device.

The Hon. SUSAN CARTER: Great. Thank you for explaining that. Dr Weise, could I ask you a question about telehealth? I think with people with mental health there's always a tension between those who are caring for them and the person themselves having autonomy. I imagine these issues are perhaps magnified if you have somebody with an intellectual disability. Are there any issues around using telehealth for people with an intellectual disability or with mental health issues in relation to them controlling who has access to the information, depending on how able they are to access the telehealth themselves? Could you speak about that whole issue?

JANELLE WEISE: Yes, I think you are right. I think it talks to the diversity of the person. You can have a person with a very mild intellectual disability versus someone with a very severe and profound disability. You may like to talk to SANE, who are currently running a trial using online mechanisms of supporting people with intellectual disability. I believe that's funded by the department of health. They're looking at those different uses of telephone, text, email and using more peer workers. But I unfortunately can't comment directly other than to note that, yes, there would be challenges in this space.

The Hon. SUSAN CARTER: With respect to peer workers, I'm familiar with peer workers in mental health. Excuse my ignorance, but are there peer workers in the intellectual disability field?

JANELLE WEISE: No, not to my knowledge, but it's something that we would strongly support. It's something that people talk to us—again, like Annie was mentioning, it's having those people that you identify with and who truly understand your experience. Some people object to that and say to us, "Well, this person has a cognitive impairment. How could they take on the role of a peer support?" I would argue that they could if they had the right supports around them and that we can all benefit from sharing our own lived experience. But it is something that repeatedly comes up as something that people would like to contribute to in society as well.

The CHAIR: I was going to ask a very different question, so if you have a follow-up question, you go first.

The Hon. SUSAN CARTER: It is slightly related, I suppose. I just wondered if you had any comments on the importance of carers supporting people in the community with which you work.

JANELLE WEISE: Yes, they do play a key role. I guess, for people with intellectual disability, perhaps more generally they play a supporting role in accessing and navigating services. When people are experiencing a mental health crisis they do play that essential piece. What people talk to us about is often this triad they experience when they are engaging with sectors, and that they really want the health system to work with them as a person but also to work with their support network and to recognise the value of what they're also bringing to the table and their lived experience of being a carer of the person.

The CHAIR: I have a question on a very different note. Something that came up a few times this morning was the intersection, or lack thereof, between the NDIS and State-based mental health services. You mentioned that in your submission as well, Dr Weise. I was hoping we could discuss that in more detail. What are some of the issues that you're aware of with the way that system is working at the moment?

JANELLE WEISE: I was listening as well. I think there is that disconnect in services, and this tension that we see between what is and isn't funded by NDIS versus public mental health services. What we would say is that where we see things going well for people is when these two service sectors can work together, can collaborate and can work proactively. For example, in one of the residual functions programs that I referred to earlier, some of them employ people who act as that kind of navigator when someone is within the public mental health system to help them engage with the NDIS to seek those supports that we know people need to maintain wellness in the community.

The CHAIR: Is that linked to—I know you spoke earlier about capacity-building specialised support within mainstream services. Do you think that should then include that sort of NDIS liaison role?

JANELLE WEISE: Yes.

ANNIE CROWE: I also have comments on that, if that's okay.

The CHAIR: Please.

ANNIE CROWE: I'm actually an NDIS participant myself, and a lot of my clients are. People come to me trying to access it. There's a lot of change obviously happening right now in NDIS, and some of it is wait and see, but also there's a lot of things we can do proactively. Some of the issues specific to the autistic community is more and more level 2 autism, which used to be much easier to access—and, yes, it's getting turned away, let alone level 1 autism. Also, psychosocial disability is intended to be phased out in the next two years, which was announced recently, which is going to leave a huge gap, I think, for the States to pick up the slack in supporting people with chronic mental illness.

And, equally, autism is a diagnosis in the DSM. A lot of people who aren't well educated on autism think that it's a mental disorder, which it isn't. It's a neurodevelopmental disability and it's lifelong. You cannot recover from autism. It's not a disease; it's just how our brains are wired differently. And yet we're also very susceptible to mental illness and a lot of that is a result of the inaccessible systems that we live in and the discrimination and stigma that we face. But the NDIS likes to keep health and mental health at arm's length and they talk about the separation between Medicare and health working to support anything related to health and wellness and NDIS being very specific to disability. My problem with that that I see show up in all my clients and my community, and I've experienced this firsthand myself, is that you can't separate the individual. People with disability need more accessibility to get mental health services that actually help them.

And so if you're just saying, "Well, that's a health issue. We're not going to touch it," and yet not give us any sort of funding towards making it more accessible, I think there's an element here where NDIS needs to take more responsibility on supporting people to access the State mental health services and, equally, mental health services in our state system really need that more integrated system of understanding how the NDIS works and what it is funding, and equally picking up what we as citizens of New South Wales have every right to access—mental health services that everyone accesses. They shouldn't be cut off just because we have NDIS funding and vice versa. There's this huge disconnect between them and it's something that I really hope is addressed in all the upcoming reviews, but I think it's something that the States need to think about more and engage federally to make sure that there is that connection and support for all disabled people accessing mental health support.

The CHAIR: Are there further questions from any Committee members? If there are no further questions, I invite the witnesses with the time remaining if there were aspects of the terms of reference that you wanted to speak to or other points of your submissions that you wanted to emphasise.

JANELLE WEISE: Annie, would you like to go first?

ANNIE CROWE: Yes, thanks, Janelle. One of the terms of reference that I would like to bring attention to is the emergency response to acute mental distress. This is something that is a huge problem for the autistic community. As you can imagine, it's sort of a problem for everyone let alone people with any additional needs. But there is a very tense relationship with emergency services and the autistic community. We still to this day hear stories of autistic mothers having their children taken away from them and really horrific stories about how behaviour that's seen as dangerous or harmful or adverse is reacted to and escalated when so much of autistic people in distress can be quite simply supported by taking that view of: What's distressing them? What in their environment can we change, rather than what can we change in them or how could we medicate them or restrain them or whatever you want to do? What's actually the cause of the distress?

It's similar to school refusal, which obviously isn't in the terms of reference but I use this as an example that's been quite a hot topic this year. It is not a wilful choice for many children, especially autistic children, to refuse school. Yellow Ladybugs uses "school can't", which is a much better term and yet we could still find something better. But, essentially, the point that they're trying to make is that these children who are refusing to go to school are doing it because school is not safe because school is traumatic for them and it's inaccessible for them.

Similarly for mental health services, I get messages daily from all around Australia and the world from people who have reached out to places like Lifeline and the emergency crisis support lines or gone into their local ED and had absolutely shocking traumatic experiences, because they've been ignored when they've told them that they have autism or are autistic and need things like low light or a quiet space or whatever—insert adjustment here—because there's such a lack of understanding of this. Often those who can actually communicate it, including if it's parents for their children, are not believed and it's gone back to "I need to see some kind of report or evidence from a doctor that says you need these adjustments," rather than taking them for the experts that they are in their own families themselves.

I think that there's definitely more that needs to be done in terms of how emergency services are trained in supporting autistic people and disabled people in general and how we respond to that. I actually personally called the emergency services for the first time in my life in May. My husband was on a work trip to the US and all of my supports fell out the door and I had a small crisis. I had a very positive experience, which is something that I rarely hear from my community. Part of the reason for that is that one of the ambulance drivers was an autistic woman herself, and she innately knew that I needed a different approach and was also just good to talk to in general.

My parents were staying at my house at the time to help me with my toddler. Immediately, my mum was quite distressed that police turned up first. That's a very common reaction because, to us, it is like this injection of maybe our liberty is going to be taken away or people are going to judge us or not understand our behaviours, which we have experienced our whole lives. It can be really scary, to the point that many of my community don't even reach out to begin with, and that's why our suicide rate is seven times the general population. That is just not acceptable. It's a complete breach of the UN Convention on the Rights of Persons with Disabilities in terms of not having safe medical health treatment that meets our accessibility needs.

I just wanted to really bring attention to that, but I could probably talk about everything all day. The other thing, just lastly, is the integration between physical and mental health. Autistic people are known to have quite complex physical health. We have much higher rates of hypermobility and Ehlers-Danlos syndrome and a number of other conditions. Anyone who has chronic illness or physical disability is at a much higher rate of experiencing mental health struggles. I would love to see more focus on connecting the dots between physical and mental health, both in our service providers' education and training, and also practices and research. I could talk more, but I will leave it at that.

The CHAIR: That's a really valuable addition. The same question for Dr Weise.

JANELLE WEISE: One of the issues we face is that people with intellectual disability can't be identified in the routine information that we collect across our health services, which means we don't know what happens; we can't track people. What we don't know happens, we don't see, and nobody responds to. It is only through our linkages at 3DN that we've been able to look at what happens to people with intellectual disability, so I would strongly encourage consideration for how could we identify people within our routine data collections. Also, when we look at outcome measures, the outcome measures that are currently used in mental health services are not standardised for people with intellectual disability, and ones do exist, so there should be consideration for whether we could expand those outcome measures that are currently being collected to be better suited to the needs of people with intellectual disability.

Lastly, we have the "your experience" survey, where we can track how do people find that and what was that like. I am not sure if you've looked at that tool, but it's very inaccessible to people with intellectual disability, so you miss that feedback loop about what was that like for you and how could we do better. So they are some of the key points. I guess the other thing to raise is that we know the workforce tells us that they feel ill-equipped in this space. A few years ago we developed the Intellectual Disability Mental Health Core Competency Framework. That was released across New South Wales, but it's not mandated and there is no check-in or buy-in to it. So we get the people who are motivated and interested and already feel passionate doing it and being involved, but further consideration needs to be given as to how do we reach those people, and what kind of incentives could we give to those who don't already see this as part of their core area of practice.

The CHAIR: I think that's given us some great questions to ask the service providers when we speak to them at our next hearing. Thank you both again. Your expertise for the last hour has been absolutely invaluable to help us understand this issue further. We really appreciate it. If there were any questions taken on notice, or if Committee members have follow-up questions, the secretariat will be in contact about those.

JANELLE WEISE: Thank you so much for the opportunity.

ANNIE CROWE: Yes, thank you so much. I really appreciate it.

(The witnesses withdrew.)

(Luncheon adjournment)

Ms GEN WHITLAM, Associate Director, Client Services, ACON, affirmed and examined

Ms SIOBHAN HANNAN, Team Leader, Counselling Services, ACON, affirmed and examined

Mx AMBER LOOMIS, President, Sydney Bi+ Network, affirmed and examined

Mx GEORGIE FISCHER, Board Member, Sydney Bi+ Network, affirmed and examined

The CHAIR: I welcome our next witnesses to the inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales. We are now hearing from representatives of ACON and the Sydney Bi+ Network. Would you like to start by making a short opening statement?

GEN WHITLAM: Thank you for the opportunity to appear before you today. ACON is New South Wales' leading organisation specialising in community health for LGBTQ+ people. We work in the client services team delivering statewide support to LGBTQ+ people in the areas of HIV; mental health; suicide prevention; drug and alcohol; sexual, domestic and family violence; and ageing. We are here today because the mental health system in New South Wales is in dire need of reform. It is buckling under the pressure of workforce shortages; staff burnout; services that lack capacity and only see clients that are in crisis; and systems where, unfortunately, people fall through the cracks.

This matters to us because LGBTQ+ people disproportionately experience poor mental health and therefore disproportionately require access to mental health services. Compared with the general population, LGBTQ+ people are 10 to 12 times more likely to be diagnosed with depression or anxiety, 18 times more likely to have experienced suicidal ideation and 13 times more likely to make a suicide attempt in the last 12 months. These distressing figures are even higher in trans people, bi+ people and LGBTQ+ people with intersecting identities—including First Nations people; those from culturally, ethnically and linguistically diverse backgrounds; and those with disability or long-term health conditions, including HIV.

This is not because they are inherently prone to mental distress; it is because of minority stress—the persistent and ongoing discrimination, vilification, prejudice and violence directed at our communities. For LGBTQ+ people, many services are simply not safe to access. Despite this, we are resilient. LGBTQ+ people face this adversity with dignity and strength and stand in solidarity with each other to forge a better future for our communities.

Our submission focuses on the experiences of our community and broader systems issues. We make 13 recommendations that we believe would be game changing for the LGBTQ+ community and for everyone. Genuine equity and accessibility of mental health services can be achieved in New South Wales if we are all committed to significant reform. Our key priorities are for a system that builds the capacity of the sector for trauma-informed, inclusive and affirming practice; values lived experience through co-design and peer-led models of care; reimagines its emergency response to be one that is trauma informed; enables prevention and early intervention initiatives; and is efficient, coordinated and multi-sectoral. The key message we wish to share is that LGBTQ+ inclusive and affirming service delivery saves lives.

The CHAIR: Would the Bi+ Network like to make an opening statement?

AMBER LOOMIS: Yes, thank you. Thank you so much for the opportunity to be here. I'm a proud bi+ genderqueer person and so grateful to be representing Sydney Bi+ Network, a volunteer-run grassroots organisation focused on improving the wellbeing of bi+ people through community building, education and advocacy. I should say upfront that when we say "bi+," we mean people who are attracted to more than one gender in any way, to any degree. Bi+ is an umbrella term that we use to describe but is not limited to people who are bisexual, pansexual, biromantic, panromantic, omnisexual, polysexual, multi-gender attracted and more.

I want to make it very clear that I very much see the current state of mental health care for bi+ people as a public health crisis. Bi+ people have extraordinarily high rates of poor mental health outcomes. For example, Australia's largest study on LGBTIQ+ health and wellbeing found that 88.4 per cent of pansexual and 79.7 per cent of bisexual participants reported having ever seriously considered suicide. If my voice shakes, that's because I take so seriously the responsibility of being here today for my communities.

Findings like this are not new. Decades of research and decades of community stories from bi+ people about their lived experiences have been telling us that systems and services need to change. Despite the high rates of poor mental health outcomes, mental health services are not equipped to work with bi+ people in safe, effective or compassionate ways. Bi+ people experience biphobia and erasure within healthcare settings, including from mainstream and LGBTQIA+ focused mental health services. Time and time again we hear stories from community about how they are put in positions where they have to educate mental health providers about what being bi+ means. We hear countless stories about the biphobia bi+ people experience from services.

This isn't just in mainstream services; it's LGBTQIA+ services too. I think about stories that I've heard from bi+ people who, when accessing support from LGBTQIA+ focused services, were told that they should consider pretending to be lesbian, gay or straight. To be blunt, these services are failing so many of us, and the burden is placed on volunteer organisations like ours, which have little to no funding, to provide significant peer support to our community. I want to say very clearly that we're here today to carry on the legacy of bi+ people who have been advocating for so long, and we're especially here for bi+ people whose lives have been impacted in devastating ways because they haven't been able to get the care they deserve. I would like to thank this Committee again for the opportunity to speak.

The CHAIR: Thank you so much for your statements. Thank you to all four of you for being here today. It's so important that the Committee has an opportunity to understand how we can improve mental health care for priority groups, including LGBTQIA+ people, so we're really grateful that you're here representing your communities today.

The Hon. GREG DONNELLY: Chair, the opening statements are very informative. Could we get a copy of the opening statements, because there are a couple of questions that I have arising from them? The secretariat could arrange a copy of the opening statements.

The CHAIR: I don't see why not. I will start off the discussion with perhaps a really open-ended question. As I'm sure you know, our role as a Committee is to make recommendations to government for how we can improve mental health in New South Wales. What would be your top priorities for change? What are the solutions to some of these problems?

GEN WHITLAM: I think we did address some of that in our opening statements. From our perspective, what we hear from community is the challenge of accessing services, the fear of not being seen and the fear of being discriminated against. Something that I think will help the mental health service system is capacity-building of the sector to work with our communities, to understand what our communities have experienced and to understand how to deliver inclusive and affirming practice. That requires resourcing of the broader service system. It also includes and looks at valuing the peer experience and ensuring that that peer workforce is diverse, represents community members and is consumer- and carer-led, and being able to access services like safe havens. When you walk into that service, seeing somebody you can connect with is so critically important.

I would like to highlight that for LGBTQ+ people living in regional and remote areas, there is a really, really limited opportunity to access safe and accessible care. There is a challenge in being referred on to services like ACON's, but we're buckling under that pressure as well. We're under-resourced and there are long waitlists for our services. The assumption is that ACON will see them, but people should be able to access—and choose to be able to access—any service and know that they feel safe when they do so.

GEORGIE FISCHER: For me, if there is one thing that I could get out it's the focus on the needs of bi people first. Due to historic reasons and due to how funding is allocated, we are an afterthought; we are an add-on. There is a service that used to be focusing on gay people and now we add on "and bisexual" without considering holistically the needs of bi people. There is no funded bi-specific service within all of New South Wales or Australia that I would be aware of. There is no-one doing any service designed to look at any needs or looking at how funding is allocated. There is no specific bucket or no specific implementation plan that looks at bi issues holistically. This is specific to mental health but this is also impacting and touching on all the other issues and areas that do impact the mental health of bi people on a day-to-day basis. There is a lack of information. There is not a single place where I can go and find information around anything—literally anything. There is no comprehensive place where I can go and get all sexual health information that is relevant for me and my partners. There is no place where I can go that talks about sexual health prevention and contraception.

Those are just a few examples from the top of my head. I could keep going on and on. There needs to be a focus on the needs of bi people and then we need to look at how it can be serviced. Do there need to be new services? Can it be sitting in existing services and be added on, because that need is actually overlapping and matching? But we can't keep going on how we have been going on, because it has been devastating. It is devastating, as the numbers are showing. This is something that has been known decades. We don't need more research; we need action.

The CHAIR: Both of your written submissions spoke about the importance of peer support in different ways. I know ACON has a lot of experience as an organisation with a peer support workforce and the Bi+ Network talked about the peer community as a protective, preventive health mechanism. I was hoping you could speak more to that. We had discussions as a committee this morning with other priority groups about the peer workforce. I think it's a really important part of the conversation.

SIOBHAN HANNAN: Yes, it is. We see a role for peer workers in every aspect of mental health services, whether they be peer-run services, obviously, but also within the public health system and with any community health system. An expansion of that peer workforce and real support of that peer workforce in terms of training and a recognition of the qualifications that are inherent in lived experience and their own navigation of mental health and mental health systems, and creative ways of looking at a distribution of that workforce and where it will be most helpful, particularly as an early intervention strategy—they are things that are priorities for ACON. Part of our recommendations is looking at how we prevent mental distress. How do we provide early intervention so that people don't end up in crisis, don't end up in the emergency room, don't end up presenting time and time again with severe suicidal ideation and so that they don't end up dead? That's our priority—saving lives and thinking creatively about a whole-of-system response that is trauma informed and that is led by people whose lived experience provides really important expertise.

AMBER LOOMIS: If I could build on that a little bit, I often hear from people in our community about how the work that we do at Sydney Bi+ Network doesn't just change lives but it saves them too. I drive home the point that bi+-specific spaces are absolutely essential in providing those protective factors, in providing a sense of community and in providing really essential suicide-prevention services for people in our community. We know from being on the ground, and we know from the statistics that we see, that bi+ people don't always feel welcome in mainstream services or LGBTQI+ services too. I will read a quote that someone shared with us as we were preparing our submission. It says:

> Bisexuals feel alienated in most spaces. Not straight enough for the heterosexual community and not gay enough for the homosexual community. The feeling of never being accepted is damaging for anyone. Not feeling safe in the hetero or homosexual community has long term damaging effects.

I think that so beautifully speaks to why what we do is so important. And we do it completely unfunded. Most bi+ services, not just in New South Wales but our spaces around the country, have little to no funding. So we're doing these things in between our jobs, in between our lives and in between managing our own mental health.

I want to be clear that we are the best place to provide this peer support. We know what people in our community need. We know how to work with other bi+ people with the incredible nuance and compassion that people really require. Yet we do this without access to things like vicarious trauma support and without access to supervision that might be available in other mental health settings. We're doing this without any sort of infrastructure that really supports us to do what we can do best.

GEORGIE FISCHER: The other issue of doing this in this way is we are also members of the community. So even for us, there is no place to go to do those things. But also, being in the community, if you're going to a service with ACON, there is some separation of places. If I'm in the community, there are friendships and acquaintances with people. You know the people and you know who people know. If someone does not want their friends to stumble over those things due to the fact that we are so community focused, which is a great thing—but due to the fact that there are not enough of us, there is not enough funding, not enough support and not enough time for more people to be there, which is leading to the really shitty situation that some people can't talk about those things in a more neutral setting because all the peer support that they have available are their friends and their close social acquaintances. This is adding another layer on top.

The Hon. EMILY SUVAAL: Thank you for appearing today and participating in this session. There are obviously specific terms of reference that go to a lot of what we have been talking about already. I wanted to try to extract some more information. You have highlighted some of the answers to these questions, but I wanted to see if we could explore it in another level of detail. It's just about how well positioned our services currently are in terms of their responsive practice for priority populations and whether there are any structural processes that support this, but also whether there are barriers and inconsistencies to delivering any of this.

GEN WHITLAM: In terms of your first question, we hear of clients coming to ACON—for example, trans clients who are being misgendered regularly within the system and using the wrong pronouns for individuals. There's a real barrier for our community to access the health system. The LGBTQI health strategy is a really great source of information and requires resourcing to be able to enact the recommendations. To be able to enact the strategy, it needs resourcing. That goes into the capacity building of the sector to train up staff and train up the primary care system in how to work with trans people, how to work with bi+ people and to understand the unique health needs of our communities, particularly the unique mental health needs and different experiences we have. It's understanding that some people are not safe in their home because they are not accepted by their parents, by their siblings or by their direct family because of their gender or sexuality. Simply discharging people to unsafe environments, which is occurring, is a problem. Being able to work with our community, it's critical; it's life-saving. I would say the health strategy needs the resourcing behind it to be able to enact it and action it.

SIOBHAN HANNAN: If I could just add to that, at the moment it's a gamble to walk into any mental health service and expect affirming care. You might be lucky enough to turn up at an emergency department or at a community mental health setting, and you might be lucky enough to engage with a worker who has an understanding of what your lived experience is, who is compassionate and sympathetic to what it means to have a transgender identity. You might find a worker who is understanding about your sexuality, but it's literally a gamble. It is specific to the individual worker that you come across. You might come across one worker in an organisation who is terrific, but the other worker that you are also engaging with does not have that understanding of your identity, your gender identity or your sexuality.

So you have these varied experiences. Every time you have an experience that does not take into account, with care and compassion, what your gender identity is or what your sexuality is, it's harmful. You present to a service in order to get better and it's very likely that you will actually walk away feeling worse, because there is no guarantee that any of the workers that you engage with have gone through culturally affirming training that understands the diverse and intersectional identities that might be part of who you are. It's a huge flaw in the system and it is causing harm to people on a daily basis. It's causing repeated harm, and we don't expect that. If we walk into a health setting asking for treatment for COVID, our diabetes or our heart health, we don't expect that every worker will have a completely different understanding of that health condition. But this is what happens in mental health systems all the time, and it's not good enough.

AMBER LOOMIS: If I could just add to what was already said about the New South Wales LGBTIQ+ health strategy, I would like to really emphasise that bisexual people are named as a priority population in that strategy, which is most welcome. However, we're not included as any strategic priorities at all in the implementation plan. What we see is being named or referenced as having incredibly high rates of poor mental health, but there's absolutely no follow-through in any sort of strategic thinking about how these services need to be operating, nor in any policy decisions that are made about our communities. The result of this is we've got so many people who are trying to access services in the mainstream and also within LGBTQIA+ settings that are being burdened by educating the people who should be providing them with life-saving support about who they are, and that's just not acceptable. When people are to the point where they are distressed and seeking help, they need to be able to access compassionate, effective help, not be an educator.

The Hon. GREG DONNELLY: I am struggling a little bit. ACON has been around for a very long time and got the reputation that it has earned very hard over that period of time. It has always presented itself as being the premier organisation for LGBTQ+ people in the State and beyond, and it does all the work that we know it does. "B" is obviously in there: LGB. Now, ACON receives around $13 million a year from NSW Health. That funds ACON. I do not understand why ACON is not accommodating the "B" part of what they say they represent. Is the argument—I'm playing devil's advocate here—that ACON is letting the team down by not dealing with the matters?

GEORGIE FISCHER: Yes, you are right.

AMBER LOOMIS: Yes.

The Hon. GREG DONNELLY: So we have this issue of ACON letting the team down. How do we get ACON to address that?

GEORGIE FISCHER: Can I jump in there? Is ACON letting the team down? Yes. But it is also how the strategy is and how funding is allocated. Funding is allocated, often, in buckets for gay and bi men, which then, in reality, often goes into, well, this is the service focusing on gay men's needs and is not looking at what would bi men need. And then the expectations of reporting back on how funding is used is for those things to be reported back in those distinct buckets. I think that is playing a part in it—if I'm looking from a systemic perspective, coming up, I think that is one of the key points.

The Hon. GREG DONNELLY: But the money goes to ACON. The money to do with health, for the community, goes to ACON. You get it. You are directly involved and were the principal participants in the negotiation of the strategy, which you have referred to. You are representing the interests of bi+ individuals in that negotiation for that strategy and what is in that document. You also have the lion's share of the final say over the divvying up of money for the different groups within the community. No-one else does that but you. Isn't it really that negotiation has to take place to resolve this between yourselves and the bi+ community?

The CHAIR: Mr Donnelly, in the interests of procedural fairness, I think it is important to allow ACON representatives the opportunity, if they want to, to respond to that question, but I note that none of you have to respond to any of the questions put to you today.

The Hon. GREG DONNELLY: Well, you are here today to give evidence.

SIOBHAN HANNAN: Part of that question I would like to put on notice, which is about the negotiation. Something that I think Georgie and Amber have alluded to is that generally in health we are talking about LGBTQ+ communities. The difficulty when you are using that acronym—and assuming that it's an umbrella and that under that umbrella everyone is somehow the same—is that these are not homogenous communities. So the needs of different individuals who are represented by the letters in that acronym can be varied. Yes, we receive significant funding. That funding is spread across HIV, health promotion, prevention. It's spread across counselling services that are trying to meet the needs of the LGBTQ+ communities.

Within that, we are trying to combat historical discrimination and stigma that does exist within our communities as well as the wider community. So there are obstacles and barriers for people who belong to bi+ communities in engaging with ACON. It might be a perception that we are considered as part of this one homogenous community, and that's not who we are. So therefore I am hesitant about approaching this organisation, or I would like to—my choice would be to—see a service that actually is specific to me and my communities. We are attempting to be all things for all people, and that's impossible.

The Hon. GREG DONNELLY: But that's what you have sought to represent yourself as.

SIOBHAN HANNAN: It's an unrealistic expectation that we can be all things to all people, without adequate funding.

The Hon. GREG DONNELLY: Are you arguing that the $13 million is not sufficient?

GEN WHITLAM: I'd like to add that ACON has advocated very strongly for mental health and suicide prevention funding and only very recently received it. We have not in the past been funded to deliver specific mental health support for people of diverse genders and sexualities. It's only a very recent thing that we've received this funding, and it is not enough, as Siobhan has said. Our waitlists continue to be lengthy despite very little promotion across the community, if any, really; it's word of mouth. We want to work with grassroots organisations because they are the prevention and early intervention. Grassroots organisations that meet the needs, that are with community—the Sydney Bi+ Network, Rainbow Families, TRICON—are prevention and early intervention. They create connection. We need to work with them to meet the diverse needs of our community.

AMBER LOOMIS: If I could add to that just a little bit more to really elevate what's already been said. This isn't an issue of ACON versus bi+ specific services. The entire sector is so woefully underfunded and so woefully under-resourced. What we see about bi+ people's experiences in LGBTQI+ services is not discrete to what's happening in New South Wales; it's global. It is a much bigger global systemic problem and I think working together to solve it is really where it's at.

The Hon. EMILY SUVAAL: In terms of the process mechanisms that are currently in place to ensure responsive practices are provided for priority groups, I'm aware of rainbow accreditation and other things. Are these working? What else is in place, or needs to be?

GEN WHITLAM: ACON does have pride training and pride in health wellbeing. Pride training delivers a range of online and face-to-face training to work with our communities. Some of those trainings are RACGP accredited and are available for health organisations. Pride in diversity is around supporting organisations to become more inclusive and affirming in their service delivery. I think they're critical to upskilling the sector in being able to work with our communities. Something that would help in the future when government is negotiating funding contracts with the sector, with LHDs, with NGOs, is to build in culturally safe and appropriate training for their staff as KPIs within those funding contracts and ensuring that it's a requirement of organisations to be able to meet the needs of our community. That goes beyond sticking a rainbow flag on their window but is about knowing how to conduct a safe and inclusive intake assessment within our community and knowing then what to do next—how to talk about chosen family. All of those things help to working with our community.

SIOBHAN HANNAN: I just want to give an example of how funding has to try and capture a whole lot of people with one service. A couple of years ago during COVID we had a very small amount of funding to deliver a lesbian, bisexual, trans, queer, women-specific AOD mental health group support program over eight weeks. We were only able to run it once so it couldn't just be for bi women. It couldn't just be for trans women. It couldn't just be for lesbian women. We had to try and include and capture everyone with that one small bucket of money.

The Hon. MARK BUTTIGIEG: Just on that, what is the specification for the funding envelope then? Is it tied to an amorphous group rather than individual groups? Is that what you're saying, that you're bound by the specification?

SIOBHAN HANNAN: That particular funding was, yes. That was the offering to deliver this particular support group. It did have a diverse number of women who attended that group who identified as lesbian, bi, trans, and it had really successful outcomes. We were really happy. The attendees reported great satisfaction with the experience, and it was focusing on alcohol use and mental health. But that's how we are having to deliver services. We are trying to capture as many people as possible to do something that hopefully will be helpful and have good outcomes for those people who attend. But there isn't enough money for it to just be for bi women.

The Hon. EMILY SUVAAL: Would that be more effective if it was just for bi women or would it be more effective or more—

SIOBHAN HANNAN: I think what we are hearing is that it's something that's greatly needed.

GEORGIE FISCHER: If I may jump in there, it's probably again coming back to asking what are the needs of the individual letters. In other words, what is the need of the "B"? What is the need of bi people? And then looking for this specific need. Is this something that makes sense to deliver as an individual service that is focusing on bi people? And then maybe bi people of all genders. I know also that splitting based on gender and based on conversation that you are having with the people, it does not, in many cases, make sense. It does not make sense. I want to be with bi people or with the entire community, depending on what the doctor gives. But, for other areas, then, yes, this might be more appropriate for bi women. Or, actually, no, this is for lesbian and bi women and the whole group. I think it needs to be about what are the needs and how can that need be serviced. Also, in terms of numbers, according to the different studies, the *Australian Journal of General Practice*, for example, which is run by GPs, states that 10 per cent of Australians are identifying as under the bi+ umbrella. We are talking about 10 per cent of the population.

The Hon. SUSAN CARTER: That 10 per cent of the population that you identified and more broadly the population that ACON services, I'm presuming it is not just Sydney based. Are there particular issues in terms of regional outreach? Maybe you could discuss which regions and perhaps also touch on the extent to which telehealth would be appropriate or the challenges using telehealth in delivering services in a regional context.

GEN WHITLAM: Absolutely. ACON delivers services in person in Sydney, Newcastle and Lismore. Since COVID, we have been delivering a lot more telehealth support to people across the State. There are unique issues, I think, for LGBTQ+ people in regional areas. We live everywhere, but what we don't have is great data to demonstrate that. The ABS and others don't collect adequate data around gender and sexuality.

The Hon. SUSAN CARTER: Just on data, have you got data from the regions or where people seek to access your services?

GEN WHITLAM: Yes. We have data on clients that access ACON services and where they reside—their postcode of residence. What we don't have is data on generally where the LGBTQ+ population lives. It's not captured in the Census adequately. The specific challenges are challenges in referral options, challenges in affordable services and people being able to pay the gap fee to access their GP. There may be one GP that we know is inclusive and affirming of our community, so it narrows our options even more. We are definitely in favour of hybrid models of service delivery. Telehealth and in-person options are incredibly important, but we have to remember telehealth does leave some people behind.

Older community members who are already isolated, particularly older LGBTQ folk who may have lost connection with family because of who they are, may struggle with technology. People living in rural areas may struggle with technology and also people who may not have a safe space. If they are residing within a family environment or home environment where it is not safe for them to be out, offering telehealth is a challenge. In-person services are great where it is able to be delivered.

The Hon. MARK BUTTIGIEG: I want to clarify the previous example you gave of lumping everyone in under the one funding allocation. When my colleague asked a question, I wasn't quite sure whether or not we elicited the accurate response. Did you get a quantum of money and then say, "Look, we've only got a limited amount of money so we may as well spread it across all these groups to get the maximum benefit for the money," or was it defined as the parameter of the funding? I think that's an important nuance.

GEN WHITLAM: Sure. Typically when we submit a proposal for funding, it is in response to a request from a department—Ministry of Health, Department of Communities and Justice—and within those requests for proposals, they will list priority populations. Within that, particularly in mental health and suicide prevention requests for proposals, the LGBTQ+ community tends to be listed as a priority population. We have put forward proposals where we deliver care coordination, counselling and peer work support to the LGBTQ+ community, and from the data we collect we can see that we are reaching the broad—you know, reaching out to western New South Wales and southern New South Wales as well as the diverse sub-populations within our community as well.

The Hon. MARK BUTTIGIEG: Because of that broad definition—LGBTQI—you are obliged to spread it, if you like, rather than target it to one cohort?

GEN WHITLAM: I can only speak from the way that we have responded to these requests for proposals. Other organisations may respond differently.

The CHAIR: I have a question that is on a completely different topic, but I think it is an important one, which is the emergency response to people experiencing mental health crises. It is obviously topical. It has been in the media. We have had discussions this morning about this with other witnesses. I know that particularly ACON's written submission contains a quite distressing description of some of the harms that police intervention has caused. I'm interested in understanding that further, but also what solutions you might see or what the preferred alternative approach might be.

GEN WHITLAM: Our community has a complex history with police. We recommend reimagining the emergency response to include mental health workers—to be led by mental health workers and peer workers. It is so critically important that we have a trauma-informed response for community when they are in distress. We have heard from community of instances or hesitations to reach out for support when they most need it because they know that the emergency response is police arriving at their doorstep, which can be retraumatising for many people. We have mental health workers and peer workers who are skilled. It is their job or their role to work with community to de-escalate, to support and to connect. Peer workers bring connection through mutual understanding and mutual experiences, which is just critically important for our community.

The Hon. SUSAN CARTER: Could I ask a follow-up question about that? If we had a model—rainbow, hypothetical, you know, unicorns—where every time there was an emergency response there was a mental health worker who accompanied the police, would it be your recommendation that it would need to be community specific? Because the challenge I see with that is that it requires the call to identify the community, and I wonder whether that would always be possible or even desirable.

GEN WHITLAM: That's a good question. I think I'd like to respond with an example where I had to make a decision to contact 000 and expressed over the phone that this individual was a trans person. I reiterated their pronouns and that this was requiring a mental health response, and unfortunately the police, several police, turned up, misgendered this individual, and it created more harm. Ideally there would be a response that was skilled in working with our communities, understood the importance of what it means to sit with an individual, and to have a workforce that reflects the community I think is critically important. A diverse peer workforce and a diverse mental health workforce that can reflect the people is critically important. In terms of a specialist, I think there would be benefit in having a specialist response for LGBTQ+ people. Having service choice for people where you are able to access the mainstream or the specialist would be—

The Hon. SUSAN CARTER: And I wonder, could I ask, if we had these specialists, would a bi person be happy if an LG specialist was there or vice versa?

GEORGIE FISCHER: If I can jump in there. In general, I would probably feel somewhat more at ease, and I guess it's also like, if we are talking here, we are talking a very single lens. We are ignoring the fact that people are sitting on a whole range of intersections that are compounding things. If someone is coming from a culturally and linguistically diverse background, if someone is sitting on a whole lot of intersections, it is sadly not realistic that there will be a peer worker or mental health worker that is 100 per cent matching my identity, my intersections. It would be nice, but that's not realistic, so I think there is that.

But I think it ties into a vital thing of people who are doing the services, they need to be aware of the whole range of things, and for bi people this is already not happening. I'm going to psychologists who are supposed to be LGBTQ-friendly, and in reality the sad truth is this often means gay-friendly; it often means they know about "gay stuff" but they don't know the nuances of bi people. So while I think in general, yes, this can be done by "any professional" but they need to be actually aware; they need to be actually trauma-informed. That is already not already happening in the system. If I'm looking at bi people, if they are engaging with health care, with mainstream services, so much of the expectations and assumptions are made based on how they present. So much is based on their current partner.

If I'm seeing my GP, assuming I'm having a girlfriend and talking about that, I will be in the system, in their head, I will be a straight person. No-one is ever asking me, "Are you bi?" No-one is asking me, "What does that mean?" How does that impact? How does that impact my need? How does that impact how my needs might change over the years when, I don't know, in two years I'm talking about my girlfriend and two years later I'm breaking up but I still keep seeing the same GP? My GP is assuming I'm straight but I might have started going to 357, going to gay saunas, going to sex-on-premises venues. My risk profile has changed for certain things.

The services that I need and the information that I need is different, but my GP would not be aware because they simply never asked that question, because—I don't know why. Also, if I'm engaging with psychologists or psychiatrists—whatever—even if they are both aware and have training, they are often not aware of the nuances of what it means to be bi. To be bi doesn't mean to be half straight and half homosexual. It is a distinct identity with distinct needs, distinct histories and distinct experiences that people need to be aware of. If we are sending a support worker or mental health professional, they need to be aware that bi people might have different needs. Also, if I'm calling an emergency service for someone, I might not be aware that they are bi, depending on what their partner is, looking at how little especially bi people are out to their entire friend circle and their entire social circle because of stigma and because of internalised issues. The reality is that, anyhow, people are going to be—even if we would be trying to perfectly match people, we would not be able to.

AMBER LOOMIS: If I could add on to that, for me, that education that frontline responders really need has to start before people get into the workforce. It has to start in schools and where people are able to learn about the distinct needs and our experiences. It needs to be embedded into their professional learnings; it needs to be embedded into the offerings that are there for them for professional development. It can't be on the job because that's when people get harmed even further when they are trying to access support.

The Hon. EMILY SUVAAL: I am interested to hear from the panel if you've heard of the Open Dialogue model and whether this would be seen as a good thing for the LGBTQI+ sector more broadly—firstly, if you're aware of it, and then whether it would be a good thing?

SIOBHAN HANNAN: Yes, I am aware of it; yes, it can be a really effective model. But, as with every therapeutic model and approach, they are not the best fit for every situation. So it would depend on the individual and their needs. Yes, it can be a very effective model. One of its strengths is that the model itself requires a coordination of care. Workers, families and the client talking to each other—that is the model of care. That conversation is essential; that conversation is part of the framework of care. In our submission—and I am sure you have heard other people talking about this fact—the lack of coordination and the lack of continuity and communication between services is a very harmful. It is a systemic failure within the system.

Anything—any model or any systems—that enhances the ability but also requires workers to talk to each other and to exchange pertinent information within the framework of consent, privacy and confidentiality—but any model of care and any improvements to the systems that require that communication and the exchange of information is going to enhance care and improve outcomes.

AMBER LOOMIS: While I'm not familiar with that specific model, what I can say with great confidence is that we really need reform across so many different areas. We really need whole-of-government responses to mental health care. We know that people in our communities have exacerbated mental health because of things like cost of living, housing affordability, climate change and racism. All of these things are really significant challenges that place incredible stress on the mental health system and for people who are trying to access them. So I suppose my response to your question would be that we need responses across the whole of government to really make things better for our communities.

The Hon. GREG DONNELLY: That's the case for everyone, though, isn't it?

AMBER LOOMIS: Absolutely.

The Hon. GREG DONNELLY: Right across the board, the population at large is under the pump in so many domains.

GEORGIE FISCHER: Yes.

AMBER LOOMIS: I agree.

The CHAIR: What a note to finish on. That brings us to the end of our session. Thank you again, all four of you, for the time you've given and the written submissions you've made to the Committee, and for the work that you do more broadly.

(The witnesses withdrew.)

(Short adjournment)

Ms JUSTINE HARRIS, Clinical Psychologist, Head of Practice Management, Settlement Services International [SSI], affirmed and examined

Mr BEN BENAZZOUZ, Provisional Psychologist, Mental Health Clinician, SSI, sworn and examined

The CHAIR: I welcome our next witnesses, representing Settlement Services International. Would either of you like to start with a short opening statement?

JUSTINE HARRIS: Yes, thank you. SSI is a community organisation and social business, and we work across the eastern seaboard and also into Tasmania. In New South Wales we provide case management across a number of programs, including our refugee and resettlement program, asylum seeker program, employment services, and we have a foster care program. The work that Ben and I do in the practice management unit sits across all of those services. We are primarily existing to support the frontline workers when they are working with clients that are struggling with their mental health. Sometimes we work like a traditional service and provide clinic-based service, but a lot of it is actually working holistically out in the community with those clients and the workers that work with them.

BEN BENAZZOUZ: Most of the work we do, like my colleague said, is out in the community. Actually, it's very, very effective in terms of helping the newcomers. Based on the time we have spent working out in the community, we've found that there is a huge gap. A lot of the new arrivals have huge mental health, and they're lacking those services.

The CHAIR: I might start the discussion with a very open-ended question. As you probably know, our role as a Committee is to make recommendations to the Government for how to improve mental health. What do you think we could or should be doing differently?

BEN BENAZZOUZ: Based on my own experience working out in the community, we know that people are displaced, and the number increasing every year. We know that there are over 50 million people currently displaced worldwide. Australia has been so generous in taking a quarter of a million refugees, but we also have another problem with asylum seekers. There are a huge number of them, a million around the world, and this number is not going to decrease but rather increase. But there is a lack of services out there in terms of, for example, the new arrivals. If I start with asylum seekers, a lot of them have been here for a decade, if it's not more, and they lack support in terms of mental health. Some of them don't even have a visa, don't have Medicare, and they are just left to their own destiny, I believe.

We take that kind of role and we try to support them, but we lack the resources ourselves because there are not so many psychologists out there to support this kind of client. I have personally experienced so many traumatic events from these clients. I'll just give you a very simple example. I picked up this client, a referral from Corrective Services. They have addiction and mental health issues. I worked with this client tirelessly for the past two years, from being suicidal to currently going to the Cumberland Hospital and getting treatment for his mental health as well as for his addiction. He always turned to me. He said to me, "I see you like God. If it was not for you, I wouldn't be here today." This is just a small example of how asylum seekers actually suffer.

JUSTINE HARRIS: One of the things that we are lucky about, because we are not tied to a contract—the work that Ben is describing with that client, he was able to be flexible depending on the need. A lot of the services are very tied to their contracts and then can only do a little bit of the work, and then they try and hand over to the next person. Ben, in working with that client, was able to—at one stage you were at the hospital with the client translating, because there was no interpreter available. You've got an employment background, so you're able to know how important not disregarding his employment means, even if it is under-the-table work that we are finding for clients. What we find with our colleagues is that their contracts mean that often we are in a big meeting and there's lots of people being funded, but their criteria excludes a lot of people and then clients who don't understand the system or the language then fall through the cracks. What we are wanting is more of the service that we have been allowed to do, where we can be across different areas of need—physical health and mental health.

BEN BENAZZOUZ: And also a holistic approach. A lot of these clients—sometimes before even getting into mental health, there is a basic need which they are lacking, and without a budget it will be very difficult. Therefore, having a holistic approach will actually help them to tackle all those issues and getting them to actually feel better, and eventually getting them into the job market, which has huge benefits for Australia. We have had quite a few cases in terms of the refugees. I worked personally with a lady who had been very depressed. She came from the Middle East and had been suicidal. Today she is working and paying taxes, she has her own home and she looks after her three children. I was so impressed that in a matter of 12 months she changed from nothing to this. Today she's got a boyfriend and she is very happy. Every time I talk to her—she's got a licence, she's got a car and has changed completely. It's thanks to this kind of holistic approach we use with these clients.

There are not so many people out there who actually do outreach to community and help, and there are a lot of clients out there. I keep getting calls. There are so many people out there asking for help and support, and we just don't have staff with those skill sets who are going to be able to go out there and support these clients. I believe if we could just have a pilot of services like that, we could have a holistic team, starting with well-trained, upskilled—and then go out in the community and start upskilling and training other teams to actually cover. Like there are some examples in Scandinavian countries where they have this kind of system. We know that countries like Sweden are usually generous with refugees, and they have been very successful in actually getting them into the job market and integrating into society.

The CHAIR: I have a follow-up question. You mentioned the lack of psychologists who are able to support your clients. I was hoping to clarify whether that's because of their visa status or because of the nature of their mental health needs or cultural factors that mean that there is a lack of psychologists.

JUSTINE HARRIS: I don't know if there is a lack of psychologists, but there is a lack of psychologists that want to work in this—

BEN BENAZZOUZ: Correct.

JUSTINE HARRIS: I think the private practice setting is swallowing them up. But we have found a really good workforce, especially people that have come from migrant backgrounds themselves. Some of them come from—there is a provisional psychology scheme. But some also don't quite meet the English language criteria, and even though they're going to be working speaking their own community language, they then get stuck on that language thing. We do get a lot of people that we see lots of potential in, but there are some barriers to getting them into that workforce.

BEN BENAZZOUZ: Yes, and adding to Justine's comment, we can't say there is a lack of psychologists, but rather trained psychologists tailored to tackle those kind of problems. We know that a lot of refugees and asylum seekers come from a part of the world where trauma is very common, and specifically complex trauma—to have those psychologists who are linguistically competent and also clinically competent to work with these types of multicultural diverse background clients is quite difficult.

The Hon. MARK BUTTIGIEG: That example you gave of the holistic approach being successful with the client—I'm interested in how that worked and why it worked, and also what the issues are, if any, in the sometimes lack of coordination or response to find responsibilities between the Federal and State governments. From my limited experience of having dealt with some of the groups that are catering to the same sorts of cohorts as you, it's a Federal government responsibility, but the State has to pick up the pieces. Could you elaborate?

JUSTINE HARRIS: One of the benefits of the way we work is a lot of the services are clinic based, and that's because their contract is clinic based. This particular client wouldn't go to a clinic. We see a lot of our clients home based, or one particular client was outside a police station. That was the only place they felt safe to meet us. We are able to meet people in their own space. A lot of services will have lots of criteria about how they are not allowed to do that. With that particular client, we were able to meet them and then be practically helpful, because people don't put their hand up necessarily for mental health support.

They sometimes present with somatic complaints or practical complaints, but along the way, as we're helping them deal with the fact they didn't have car insurance—that was one of the issues that Ben was helping them with—or with language translation problems with documents, you are doing a lot of mental health work on the fly. You're talking to people, calming them down and teaching them distress tolerance in real-life situations. When the client is then more stable, because they have those practical skills, and their life starts getting a little bit more ordered, then they are able to actually get into the workforce. Our colleagues do amazing work for those clients who are well enough to go to those services, but there are clients who aren't well enough to go to the services, because they maybe have young children or they don't speak enough English to know—we've had migrants who have been here 10 years who still don't know how to use the train system.

BEN BENAZZOUZ: There are also clients who are severely mentally ill, and they can't even leave their homes. I currently have a refugee family of five children. Two of their children—one is 17 and one is 19, and the 19-year-old is so sad that he has been locking himself in his room for the past 12 months. He doesn't go out. There have been multiple services involved, including STARTTS and other services but, again, those kinds of outreach services that are going to go to their home and look at what they need, what sort of doctor this person needs to be referred to and what sort of services they need—that is lacking. Despite the fact that there are multiple organisations involved, they are crossing each other, trying to do the same thing, which is just a waste of resources on the other hand. Now most of them have been put out, except myself. I am still working with them and actually achieved a bit more than what we would have achieved if everyone else was involved. It always goes down to those outreach services and trying to connect with the person and see what their need is, and trying to tackle that need in terms of a holistic approach.

JUSTINE HARRIS: As we're doing it, we're also trying to upskill the people around us to do some of that work, which is similar to the suicide field, where you make sure everybody knows how to have that conversation. Sure there are specialists but, so that everybody knows how to have some of those conversations, we train up a bigger cohort of people.

The Hon. MARK BUTTIGIEG: What about your experience with the Federal and State government interplay?

BEN BENAZZOUZ: That's a very good point. We haven't personally had a lot of experience in terms of reaching out to the Federal Government, because I work for an NGO that actually has a contact from the Federal Government and who works with resettlement of refugees and also asylum seekers. That's an experienced person. I don't have that, but I can see the gaps where support is needed.

JUSTINE HARRIS: Because the Federal Government, again, are paying us to do the settlement work and then another agency to do the mental health work, the actual cohesion part of it is missing because they are siloed services that they are funding. And then the State Government is left to pick up the pieces of those people who just fall through the cracks.

BEN BENAZZOUZ: There is also the coordination. It is so important that those organisations who are getting support or getting resources—there needs to be some coordination between them to actually tackle the problems and try to see what sort of approach we need to utilise here or to use to help these clients. I see that every day in my work, every day, and I see the challenges that arise. It's kind of like—a lot of work needs to be done.

The Hon. SUSAN CARTER: Just listening to the stories of the siloing and the too many cooks, if you like, do you think there is any benefit in exploring a model of funding the person and allowing them to reach out to services, almost like a voucher system or something? So we fund the person and they attract the services to them, rather than the other model?

JUSTINE HARRIS: Yes, I think their lack of knowledge of the system would mean that they would probably buy services that might not necessarily be in their best interest.

BEN BENAZZOUZ: Correct. I have seen that in terms of clients who've got children with autism, and they have NDIS package and I see that also has been really not used in a proper way as well. I think the best option, as I said earlier, is to have a holistic approach and to have people who are actually compassionate and like to work with this type of group or demographic and upskill them, give them the right training, and use them as a pilot, and then expand upon that.

The Hon. SUSAN CARTER: For a holistic service, what sort of workforce would you need? Would they all be psychologists or would they be—

JUSTINE HARRIS: Multidisciplinary, definitely.

BEN BENAZZOUZ: Yes, multidisciplinary. For example, a social worker, you've got a case worker, you've got a nurse, you've got a psychologist. Now there is this kind of holistic approach, but it's kind of disintegrated—everyone works on their own, and they don't achieve a common goal.

JUSTINE HARRIS: Plus, the service has to be 24/7.

BEN BENAZZOUZ: Correct.

JUSTINE HARRIS: Ben gets calls all through the weekend and some of those calls are—the most critical part of your work is when someone is ringing in distress. A service that says, "Sorry, ring back Monday morning," and then you've got a two-week waiting list—clients just won't bother.

The Hon. MARK BUTTIGIEG: It's an interesting concept, because you could theoretically have an allocation to the client. For example, you guys would be then the stewards of that allocation, and then you could go to the various services and coordinate it all.

JUSTINE HARRIS: Like a linker. It's sort of like a linker or navigator or something, isn't it?

The Hon. MARK BUTTIGIEG: Yes.

JUSTINE HARRIS: I think what helps in the NDIS world is someone that understands that service system but doesn't benefit from the money. So they are not interested in the money side.

BEN BENAZZOUZ: I just want to add with an important example, which I would love you to hear today. I work currently with a client who is an asylum seeker who has been here for 12 years. He has extremely severe mental health and drug addiction, and the reason he takes that is because to overcome his mental health issues. He has been involved recently in an incident, and he has been an inpatient in hospital. I've been involved personally with Cumberland Hospital, Westmead Hospital, as well as Blacktown and Mount Druitt Hospital. I spoke to different doctors. I gave them my professional opinion. I said this client is in—"No way he should be discharged. He needs to rehab." I stated the point, and the doctor turned to me and said, "I hear you. I agree with you, but I can't keep him here." I said, "Why?" He said, "I have pressure on me. I can't keep someone more than two, three days. He has to be discharged." They discharged the client, and we went back to square zero. This is the problem we're facing with quite many clients as well, and they give up.

The Hon. MARK BUTTIGIEG: We heard some similar evidence this morning about the hospital system being used as kind of a mop-up for where you need very specialised, tailored care.

The Hon. EMILY SUVAAL: What services are currently available for people who don't have a Medicare entitlement, in particular, and may not meet eligibility for State-funded services?

BEN BENAZZOUZ: Currently, we have a specific program called the SRSS program, which looks after asylum seekers. Clients who don't have Medicare, they will get a document from the program, which allows them to see a GP.

JUSTINE HARRIS: That's only a very small percentage now on SRSS—

BEN BENAZZOUZ: That's a very small percentage.

JUSTINE HARRIS: —because the Government has reduced the criteria, so it's only very small. Most of the ones are relying on the asylum seeker resource centre and, really, just the NGOs, and are begging, borrowing and stealing from different services. Some of them are in very bad physical health because their health in the detention facilities was poor, and then they've come here and their teeth are rotting and they've got poor eyesight.

The Hon. EMILY SUVAAL: You said the SRSS numbers have been—was that as a result of criteria?

JUSTINE HARRIS: Yes, it used to be a wider sort of support service, and now it's only for those that we can prove are, like, extreme needs—so mums with very young children, really severe physical and mental health—but they have to keep getting reassessed all the time to stay on that program, and then still the money is less than what you would get.

BEN BENAZZOUZ: Correct, because sometimes we have to go out there to charitable organisations and actually beg them for some support. Sometimes we get a bit of money for medication—

JUSTINE HARRIS: For rent, rent relief.

BEN BENAZZOUZ: —for rent, for food.

JUSTINE HARRIS: They're very open to exploitation, then, because—

BEN BENAZZOUZ: Yes. Like, we currently have clients who have been doing that for the past 12 months we have been lucky to get some funding to support, but that's coming to an end and the client is going to end up homeless.

JUSTINE HARRIS: One of our other services is in the domestic and family violence space. Some of the women get—it's exploitation, because some people offer to help them, and then that ends up being a disaster. Then we try to get them in, and there is some funding for women where there's domestic and family violence.

BEN BENAZZOUZ: We have also LGBT who come from overseas, knowing that that's not really popular in many parts of the world. What happens to them? They have been discriminated against. They have been mistreated. I have a very good example. I work currently with a client who has suffered hugely when they were back in Thailand for 10 years. As soon as they arrived in Australia, all happy and say, "Look, this is a country of freedom," they face also discrimination and harassment in this country and lack of resources as well.

The Hon. EMILY SUVAAL: In terms of the workforce that is currently available, is there an issue with the workforce not accurately reflecting our client groups? What needs to change to actually achieve that?

BEN BENAZZOUZ: That's a very good point. Thank you for asking this question. I will tell you briefly, because I have been involved on both sides of the equation. Before I joined the mental health and I was doing my psychology degree, I used to work in a very unique program within SSI called the Ignite program. This program was specialised in helping asylum seekers and refugees to become entrepreneurs. I have seen the motivation and the dedication of these people when they come here. Actually, they come to Australia and they see Australia as a their gateway to independence, financial independence and so on, and they work very hard. But you have to get them early on, before the mental health kicks in. I have worked with probably 500 of them; I worked in that program for five years. There are some of them currently still operating and having a successful business and employing Australians. I can give you examples. You can google and find them.

JUSTINE HARRIS: But you were talking about the mental health workforce, were you?

The Hon. EMILY SUVAAL: Broadly.

JUSTINE HARRIS: Because I was thinking one of the things I strike—I have regular clinical students, and they are coming straight through from school. But the people with lived experience, they are finding that the fees are so high that it puts them off actually then going through the system to be trained up, and then having HECS debts for quite some years. The people that we think would be the best, the amount of money that they need to go to uni puts them off.

The Hon. EMILY SUVAAL: So this is for people that want to then become qualified. Would they be studying as a domestic student or is it—

JUSTINE HARRIS: It would be a domestic student.

BEN BENAZZOUZ: Domestic student, yes.

JUSTINE HARRIS: Even that's still very high.

The Hon. EMILY SUVAAL: It is, yes.

JUSTINE HARRIS: You've got to do your six years and—

BEN BENAZZOUZ: The process of becoming a psychologist is quite lengthy and complex. I don't believe it's for everyone. It's for people who are compassionate, empathic and really want to work in this space. It's not an easy area. But it is very important also to notify that a lot of the people who come here, whether they are refugees or asylum seekers, they come with the idea of improving their life and they want to work. I believe that it is very important to get them at the early stages and help them. Despite their mental health, they are very resilient, and they can overcome that if they receive help as early as possible. The more we delay, the more complex this becomes, and Australia is losing a lot of productivity here.

The CHAIR: Any further questions?

The Hon. EMILY SUVAAL: I have another one, if no-one else does. In terms of—I've just lost it.

The Hon. SUSAN CARTER: I might jump in. Clearly, you're aware of ideas in Scandinavia and other places. Is there somewhere else in the world that we could look that does it better and that we could learn from?

BEN BENAZZOUZ: Yes, Germany is doing something. I personally lived in Scandinavia. That's why I used the example. I used to live in Sweden, and I used that example because I was quite surprised by the fact that at the time when I lived there, they had one of the lowest crime rates. People don't reoffend when they go to prison. The prison is completely open. People will go there. I did some volunteer work where they get them a job. They will leave the jail in the morning, go to work and come back in the evening. Then, by the time they serve their prison sentence and they go out into the community, they are integrated, they have a job, and they have learned from their experience. Again, with people who have mental health issues, they have addictions, they have very specific venues where they send them. There is one outside Stockholm. It is in the country, like a farm. They have access to everything there from a psychologist, nurses, case workers. Then they start getting better and they get them to start doing some work, learning some skills. By the time they leave the venue, they are actually ready to do something.

JUSTINE HARRIS: Also, in Germany they have a model where they are trying to do it more stepwise. They assess and make sure that the service meets the need as people come in. Everybody gets a bit more of the basic problem-solving and stress management type stuff, and then it goes through to assessing when there is higher need.

BEN BENAZZOUZ: We're more than happy to provide you with some examples later on. If you would like us to send you some examples you could read about it yourself. We're happy to do that.

The Hon. MARK BUTTIGIEG: It sounds like we're going to Sweden, Chair.

The CHAIR: I thought we had a budget black hole.

The Hon. EMILY SUVAAL: I've remembered the question that escaped me. As you were talking before, I was thinking about how we've heard a bit today about the role and merits of peer workers and people with lived experience, as you were talking about the barriers that exist for people going on and studying. Is peer work currently an avenue that is available? Is it of merit? What should we do?

JUSTINE HARRIS: Definitely. That's the beauty of a multi-disciplinary team. When I get students through—students who come from lots of the countries that we work with—we learn so much. Having people who have lived experience and peer workers, they are able to understand what the need is. So that would definitely be a rich part of any multi-disciplinary team. A lot of our case workers have come through and had refugee experience. They bring that into the case work team that we work with.

BEN BENAZZOUZ: Absolutely. It also makes the process to deal with those kinds of problems and try to solve them quite easy. We know that there is evidence out there. Some research has been done, and they found that with culturally linguistic psychologists or social workers, not many of them out there actually understand how to work—it's not that they can't or don't know, it's that they are not trained or upskilled to deal with this kind of demographic.

The CHAIR: Thank you so much for the time that you've given to us today, as well as your written submission and all of the work that you're doing more broadly. There is an opportunity for questions on notice or for the Committee to put further questions, and the secretariat will contact you in relation to that.

The Hon. MARK BUTTIGIEG: Thank you very much. That was very helpful. Thank you for all your exceptional work.

(The witnesses withdrew.)

Ms ZOË ROBINSON, Advocate for Children and Young People, affirmed and examined

Mr KYZAR JING, Lived Experience Adviser, Office of the Advocate for Children and Young People, affirmed and examined

Mr ASHLEY de SILVA, Chief Executive Officer, ReachOut, affirmed and examined

Mr BEN BARTLETT, Director of Government Relations and Communications, ReachOut, affirmed and examined

The CHAIR: I welcome our next witnesses. Thank you all so much for making the time to give evidence today. Would you like to start by making a short opening statement?

ZOË ROBINSON: I have only 30 seconds, and then Kyzar will give the opening statement. I thank the Committee for holding such an important inquiry. I acknowledge that we are on Aboriginal land today and pay my respects to Elders past, present and emerging. I also acknowledge the five people who contributed to our submission and shared their own lived experiences with that. But Kyzar will be giving the opening remarks for ACYP.

KYZAR JING: Good afternoon, Chair and Committee members. Thank you for allowing me to be here today. My name is Kyzar Jing. I am 21 years old. I'm a lived experience adviser at the Advocate for Children and Young People's office. My lived experience ranges from domestic violence, homelessness, being involved in the legal system and experiencing youth justice system from ages 15 to 20. Since a young age I have been no stranger to the impacts of mental health. Both my parents suffer from severe mental health issues and I've had my own battles with my mental health throughout many periods of my life. Today I speak from my own experiences with mental health, and acknowledge that each individual is unique and there is no one-size-fits-all approach when it comes to mental health. How I overcame my mental health may not work for someone else.

My battles with mental health started in primary school: always feeling alone; never being able to concentrate in class, which led to a disconnect and misbehaving at school; and never wanting to be home as a teenager because it reminded me of pain and hardship, which then led to me being involved in the legal and youth justice system. Up until my incarceration at 15, I never had a single bit of support in the community. Once I entered the youth justice system I finally had access to professional support. From my experience, I believe there are still many issues with the type of support given to vulnerable and at-risk youth. My mental health worsened from the ages of 16 to 18, when I was referred to a psychiatrist by my psychologist within the centre and placed on medication. I remember the first day that I took the medication, I couldn't even get out of bed or think for myself. It made me really tired. I knew that wasn't the solution to my problem.

Through my sheer determination to change my life and better myself, I went on a journey to educate myself on how to have a more holistic approach to my mental health where I could find the tools that worked for me to battle my mental health. That ultimately led me to be able to break the cycle and release back into the community. As I said before, there is no one-size-fits-all approach, and I have seen how a traditional approach to mental health issues and medication has helped many young people. But I have also seen the other side of young people who are placed on medication. They see a psychologist and psychiatrist every week but they still attempt suicide and inflict severe harm on themselves, or misbehave as an outlet for their issues. They're released back into the community with no support again, whether it be that they do not know how to ask for help, their lack of access to help or the issue of poverty in this country—and I've been able to afford professional help—and many other issues that I hope to get to speak on today. Thank you.

ASHLEY de SILVA: I also acknowledge the traditional custodians of the land that we're meeting on. I also acknowledge those with lived and living experience, as well as the people who love and care for them. Thanks, Kyzar, for sharing your story. Thank you all for the chance to speak today. ReachOut welcomes this inquiry. It's very timely. We appreciate the opportunity to speak and also answer your questions today. We're a non-clinical digital mental health service that supports young people to access a range of different types of supports, from one-on-one peer support through to online forums, as well as self-help materials. Through our parents and schools programs, we also provide support to the people that young people very often turn to.

When I say "timely inquiry", it's particularly because we know that the statistics around youth mental health at the moment aren't good. Forty per cent of young people are recognising that they have a mental health challenge at the moment, and suicide is still the leading cause of death for young people in Australia between 14 and 25. It's obviously also been a challenging few years here in New South Wales as well as elsewhere in Australia, but here particularly with floods, fires, lockdowns, remote learning and the continued impacts of COVID-19.

Across Australia, more than one million of those young people I mentioned with a mental health difficulty aren't seeking any kind of professional support, and there are many barriers to that. We know a lot about this space, but some of the things we will have mentioned include financial limitations, limited service accessibility or availability, and concerns about confidentiality and stigma are also still high. There's obviously no shortage of challenges in the mental health system. I'm sure you are hearing and discussing those at depth. But we do know digital services can play a stronger role than they have in the past and that they also overcome many of the barriers that young people typically face. We also think that they can help create a more efficient and effective service overall as well.

For those who do seek support, unfortunately, navigating a system also brings with it many stories of challenge, in particular for those young people who are in distress. We often hear experiences from young people at ReachOut commenting on being turned away without pathways to further support, being seemingly too well for some services but not well enough for others, and being distressed as a result of poor experiences as well. We've worked in this space for 25 years as an organisation and we wish there were easy solutions, but mental health is complex and fragmented. Part of that is the way that it has to span Federal and State jurisdictions as well. Whilst there is no one-size-fits-all approach, what works for young people may not work for adults, and we know different population groups have different needs as well. That said, we do hope and think that there is more that can be done to improve it, and Co-Design is a big part of that. We hope to be able to speak to some of those issues more with you today. I will leave it there for now. Thank you.

The CHAIR: Thank you very much. I might start the discussion off with my own question. We had a conversation this morning with a person with lived experience who was talking about the challenges with mental health literacy. It took them a long time to develop insight into their own symptoms, it took them a long time to develop the language they needed to be able to seek help and then it took them a long time to understand how to navigate the system to actually access the services that they needed. In terms of young people and promoting that kind of mental health literacy, what do we need to be doing? What do you think some of the solutions could be?

ZOË ROBINSON: In the work we've done, obviously children and young people speak a lot about peer-to-peer support and being able to relate to and have conversations with people who have a similar understanding or have similar experiences. I think that's really important. Certainly there is some complexity in understanding all of the elements that you have just raised. Making things appropriately worded and child-friendly that sits and reflects the people that we are trying to work with and reach out to is really important. Kyzar, I don't know whether you have anything in terms of mental health literacy because you talked in your opening about not having access to things until a certain part.

KYZAR JING: No.

ZOË ROBINSON: I think we just have to make sure that it is accessible in a variety of places. I think the thought that it can only come from certain professionals means that it is harder for children and young people to feel comfortable about going to access it and to walk into a certain—whether it is a councillor or a psychologist or even a headspace necessarily. One answer is places where they can access it easily. Online is something that particularly children and young people talk about and 24/7 access to that as well and peer-to-peer support is very important.

ASHLEY de SILVA: I would just add that one of the big challenges young people have is even determining whether what they're experiencing is worthy of seeking help. Mental health literacy can play a big part in helping them better understand their experience and potentially validate what they're going through in terms of it being help worthy. We have seen real success at doing that in almost every stage of care. The thing that's got the lowest barriers is just high-quality information, written in language that resonates; it's not medical. It really does frame the experience in the way that a lot of young people experience it. Sometimes it might not be through an anxiety lens. It could be through the stress of study or it could be through feeling like "I'm lonely," or "I'm finding it hard to find friends." Very often, the starting point for young people is not that medical lens.

Then thinking about, like Zoë touched on, the step-ups from there in terms of the conversation types that feel less threatening and that feel more relatable to young people. Those are things like online forums where you can ask any question that's on your mind in a safe space and know you're going to hear back from people who know what they're talking about and be supported in that way, or speaking to people who feel like they've walked a day in your shoes, which is kind of the peer support model. One that we launched a year ago is a text-based model of that, which, again, is around taking out the need to even vocalise to someone that you don't know. All of those things can play really, really big parts in helping people latch on to, "Actually, there's more here for me and maybe I can think about better understanding it and knowing what my next steps might look like."

ZOË ROBINSON: The young people themselves talk about providing training to frontline workers around relating to young people and the language that young people themselves use. Certainly the young people who provided their own stories in the submission talked about the importance of being able to—and that is young people in their spaces broadly always wanting to ensure that everyone is supported in community. They are thoughtful in their approach to things. It is not about pointing fingers at anyone for not doing something; it is saying let's work with frontline workers and others to ensure that they are also informed in the language and the kinds of ways that children and young people want to have conversations about this.

But that point about not recognising or necessarily knowing, it is that we have seen in our surveys that children and young people are talking about cost of living and that is being a pressure for them. We know that the links between that kind of pressure may lead to things, but it is not necessarily that they're walking in knowing exactly what it is. It is just that there are feelings and understandings of what is going on. Being able to work through that with children and young people in appropriate language and in appropriate ways is important.

The Hon. EMILY SUVAAL: Thanks so much to you all for appearing today. I am going to ask you a question around school counsellors. I know that they are referenced in the youth advocate submission. I am particularly keen to hear your thoughts on their role, their effectiveness and—in particular, Kyzar, if you're comfortable sharing whether such a model would have been useful or is useful.

KYZAR JING: I remember when I was at high school I didn't know the school counsellor existed, to be completely honest. I remember going into a high school when we were doing our work around vaping and we spoke about school counsellors—they didn't even know who they were. School counsellors, you don't really see them often. It's one of those things, like, can you really relate to that person as well? That's sort of the issue that I've always had with professionals and seeking professional help. Maybe competence isn't the right word, but you're relying on that person to truly understand where you come from and to be able to have an open discussion, like, again, with someone you don't completely trust.

ZOË ROBINSON: I think that's an important piece that you touch on there. It is not a reflection on the fact that we know that there are incredible counsellors who are doing amazing work in a lot of spaces. The flip side is we always have to understand that it is often really hard in many circumstances to take that step through someone's door. We've heard in a number of scenarios, where we've done various other consultations, where you have to come out of class, you have to walk down a corridor, you have to go to a certain door—so in terms of discretion, that confidentiality piece, even the physical process of going to a counsellor requires you to almost make it very clear that's what you're doing.

We have also heard from children and young people that it is not always clear to them necessarily whether that counsellor is there for them or whether anything that is disclosed will need to go back to a parent. That's not necessarily saying that—we acknowledge there are scenarios in that—but there is this, "Are you here for me as a student and the things that I'm going through," or is it you are going to go to the principal or the teacher or to other people to have that conversation? One of those things is about consistently working with and understanding where children and young people will engage.

We also know that they will want to take matters into their own hands and have conversations, and seek help and all of that, but it is about designing systems, as my colleagues have done here, that reflect chat functionality or 24/7. I'm certain you would have heard today that it doesn't always happen within school hours, so how are you dealing with those things outside of school hours? For example, to acknowledge the incredible work that's done, we also hear that children and young people—simple things like not wearing the school T-shirt but wearing a T-shirt that says, "We're ReachOut," so it feels like you're separate from the school and you're someone that they can speak to. But then, also, how do you manage the actual process of going to a school counsellor and what that looks like?

The Hon. MARK BUTTIGIEG: Can I ask a follow-up?

ZOË ROBINSON: Sure.

The Hon. MARK BUTTIGIEG: To what degree is that a function of specific parameters put around what counsellors can and can't do and/or a function of lack of adequate qualification and training? Excuse my ignorance. I'm just not aware of what school counsellors are required to undergo in terms of professional training before they do that. Sorry about the two questions.

ZOË ROBINSON: I can see my colleague leaning in, so he might want to respond. It would be inappropriate for me to have a genuine understanding of the parameters in terms of a psychologist-counsellor relationship. I'm not an expert in that. What I would say as an example is in a report that is yet to be released, which is the vaping report that Kyzar is talking about, one of the recommendations around that is perhaps a piece around both understanding from counsellors but also for students. What are those parameters and what are the boundaries in terms of how is it that you can work, like in all scenarios, with the person who sits in front of you, your patient, the person you're caring for, so that they can progress through things? But also what are your duties of care in other places? How are we actually explaining that between people?

The Hon. MARK BUTTIGIEG: I'm interested—from Kyzar's response—because I imagine in an ideal world you would just want total autonomy where the counsellor has a professional qualification and is able to act autonomously to what they think needs to be given in terms of care and whether or not there are restrictions around when they have to escalate things because "that's a red flag; you've got to tell the principal or the parents". I'm just interested in that kind of interplay.

ASHLEY de SILVA: I could add a perspective on it. ReachOut promotes being an anonymous service but there are boundaries obviously even to that, so we are always really transparent with the limitations of where we would need to breach confidentiality to keep someone safe. But for us that would usually be around escalating to emergency services using an IP address if there is risk of suicide. That is the most pointy end of where we would have to breach that confidence. You obviously work really closely with a young person to try to keep them in control and encourage them to make disclosures that will keep them safe, but in those events there are ways of doing that that I think are really transparent and would be common practice.

I think the reality around counsellors that we hear is very similar to what Zoë shared, which is kind of more that idea of, "I know you're there"—if they know they're there—"but going to you in this environment is not what I think I need right now." I remember this story; it stays with me. We do a lot of qualitative research in conversations with young people and we were looking at the kinds of barriers to different access like this, and she shared a story about a teacher who had kind of said, "Look, I know year 12 is a stressful time. If anyone needs time after class, come and have a chat with me." Her initial thought is, "Great, now I can't come and speak to you because you've just made it clear that if I do, I'm signalling to the rest of my class that I've got a problem and that's not something that I want to do." It's a really fine line in terms of getting young people to feel comfortable, and the realities of doing that in a school environment can be limiting in terms of the school counsellor perspective.

The Hon. EMILY SUVAAL: It sounds like having a school counsellor sitting in a room is probably less effective than having someone on the other end of a chat function that can then answer to people wherever they are at whatever time they need. Is that the case?

ASHLEY de SILVA: I would say you kind of want both. This is the thing. We're always looking to create options for young people. So in ReachOut we might say, "We recommend you have a chat to a peer worker but you could also read this article. You could also contact this other place." I think we kind of want it to be that flexible for people so if there's someone who's comfortable going and seeing someone and they want to be in the room with them and eyeball them and be in that space, great, but we know that there are a lot of young people who wouldn't. The idea of what you just described there goes to lot of the young people who wouldn't have that preference. When I referenced in my opening statement that there are more than one million people in Australia with a mental health challenge not seeking professional help, these are some of the reasons why.

ZOË ROBINSON: I think also this is on the assumption that you are attending school. The balance is if you are attending school and you feel comfortable that you want to go have a conversation with someone and your school counsellor is available, what an incredible avenue to have. One of our people who provide their story in our submission talked about the fact they didn't have a good experience with the counsellor but that they were referred to headspace, and so as a result they got some help that they needed. That is why I think it is—and as Kyzar said in his opening statement—a holistic approach. Our view would be that, based on what we've heard from children and young people, the more options you have that have been informed by and designed by children and young people, the better outcomes you will have for children and young people.

The Hon. MARK BUTTIGIEG: Kyzar, you know that experience you relayed in your opening, was there a touchpoint with external services like counselling or health professionals where it helped you to turn the corner, or was it largely under your own steam, or was it a combination of both? I'm interested to hear.

KYZAR JING: Like I said, the only time I sought professional help—you don't have to seek it; it is sort of there. You have to do it within custody; you have to see a psychologist. You don't really have a choice. Well, you do, but if you don't you get in trouble for it. The thing with me with professional help—and me saying this is not undermining the work that psychologists do; I understand they are a very important part—is that a qualification is a qualification. Sure, my psychologist might understand the science behind how my trauma has affected me growing up and why I behaved a certain way, but do they truly understand what I've been through?

Maybe that was a bit of arrogance when I was a bit younger and that thinking that no-one understands what I've been through. But that was the sort of issue that I personally had with psychologists. You could tell sometimes when you speak to a psychologist. They would shut you off sometimes when you talk about certain things. It wasn't denying your experience, but I don't think sometimes they truly understand. So that's where I went on my own two feet and found a more holistic approach where I could help myself. I am really big on self-help.

The Hon. MARK BUTTIGIEG: In your situation you've obviously had some sort of inner strength to pull yourself out, right?

KYZAR JING: Yes.

The Hon. MARK BUTTIGIEG: What about for people who can't do that—and you're saying the psychologist might not be the solution—then who do they talk to?

KYZAR JING: I'd say a big pivotal point for me as well was at the time I was in custody an external organisation had come in and was made up of lived-experience youth mentors. They had all served jail time and they had all done custody. So that was a big thing for me. I had seen these people who have come from where I have come from and who have gone through the same things and they have changed their lives. You know, they are doing not-for-profit work and they are youth mentors. That is what really kickstarted the fire in my belly to come and do this kind of work, because I saw the impact it had on myself.

The Hon. MARK BUTTIGIEG: The fact that they had been through it comes with a lot of credibility and allows you to—

KYZAR JING: Yes.

ZOË ROBINSON: Kyzar has worked at our organisation for over a year now. This year we also witnessed another young person who exited who wanted to come work with us, but who was very different to Kyzar. One of the things that I thought it was important for this Committee to hear is that we often think about these settings in terms of a hospital setting that you have come or exited from, or that there is an acute response. This is an example of someone who has gone through a different government setting and has also exited without necessarily connections into counselling services on exit. Kyzar has worked really hard for a year. Unfortunately, the other young person who exited we thought should have had connections into that—like a psychologist, like support—but didn't receive that and is now back in adult custody.

We think of it often in terms of a school setting or a hospital setting and how we continue to have through care for people. I think it was a really interesting learning for me, seeing that we have exited people from places where we've known when they are coming out and there is not necessarily any community support that is automatically set up in that scenario, unless someone takes it upon themselves to go and find—and you can imagine what that is like if you have been somewhere for five years and then you're being asked to go and walk into a psychologist's office.

The Hon. GREG DONNELLY: Thank you all for coming along today. Thank you for the submissions; they are very helpful. We have received many submissions, as you know, and there will be further hearing days, and we have had evidence today. I am challenging myself to try to work out how we are going to deal with, as a Committee, making a report with recommendations, which will hopefully be helpful to the Government. What I am coming up against is the sheer size of the problem, if I could use that phrase. It is manifest; it is everywhere. It is long, deep, wide—however you'd like to define it. So there is a big call on the need to really improve matters regarding mental health in the community across the whole population, and I don't think there is any real disagreement about that.

But as we are looking at that, there were many submissions and arguments put that we also need to, in terms of addressing this at a complete level, at a global level—that there are a whole lot of groups parked within which are deserving of and necessarily need quite specific attention. There's this tension between dealing with the global issue, which we know is large, and at the same time dealing with these individuals. I'm not dismissing the significance of this but I am just looking at it from the point of view of affordability, to be perfectly frank. Where will the money come from to deal with the global matter, but also at the level of specificity that is being asked for by the individual groups? I'd welcome some comments or observations around what's possible. We can talk up what we'd like as much as we like but, realistically speaking, what should we be doing?

BEN BARTLETT: I'm happy to jump in. I think there are things that at a system level can make a huge difference, like improving service interoperability and system navigation. Helping people find the support that's right for them that, at a system level, will make a huge difference across the population generally. But we see specific needs from key priority population groups who often have worse mental health outcomes than the general population as a whole and some different barriers to accessing services, particularly around language or seeing themselves and their culture represented in a service and feeling that that service is safe for them. There's a real mix of things that can be done at a more micro service level to address the priority population groups as well as the broader system design things.

In terms of cost, obviously the demand on the system is enormous. The Federal and State government funding is very significant, but there's still a huge surplus of demand. But it's important to keep in mind that the economic studies have all shown and the Productivity Commission report from a few years ago was very clear that the benefits of actually investing in mental health over the long term will save a significant amount of money over the long term, even if there is a high cost at the beginning. At ReachOut we've consistently argued for greater investment in prevention and early intervention to help address issues, when perhaps they're easier to head off, before they sort of spiral or develop over several years and become the critical types of issues that have the biggest impact on people and their ability to contribute to society in different ways.

ZOË ROBINSON: Mr Donnelly, I've appeared before you many a time, so you would know I quite like an ideal world where we can meet the needs of every person and individual, and I think we should still aim for it. But I think there are systemic things, and the intervention side of things is incredibly important. From us, when we're talking about children and young people, and the 2.5 million children and young people who are in New South Wales are incredibly diverse, they are talking about similar things—school stress. Perhaps it is less about thinking about what a service looks like—because we have designed services, we've included children and young people in that design and they've made it very clear what it looks like—than actually looking at those thematic things that people are sharing. We would absolutely agree with that early prevention.

Sometimes there is lot of focus, as you asked in the first instance, around language and how we actually speak about this, when it's quite clear children and young people are talking about school stress. So how are we having conversations about that and helping them early to set themselves up for success so that school stress doesn't become something this generation is facing? I think less about the groups as such and more about the themes, and then also the structure of how we're making it accessible for people to get the help that they need. That's why it's so important to have programs that are 24/7, that are chat functions, that are approachable, that have language inbuilt and translation, and that are culturally appropriate as well.

The Hon. GREG DONNELLY: Finally, I turn to the question of being safe. I've got limited experience in this area. I'm not trained in it and have not worked in it but have knowledge of people who have been involved in mental health matters. It struck me as a bit surprising—maybe I'm just naive—in a number of the submissions and some of the evidence that the statements made, or the implications of the statements made, is that it's not safe to access what's there. In other words, what's out there is there. However good, bad or indifferent it is at the moment, there are mental health services out there. But a number of the submitters have said it, and earlier today the point was made very explicitly that it's not safe. They don't consider the mainstream—the generally available and can be found pretty easily—mental health services to be safe. That's a striking statement, I thought. There are individuals who obviously just find it unsafe to contemplate going to access what is already out there. I just welcome that. I don't know whether I'm misunderstanding the actual meaning of "safe" or if it really is worse than I actually thought it was.

ZOË ROBINSON: I certainly know that in our submissions the young people spoke about the stigma that they still feel is involved.

The Hon. GREG DONNELLY: That's different from safe.

ZOË ROBINSON: Correct—absolutely. But I think that is still part of the experience of feeling comfortable—perhaps the word "safe"—to go to a place and approach that. If you are dealing with a complexity already and you don't feel necessarily like it's going to be easy for you to have that conversation with someone, then that can absolutely make it difficult for you to take that first step. Some people might describe that as feeling unsafe.

The Hon. GREG DONNELLY: I am a bit concerned about the sense of pathologising a situation. Things can be uncomfortable—talking about difficult things. In fact, it might be very, very difficult to do so. But to then imply that dealing with it is unsafe seems a bit of a leap for me. As I said, maybe I'm misunderstanding it.

BEN BARTLETT: I think the term "safety" has a slightly different meaning in that context. It is less about a service being medically safe or effective and more about that sort of safety to access for that person.

The Hon. GREG DONNELLY: What does that mean?

BEN BARTLETT: I guess it's around that comfort and feeling like this is a service where you'll be understood and they'll get the issues that you're going through, rather than it potentially being effective or not.

The Hon. GREG DONNELLY: Which brings me back to the point. This is where I think there is a tension. If there is this overarching view that the best practice is to be able to deal with these issues in a segmented way—to deal with the specifics of the different groups, whoever they might be—that has got to be dealt with, and then there is the overarching provision of mental health services. I'm just wondering how that is all afforded in the real world.

ASHLEY de SILVA: I think it goes to breadth and depth. You have heard people talk about the breadth of issues—look for the familiarity of issues that will be helpful to cover for large numbers of people. But also, this is really then on services, as well, to develop the capability to go narrow and to signal to people. ReachOut—to use an example from our experience, we are a mainstream service but we know that the proportion of First Nations people accessing ReachOut doesn't reflect the need in that community.

For us, it was a very thoughtful approach to how we develop materials that Aboriginal people would feel are culturally safe—that are reflecting their particular perspective, need and experience—even though we are a mainstream service. For us, that does end up manifesting as: Who is on your workforce? How are you making decisions? How are you translating something like study stress into language and issues that resonate in the community? And doing it in partnership with community—that is how we have done that. You're right, there is a limit to how many areas organisations can go narrow on, because there is an adaptation involved to be able to better meet those needs.

The Hon. EMILY SUVAAL: Would this be where, say, digital services might be useful in terms of mental health reform more broadly?

ASHLEY de SILVA: I think it is. A good example is that we've had lots of information around different ways of helping people across a range of issues, but when we did that translation with First Nations people, it kind of comes through in language, like "how to yarn about a difficult problem" or "how to connect to your culture through dance", for instance. Things that are going to help a First Nations young person that might not resonate with someone who is non-Indigenous but that are actually—once we've got the structures in place as an organisation to create and deliver those, it's possible and not too complicated.

ZOË ROBINSON: Perhaps in terms of mental health literacy—in your question we seem to be thinking about those who are in a situation where they need to get help or people who provide that help. We've still got to have a conversation with the greater population, who may not be in those situations, about the language we use and spaces that we provide. Knowing the work that you have seen us do, we have heard from a number of people that, if they turn up to a space to seek help, there are people there who know why they are there and make them feel unsafe and uncomfortable.

So a very real conversation, when talking about investment in health and health literacy, is that if you are not a person who is seeking that, what are the things we also need to work on with mums, dads, teachers, frontline workers and everyone to say, "The language we use and the interactions we have need to look better." Not to speak for you, but when you talk about sitting in front of a psychologist when you're in custody, and they shut down when it's a difficult conversation or it's something they don't understand, how do you approach that differently? It is still really important to be able to say, "I may not be able to understand it. I may not have experienced it, but I want you to still feel comfortable and confident to be here." We need to also think about the greater population and working with everyone to understand what good health and good health conversations are like.

ASHLEY de SILVA: Can I build on that point? A really important one that I haven't made yet either is that often a lot of the research comes from people who have sought help, but again, I heard in what you were saying, Zoë—and ReachOut does lot of this work—that we focus a lot on understanding the perspectives of people who have a mental health challenge but are not seeking help. Sometimes in conversations like this, for good reason, we want to hear how the system's not working, but you can end up just refining parts of that system rather than thinking about the people who haven't even engaged in it yet.

The CHAIR: One of our terms of reference, as you would have seen, is the risks and benefits of telehealth services. We've received lot of evidence about people wanting to be able to access support and care on their terms, at all hours of the day, whether that's online services—I'm particularly asking this question because ReachOut is here, and you have quite an innovative model. In what ways does that work really well? What are your limitations and how have you overcome some of those things? I'm particularly interested in if, for example, a young person in one of your online forums discloses something like childhood sexual abuse or signs of psychosis, how you are able to manage that.

ASHLEY de SILVA: Firstly, the benefits are—you have said it—that that's what people are asking for. Digital does lends itself very well to creating what it is that young people or others are looking for. I think it goes to all of the things around access. It has a lot of things in there around anonymity, if that's a preference for people. Again, we design that way, but there are online models where that's not the case as well. There are many different ways of doing it. On the safety side, Australia is just going through the process of introducing a new accreditation system for digital mental health services, which is a fantastic thing because there hasn't been one. That's a Federal initiative.

Services like ReachOut are going through an accreditation process at the moment; we're at the tail end of that. It really systematically looks at the kinds of expectations we should have of services so that we know, even though they're digital, they are underpinned by evidence, they have the right safety protocols etc. That's probably a missing piece. But then in practice, what that means is the kind of scenarios that you're referring to, organisations like ReachOut are set up well to deal with. We have mandatory reporting obligations. It goes to how you escalate for different types of issues. We have a whole range of systems in place like clinical advisory groups and debriefing for our staff. So you look at it from the consumer's perspective but also the perspective of the staff who are providing support. I can speak specifically around something, if you're interested there, but I'm saying more broadly you do have to have, and should have, all of those kinds of systems in place that mean you're upholding the standards of safety that you'd expect.

There are particular boundaries. For instance, being an anonymous service, to build out on your question around the forums, we keep barriers to entry low. We take enough information so that in any kind of risk situation, we can then act in the way that's appropriate. In an online forum, it's a pseudonym someone can provide, but we have an email address, an IP address or a phone number which we can use when we have to escalate. For us, there is some additional risk that comes into managing an environment like that. For instance, the forums aren't real time, so our replies are not like live text chat. So we have to have different systems in place that help us assess when we need to act based on how much time has passed hearing back from someone. For example, if they're in a high-risk situation where suicide risk is likely, the team knows the protocols in place around that. We're not going to leave it 24 hours if we haven't heard from someone. You have to modify and use clinical judgment to make sure that you've adapted well enough but are still keeping people safe.

ZOË ROBINSON: Aside from organisations like ReachOut and other services, there is a very good example, which we have done a lot of work around—and that in fact our staff have the benefit of and youth advisory have the benefit of—which is Sonder. It has been set up by people who are ex-military and there are first responders who are part of that group. Every person who is onboarded into Sonder—and there are very big organisations that participate in this now, such as Woolworths and the Commonwealth Bank, and there are smaller organisations. There is a DV service that's on it; Youth Off The Streets has partnered with them as well. The person on the other end of that phone is a trained nurse and has a health background. If it does escalate, it can go up to the person who is the head psychiatrist or head psychologist there at the time.

That is all online, but it also has enabled things—for example, one of the stories that we heard when we first started to work with them was of a young person who was going through self-harm and had engaged on the chat. Whilst that was happening, and with the way it had been sent up and with consent and everything like that, the service was able to engage with a case worker and send an ambulance out at the same time. There are some really sophisticated platforms that do exist that have been designed by users and have very good medical practitioners behind them as well. We have certainly seen the stories of success in that. It can be not at that acute end; it can be that you're a single mum dealing with a young baby and you are having a real panic about what to do. They will work through that with you and engage with you. If you need to go to hospital, they'll ensure someone is collecting you and supporting you through that. There are some very sophisticated services that have been designed in a different way, but we've certainly seen them be successful for children and young people as well.

The Hon. SUSAN CARTER: Changing gears a little bit and going back to that idea of early intervention, especially for young people who may not really have the language or awareness to know that the way they feel is different to the way that they should be feeling, and thinking about what we've heard in relation to school counsellors and that they are "other" and difficult to access, I am wondering about the utility of peer support workers in sports settings and youth group settings. I wonder, Kyzar, whether you have any views about whether, if you'd have encountered somebody like that at about 13 who you were kicking a soccer ball around with and who was able to have conversations with you—or do you think that sometimes people need to reach a crunch point in their life, a decision point and an access point?

KYZAR JING: I think 13 would have been still a bit too late for me. I speak for other young people and children that come from similar experiences to mine. I really needed that early intervention from a young age. Most of my issues that I didn't have control over stemmed from probably about zero to five—obviously police coming to the house in terms of DV, Family Court, supervision orders with my father and a whole range of other things. It's remarkable how I didn't have to see one professional. I'd never seen one professional. I really think early intervention is very key from a young age, especially when there's a lot of trauma in the household. I think by the time I was 13, something needed to happen drastically in my life. That's where custody—I still to this day say it was a blessing for me because it gave me professional support, gave me time to be in an environment where there was no negative influence in my life and I could really work on myself. I'm really big on early intervention. Maybe if I'd seen a psychologist at the age of three or four or five, it would have helped me lot more than 14 or 15.

The Hon. SUSAN CARTER: But I guess at that young age you would have needed an adult to facilitate that in your life, and that wasn't available.

KYZAR JING: That's the issue, right? My parents both had significant issues and severe mental health issues. When they need help themselves, how are they going to get their child help? I just don't know how—for example, if police come to the house for DV, how can they not—you know what I mean? How can they get the child help, or how could DOCS get me help—it was DOCS at the time—or now FACS?

ZOË ROBINSON: And we've certainly heard, in terms of other programs like sports programs—again, if I think about when you're talking about what is possible, it's because you are coming to sport regularly and you are there and people see you, and then suddenly—

The Hon. SUSAN CARTER: But you're not—

ZOË ROBINSON: —you're not coming or your footy boots are starting to look a bit ratty. There are these ways that you can see what might be happening with someone. Again, that's about how do we work with educating all people who are seeing children and young people in a variety of spaces to not just identify and jump to a particular conclusion but actually ask, "How are you going?", that kind of language. We've certainly seen really good programs. The NRL run a number of programs, including responses to when things have happened, like responses to when bushfires have happened in the community, and they send out players.

Again, I think it's that listening to the fact that children and young people want to hear from people like them, people that they respect or people that they know for various reasons and how that works together to say, "Whilst we're in this space, we're also going to just make sure that you're okay. We might have a different conversation with you as well, but if you just want to throw a footy, great. If you just want to do some amazing art with us, amazing." Again, it's about saying not everyone is going to be playing footy, so what do we do to make sure we are meeting children and young people where they are? How are we facilitating conversations, even if it's just, "Sit down. Have a meal. How are you going? What's going on?" It might be simple as that, sometimes. Again, it's equipping everyone—frontline workers, people who are working with children and young people—to able to have those conversations and then potentially recognise what might be needed.

The Hon. SUSAN CARTER: And that should be primary school as well as high school, by the sound of things.

ZOË ROBINSON: Well, we've heard zero to five, so early.

The Hon. SUSAN CARTER: Can I just put on record how much I respect you, Kyzar, for what you've done in your life. I know you're proud of yourself, and I just want to put on record how much I respect you.

KYZAR JING: Thank you. I appreciate it. Thank you so much.

The Hon. GREG DONNELLY: It's a bit sensitive, but I want to broach the issue because I think it just needs to be discussed, and I would appreciate your opinions. In the ACYP's report *The Voices of LGBTQIA+ Young People in NSW 2022*, on the issue of gender-affirming care and specifically gender-affirming surgery, the commissioner would know—this is on page 120—you say that:

> Trans and gender diverse young people also shared their frustrations about gender affirming surgeries not being available to people under the age of 18 in NSW.

Then on the next page it goes on about concerns about not being able to get certain advice about binding, which we all understand what that is. I'm just wondering, though, on matters of such significance like surgery that's being considered, both for males and females—there is a real preponderance these days, which the numbers bear out, that it's significantly more a matter for young women than young men—is not there a great deal of care that needs to be taken before we say that the affirmation approach is the one that we simply endorse as the way to deal with this matter of surgery? It just strikes me that—stating the obvious—it is irreversible. That's it. They're sterilised for life, and they're on hormones to the end of their life. That's the effect of the surgery. That's the actual medical reality. I know that's putting it bluntly. But is it not really a matter of great care that we need to take in dealing with these desires of young people who are less than 18 years of age—accepting that 18 is adult—wanting to push ahead with treatment that is pretty significant and life-changing?

The CHAIR: I will just note that that question is well outside of the scope of the terms of reference of this inquiry. If witnesses would like to answer it, I will allow them, but they may choose not to answer that question, given it's well outside the scope.

The Hon. GREG DONNELLY: Well, no. I take a point of order: It's not outside the scope at all. It's specifically part of the terms of reference. The terms of reference specifically state:

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

We know that the matter of what I've raised is done and dealt with and considered in the context of mental health discussions that take place with children and young people.

The CHAIR: The terms of reference are about the accessibility of the mental health service, not about what may or may not need to be done in the services that are offering gender-affirming care.

The Hon. GREG DONNELLY: No, this is my very point: the mental health services that are provided to children and young people to discern over this decision. But isn't it really important that that's got very right, because of the consequences?

The CHAIR: I'll leave that up to the witnesses.

ZOË ROBINSON: I agree that I would have suggested it was outside the terms of reference. However, I would never expect that I would appear before you without you asking a question like this. What I would say to you, as I've said a number of times about this, is you've used the word "care", and that is an incredibly important thing to think of when you're talking about these particular—

The Hon. GREG DONNELLY: That's the language that's used.

The CHAIR: Mr Donnelly, could you please allow the witness to answer the question that you've asked?

The Hon. GREG DONNELLY: Well, just so words are not put in my mouth, the matter of "care" is what's used by others.

ZOË ROBINSON: As I was going to say, it is incredibly important that, when we are talking about a particular cohort that has incredible vulnerability and that has been spoken about a lot in this place, we approach this topic with incredible care and incredible understanding and, I would say—perhaps a word that we need to say more—love and kindness about what is happening. That is a very personal—that is a family conversation; that is an individual's conversation. So the part that you were talking about, which is so far down the track for someone's journey and their experience, is one end.

The Hon. GREG DONNELLY: Well, it's in your report.

ZOË ROBINSON: When we are having a conversation about this, it is important to think about all of the care that should be given by all of the people that are in this person's life. That word "care" comes from a place of understanding and kindness and working with a family and working with an individual to ensure that they are safe, that they are heard and that they have the opportunity to not necessarily be talked about so consistently in a place that is—you're talking about one particular end. Let's start at the beginning, which is, let's have conversations. Let's create space for all children and young people to feel safe, to have an opportunity to be heard. And then we work with families, we work with the individuals, we provide them support, we provide them access. That's the conversation that we should be having.

The Hon. GREG DONNELLY: Would ReachOut care to offer a response?

ZOË ROBINSON: It's not their report; you can feel free to bow out if you like.

BEN BARTLETT: I think I will decline to answer that but note that nobody rushes into accessing that sort of care lightly.

The CHAIR: I might just invite our witnesses to comment if there's anything that you would have liked to have the opportunity to address that you haven't been asked about.

The Hon. SUSAN CARTER: Sorry, could I ask another question? Are there places that do it better than we do? Are there places that we should look at? Should we go to Sweden? Should we go to Germany? Are there other jurisdictions from which we can learn?

ZOË ROBINSON: I would suggest there are a lot of incredible leading practices here in our own State. You're sitting with colleagues of mine, who have done incredible work, and there are really amazing places here. For us, it all starts by actually having conversations with the people you serve. In our space, talk to children and young people. They are experts in their own lives, so you can do that here. However, if you are taking a trip overseas and you need experts to attend with you in Sweden then I'm sure that we can make ourselves available.

The Hon. MARK BUTTIGIEG: We're all on a unity ticket for Sweden.

The Hon. GREG DONNELLY: We'd attend remotely, I think, somehow.

ASHLEY de SILVA: I'd agree. I think we've got a lot of the pieces in place, but it's the challenge of putting them together in ways that start to address a lot of the things that other reports and inquiries point to. In terms of digital, that's an area of speciality for ReachOut. I think there are some interesting parts of the world. Again, a lot of them also refer back to Australia. But just to answer your question, interestingly, New Zealand has done quite well with digital—and you kind of see that reflected in the proportion of investment in digital mental health services and design—as well as places like Canada.

The Hon. MARK BUTTIGIEG: Are they app based?

ASHLEY de SILVA: It's a mix. There are definitely always apps within what we refer to as digital, but also services that look similar but also different to ours.

The Hon. EMILY SUVAAL: With your indulgence, Chair, I have one final question. In terms of the youth advocate, what have you been hearing more generally regarding the youth advisory council on mental health? Is there any area in the State in particular that has more need or where we could do more?

ZOË ROBINSON: You would have seen in the submission the inclusion of regional children and young people and obviously also in the metro.

The Hon. EMILY SUVAAL: Yes.

ZOË ROBINSON: Those who shared their story, who were all on our youth advisory council, did talk about some of the disparity between the regional experiences. Again, some incredible work's been done in terms of investment in that. When you're talking about technology, some of that relies on all of the things to be lining up—access to internet and all of that as well—and also wait times. We have certainly heard in regional areas that there can be longer wait times to get access to things like headspace and a physical face to face. I would say, from the youth advisory council's perspective, they've talked about the difference between the schools—public, private, independent, and what kind of supports might be coming into those schools—and then obviously the community you're in: if it's regional and, if there's a place to go to, if it's easy to get to. Again, when you're thinking about the whole issue and the systemic, if it's a place you have to go face to face, you have to be able to get there and do it at a certain time. We have heard the differences between regional and metro.

The Hon. EMILY SUVAAL: In the couple of minutes we have left, I note you mentioned the Safe Havens in your submission. We have heard a bit about them today. Could you give any observations on how well or otherwise they're working for young people in particular?

ZOË ROBINSON: Noting we haven't done a specific piece of work on that, we are incredibly supportive of Safe Havens, as we've said, because it provides a place for people to go and access a variety of services that they might not always get. Subject to other things that we're doing right now, what we always like to do is go back to the children and young people themselves and test out and say, "How has it worked for you?" That could be a piece of work that we could undertake for the benefit of this inquiry, if that was useful.

ASHLEY de SILVA: That's probably an area we know less about as well. I think that would be something we'd be interested in, too, to learn a little bit more around how those spaces work. But I can instantly understand from an access perspective that there would be a benefit there.

The Hon. EMILY SUVAAL: We heard in particular that people still weren't aware that they existed, that promoting them in some way needed to be done. Have you got suggestions about how we could do that, particularly for youth or some of these other priority groups?

ASHLEY de SILVA: We work a lot in connecting with young people, framing mental health topics and ways, again, to increase access. It is tricky because it comes down to, particularly, how these places are framed. If they feel too much like a mental health service, you're going to lose that group of people I've referred to a few times today who just won't identify. But again, if the issue is around awareness, then I think looking at local areas and using digital marketing channels—making sure you're in the places that young people are. There can be a tendency for these things to land a little bit too government-y, honestly, and feel too much like a service where a lot of young people would just go, "Oh, that's not really for me." As much as we've talked about language and framing, those things are really important when you're trying to reach young people.

ZOË ROBINSON: Children and young people often speak to us about spaces. When we're having a variety of conversations about access to health but also activities and things like that, they talk about wanting spaces. The key thing is making that space feel like something that children and young people would go to. Kyzar and I went on the road recently. There was a beautiful place in the middle of a suburb and there was not a single child or young person. We literally got in the car and drove around and saw people. We said, "Do you know about this space?" They said, "We don't." It was 20 metres from where they were. Part of it is probably the look and feel of it but also, "What are you doing in that space that is inviting children and young people to come in the first instance?" It doesn't have to be about health. It can be about activities in the first place—afternoon teas, all of that stuff. They always talk about wanting spaces, but it needs to be designed with them in mind.

The CHAIR: Thank you so much to all four of you, and especially to Kyzar, for the time you've made to share your expertise with us today, and for all the work you're doing more broadly. The secretariat will be in contact with you in relation to any questions on notice.

(The witnesses withdrew.)

The Committee adjourned at 16:30.