

REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Macquarie Room, Parliament House, Sydney on Monday 16 October 2023

The Committee met at 9:20.

PRESENT

Dr Amanda Cohn (Chair)

The Hon. Susan Carter (Deputy Chair)

The Hon. Greg Donnelly

Ms Cate Faehrmann

The Hon. Wes Fang

The Hon. Emily Suvaal

PRESENT VIA VIDEOCONFERENCE

The Hon. Mark Buttigieg

* Please note:

[inaudible] is used when audio words cannot be deciphered.

[audio malfunction] is used when words are lost due to a technical malfunction.

[disorder] is used when members or witnesses speak over one another.

The CHAIR: Welcome to the second 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.

I ask everyone in the room to please turn their mobile phones to silent. Parliamentary privilege applies to witnesses in relation to the evidence that 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.

Mr GRAHAM BRERETON, Registered Nurse and Psychologist, sworn and examined

Dr TIM SENIOR, General Practitioner, sworn and examined

The CHAIR: I welcome and thank our first witnesses for making the time to give evidence today. Would you like to start by making a short opening statement?

GRAHAM BRERETON: Thank you for inviting me today. I trained as a general nurse and as a psychologist and then as a psychiatric nurse over a period of 40 years. Over a period of 40 years, I have worked entirely for NSW Health in psychiatric hospitals, in drug health and predominantly in community mental health. That has been my last 27 years. I would like to say that the responses that I am giving to the Committee are based on my personal experience and don't necessarily reflect the position of my employer. I am technically retired but still on the books, as it were. I grew up in a family troubled with mental health issues and regard myself as both a consumer of services and a provider. I have the utmost respect for people who work in mental health and even more so for the patients—and their families—dealing with mental health issues on a day-to-day basis.

TIM SENIOR: Thank you for your acknowledgment of country today. I would like to acknowledge the Dharawal people where I live and work, because they have taught me so much about what we will talk about today as well. I work as a general practitioner in an Aboriginal community controlled health service. I also have various roles with the Royal Australian College of General Practitioners and recently have been awarded a Churchill Fellowship to go overseas to look at provision of general practice care in deprived communities.

There are two main issues that I think are really important and want to raise today. One of them is that health equity has to be central to any thinking about the mental health system and any reform about mental health system. We know that people who need mental health care the most are the least able to access it. That's true for people in rural and remote areas of New South Wales; it's true for Aboriginal and Torres Strait Islander communities in New South Wales. That has a large overlap with income, deprivation and poverty. People who can't afford services are those who have higher rates of mental health problems but also have the least access to care, and any health system needs to grapple with that.

Arising from that as well is the crucial role of GPs in the mental health system. As the first point of contact for the vast majority of patients, mental health forms a large workload of general practice and rightly so. It's a large, important part of our workload. That's because GPs are experts in managing multimorbidity, the presence of multiple conditions in one person. Those mental health conditions can have physical symptoms as well, and often those can mimic serious physical problems and GPs are expert at nutting out the main cause for those symptoms. People who experience mental health problems also frequently have physical problems and need the preventative health care that GPs can provide. I think those are the two issues that are the crucial foundational issues in considering any health system and particularly mental health system. I am really grateful for the opportunity to give evidence today.

The CHAIR: Before we go to questions from the Committee, I want to start off by thanking you both so much for your time today, as well as for your advocacy for both the patients that you care for and your peers in the mental health workforce. It is a really important perspective that we're hearing today.

The Hon. SUSAN CARTER: Thank you for both being here. I will start with you, Mr Brereton. I was very interested in your submission where you talk about telehealth and about the challenges in relation to impression management. Could you perhaps talk a little bit more about impression management and some of the challenges of telehealth in a psychiatric and mental health setting?

GRAHAM BRERETON: On telehealth particularly? I haven't had a lot to do with telehealth. When people are engaging with someone coming into the service, that person is as much interested in your impression of them as you might be interested in what's going on for them, so they don't necessarily tell you everything that's going on. They're also inhibited by their own beliefs about mental illness and the way they have been treated in the past. There's a particular attention needed to understand and engage a person in talking about their problems. One of the problems with telehealth is you risk missing or you are in less of a position to read how the person is travelling. A lot of communication occurs non-verbally. If someone has got an anxiety condition, for example, most people are able to pick up on that in the first few seconds of interaction from non-verbal cues. If you're doing it over some sort of electronic device, it's much harder to actually address those sort of issues.

The Hon. SUSAN CARTER: I think you described that what's required is to build a therapeutic alliance. Is that easier or harder with telehealth?

GRAHAM BRERETON: Definitely, yes, talking to someone even over the telephone, and people who have had lots of experience developing those skills risks missing what's really going on. I guess the most decisive

way of understanding another person is actually to visit their home and the original—or at least the mental health standards that I grew up with, one of the first things they said was providing care in the environment that the client actually prefers, and quite often that is actually their own home. Certainly, if someone invites you into their own home, they're actually signalling that they're willing to actually provide a lot more information about themselves than they might otherwise.

Someone can walk into a community health centre and talk to you, and you think, "Oh, yes, that's a serious problem." But they're still actually trying to, understandably, give you a good impression. If you walk in their front door, you see what's going on straightaway. Many years ago, I had a chap who used to show up in a suit and looked absolutely spick and span until I went to his house. I actually went with the psychiatrist. She nearly fell down the stairs from the smell. She was so shocked by it.

The Hon. WES FANG: Isn't it the case that telehealth provides people with the opportunity to access care that they may not necessarily be able to access for any number of reasons?

GRAHAM BRERETON: Yes.

The Hon. WES FANG: It provides that flexibility that the treatment is available at the end of a computer or the end of a telephone, and I guess it also provides a specialty that may not be existent in the area with which that person lives. There are benefits of telehealth as well as some drawbacks around not being able to read the person correctly. You've got to weigh those things up. Is that not a fair thing?

GRAHAM BRERETON: No, I'm not objecting to telehealth at all. It just needs to be tempered with the understanding that it does reduce the amount of information and understanding that's possible.

The Hon. WES FANG: Dr Senior, do you have some views?

TIM SENIOR: Yes, I think the COVID pandemic allowed the health system to transition on a sixpence, really, to turn around to doing telehealth. The convenience of that for a large number of patients is really significant. The vast majority of that was done by telephone rather than video link, and I think there are differences in those in the way that relationships are formed. There are some patients that I know—particularly with anxiety, where it's been really difficult to get out and see practitioners—where telehealth actually works really well for that. There are some, obviously, rural and remote places that can be really well served in geographically getting people there. That would even be true in areas of south-west Sydney. For example, psychology—there are fewer psychologists there, and so telehealth may well be an option.

I think we need to be realistic that in areas where people have less income, often their access to telehealth can be less. I have plenty of people where they don't have data on their phone or they're doing pay as you go and don't have data. I have people who don't have access to a computer at home, and so their access to both telehealth and also other services, a lot of which are going online, goes through the local library. There are privacy issues around that about talking about important things.

I'll mention it now—it's more related to the e-mental health things than telehealth, but they're all sort of IT addressed. The technological literacy and the literacy levels required to do that are often beyond many people. We often set up health services that are convenient for people like me, who work at a computer on my desk and are used to using the internet and finding services like that and are really comfortable doing that. That's often not the case for people without as obvious access or not quite as easy access, and also where the relational aspect is really important to them—about engaging with a human being and talking about a problem together to solve that. There's no doubt that telehealth is really important and adds something to face-to-face care, but it doesn't replace it. We need to do it in a way that doesn't worsen health inequities just because we assume that everyone can do it.

The Hon. SUSAN CARTER: Could I just ask for one quick comment from each of you about sufficiency of training, especially in light of the ability to build that therapeutic alliance for everybody involved in mental health care, including those in general practice and other clinicians, and the extent to which that needs to be learnt from senior colleagues? What issues might exist in that training if there aren't enough senior colleagues available?

TIM SENIOR: In theory, GPs are taught. It's a core skill in general practice. We have training in both communication skills and different ways of engaging with people of all sorts of different backgrounds. We have training in the ways of running a consultation—so being aware of the dynamics of what's happening in the consultation. That's part of the GP curriculum. It's a core part of GP practice, philosophy and teaching. It is something that GP supervisors in training—qualified doctors doing their GP training—will be taught, as well as medical students.

The experience of many of our patients tells us that that's not always their experience. I think there's a disconnect there between what many GPs are doing and talk about amongst ourselves and teach and research,

where there's a large body of that work, and then the experience of many patients where that's not what they experience. Sadly, they get to feel that the more transactional, short, quick consultation is what general practice does. That's actually not the strength of general practice. It's a really important part of our training but, sadly, it doesn't filter through to every patient's experience. Frankly, it should.

The Hon. SUSAN CARTER: Mr Brereton, do you have a quick comment on training?

GRAHAM BRERETON: Yes. Some people are very good at talking with other people and engaging them and are able to put them at ease, but that's not true for all clinicians, by any means. I think it is a learnable skill, but it's not a skill that really is taught in a way that identifies its central or crucial role for what's going on. Clients, patients, are exquisitely sensitive to—as we all are, really—the anxieties and prejudices of clinicians, who don't have to say anything for them to know that they're getting a bad deal. They usually have made their mind up about that within about 30 seconds of meeting you.

The Hon. EMILY SUVAAL: Thanks so much to you both for attending today. I might start with a question directed to you, Mr Brereton. Dr Senior, please feel free to also comment if you have thoughts around this. I was interested that in your submission, Mr Brereton, you mentioned the assertive community treatment, or ACT, model, and in particular its decline or its disappearance. Could I get your thoughts on what you think has led to that decline and what it would take to bring that back to the forefront, if you like?

GRAHAM BRERETON: When I went to work in the community, that was a bit of a watershed for me. I went, "Oh, wow, you can actually do things that are really quite constructive with people." The amount of time that you're willing to devote to someone and the perseverance and the willingness to put yourself out makes a big difference to engaging that person. I won't elaborate at this point, but community treatment orders have quite a deleterious effect on that process.

But over what's been a fairly long career, the understanding of those core elements of intervention, which are outlined in the Richmond inquiry report very distinctly, have vanished. One of the things is the lack of valuing or understanding of community mental health interventions as actually being something quite distinct from hospital interventions and medication interventions. The other thing is that people come up with new ideas which are actually parts of the assertive treatment sort of thinking. So you'll get early intervention and this sort of care or that sort of care, and it takes people's view away from the bigger picture. Yes, I'll stop there. Tim?

The Hon. EMILY SUVAAL: Did you have anything to add?

TIM SENIOR: Yes, I read your submission and was very interested in this model, because I hadn't heard of it before. But, actually, my understanding of it would be that those are some of the key features of primary care at its best—about knowing your patients well and following them up actively and, where there's higher need for that, doing that more assertively. One of the problems with primary care at the moment, or general practice, is that we're only funded when we see patients. By definition, that model isn't well funded in general practice.

It remains to be seen whether MyMedicare will help with that. It's not clear how that's going to work yet, but there's a possibility that that will allow some funding for management of a patient population, which would include that sort of assertive follow-up. But whether that would be approachable—I'm fortunate enough to work in Aboriginal community control, and we have a separately funded, outside Medicare, social and emotional wellbeing team. They do much more of that sort of model where they can assertively call people and follow them with Aboriginal mental health workers and just keep a really strong, close eye on people, help them attend appointments and just provide support at moments of crisis or before moments of crisis. I think that assertive follow-up model, whatever it's called, is actually going to be core for many people, particularly with higher needs, in the mental health system.

The Hon. EMILY SUVAAL: I suppose that is a good segue to my next question to you, Dr Senior—but again feel free to comment, Mr Brereton, if you have input. Dr Senior, in your submission you mentioned the coordination of care generating no rebates but that the care, which is predominantly provided by female GPs, is one cause of a significant gender pay gap in the profession and is also cognitively and emotionally taxing, leading to burnout. Of course, the Committee is going to make recommendations to the Government. If we were going to make a recommendation around this, what would it look like?

TIM SENIOR: That's a really good question. I think we, to some extent, come at the divide between State and Federal. I think you may not have that much influence about what Medicare rebates do for funding that. It's quite possible that the New South Wales Government could say, "This is really important, and we'll tip in some extra money for primary care treatment of mental health." I attended a NSW Health workshop on encouraging GPs to have difficult conversations with patients recently. That provoked some really interesting thoughts in me. One of the most useful things that NSW Health could do would be to provide clinical supervision

and support for primary health workers, so GPs, but including other primary care staff to prevent burnout and keep people working in the areas that they work in.

I drive in to work every day feeling anxious about what the work is going to throw at me. That's usually related to complex mental health; it's almost never related to minor surgery that I've done. That's the sort of emotionally draining—and we take active steps to look out for each other at work. GPs do that, but it's quite informal. I think psychologists and psychiatrists have clinical supervision but there's very little scope for that in general practice. That would actually be something that would be a practical step that could be taken: formal clinical supervision supports to prevent the emotional burnout from high mental health loads.

The Hon. EMILY SUVAAL: Thank you. Mr Brereton, do you have anything to add?

GRAHAM BRERETON: I think I made a suggestion in there that GP practices would benefit from having a mental health worker who was specifically about actually maintaining the relationship with a client. The idea of being assertive really means being proactive in the care of someone. For a GP, they're not really in a position, with clients coming and going, to chase people. That's something that I think has been lacking from GP practices generally. Having someone who actually rings up someone and says, "Hey, you didn't come in for your medication or you missed your appointment", for mental health clients would make a big difference to the outcome and relieve some of the stress on GPs. Someone not showing up who expressed suicidality last time they saw you is actually quite a burden to deal with on a day-to-day basis. There's lots of other permutations along that sort of scenario.

The Hon. EMILY SUVAAL: That would possibly require a better integration between various components. I note that Dr Senior also mentioned in his submission, specifically thinking about telehealth, their inability to run alongside that face-to-face care without integration.

GRAHAM BRERETON: Yes. There are, on the part of community mental health services, efforts to integrate patients into GP care. That's been prompted by recognition of the physical health problems that come with mental health problems or vice versa, but that's still a very difficult process. I have a good friend for whom that's one of his main areas of endeavour in his job, and he throws his hands up in horror some days. It's something that could actually be worked on to improve services generally. It's the talking between the different parts.

The Hon. EMILY SUVAAL: Did you have anything further, Mr Senior?

TIM SENIOR: Yes. The health system, particularly the mental health system, is really complex. I think it's difficult enough for practitioners to navigate that. For patients, it's really difficult. I think it's worth acknowledging that mental health conditions aren't just a condition that exists independent of that. It actually takes away people's ability to navigate the system, either through anxiety or through the sheer effort that that requires. People are anxious about the attitudes that they will meet when they come into contact. It's a really complex system to navigate even for those who know the system. Having care coordinators who know that—and I have seen this work really well with patients, where they have a care coordinator and navigator who walks with them around the system, comes into consultations with them and, with the patient's permission, can advocate for them about what's happening.

I don't think the system will ever not be complex, but I think that recognising it's complex and there is a burden of care—and that for many patients who have other co-existing conditions as well, they can be bombarded by multiple appointments, multiple multidisciplinary teams all contacting them, and they are not sure who's from where and what their role is. It can be really difficult for patients. I think that coordination of care and care navigation can go a really long way to helping people around a complex system.

The Hon. EMILY SUVAAL: Who would be best placed to do that care coordination, would you say?

TIM SENIOR: We almost need to create a new role called "care coordinator" or "care navigator". I've seen Aboriginal health practitioners do it really well. I've seen people from non-government organisations like One Door Mental Health do it really well. Some GPs and practice nurses sort of squeeze it in around the edges of the work that they do for patients who they are really concerned about. Family members and carers are often really important in doing that, too. I think we can't underestimate their role in doing that informally and often without knowledge of the system.

The CHAIR: I have a question for Mr Brereton, but please feel free to comment as well, Dr Senior. I was interested in your description of your experiences of community treatment orders under the Mental Health Act, which you described as sometimes being put in place for the convenience of the service. I was hoping that you could expand on that.

GRAHAM BRERETON: I don't think it's just community treatment orders that are co-opted into—when I say "convenience of the service", I really mean management of workload: "What's the best way of actually

managing this situation given the resources that we have?" Community treatment orders look like they save time—and they actually do shorten the length of stay in a hospital—but that doesn't necessarily make them beneficial. They are coercive in their very nature, and people already start from a base of not having a sense of autonomy over their own lives because of their mental illness and the treatment they receive from other people.

A community treatment order doesn't necessarily mean that you can't build that person's sense of autonomy but it makes it a lot harder, and the health services don't really address that direct on. For example, I have searched long and hard and there are not clinical standards for applying or using a community treatment order, which should really be thought of as a therapeutic tool. There are no guidelines for how you might do that—how you actually explain it to a client, how you work at separating the compulsion for treatment from the other things going on in their life. Usually what happens—not with everyone, by any means—is that the person becomes very focused on the idea that their autonomy has been taken away and all the other work goes out the window. Does that answer that?

The CHAIR: It does. As you would know, under the Mental Health Act, CTOs are only supposed to be used as the least restrictive means and only where they are needed to keep somebody in the community safe. I am interested in recommendations we can make to support people to minimise their use.

GRAHAM BRERETON: One of the most striking things, in my experience—I'm sure people do it differently in other locations or wherever—is that the process of explaining a CTO and of implementing a CTO is essentially controlled by the hospital. So that is the hospital staff, and they're not ill intentioned or anything like that. But the person who actually administers or has oversight of a community treatment order is actually working in the community and, generally, when someone starts on a community treatment order, the patient and the clinician are unlikely to have even met let alone had an in-depth discussion about what they're trying to do. So, in terms of guidelines, I really think that it's a no-brainer that the person implementing the order should actually be there discussing it with the client in the hospital. But that's actually very time consuming and often doesn't happen.

TIM SENIOR: I would agree about the autonomy point. I have—not specifically community treatment orders, but—a patient who frequently feels suicidal but is really reluctant to go to hospital because this patient fears that they will be scheduled under the Mental Health Act. I have had more than one person where I have given them information about the NSW Mental Health Tribunal, which, I think, from looking at it, is a really good organisation in terms of being able to give people the right to review schedules under the Mental Health Act. I'm not sure how well it's resourced, and certainly many of my mental health patients don't know that it exists. That's, sort of, protecting their rights by doing that. I would say, community treatment orders—there's always going to be some necessity, I think, for them, in terms of keeping people safe and keeping the community safe.

GPs feel very distanced from that sort of service. I know of one person who was getting side effects from the treatment under a community treatment order, and the patient was just, "Well, I'll go to your GP. They will adjust the treatment." But the GP didn't know what the community treatment order had in it. It should really have been their responsibility. Either the GP should have known what was in the treatment order, or the people conducting the treatment order should have been adjusting the treatment. I know of another patient who—the people doing the community treatment order couldn't find the patient, and so the GP said, "Can you find the patient for us?" The GP didn't know about the community treatment order. It turned out the patient was in jail. I think it's not a joined-up system, when that's happening. I think we need a system, not multiple little bits of systems.

The CHAIR: Following up on that comment, how could we improve that collaboration or information sharing to bring those bits of the system together?

TIM SENIOR: I think a community treatment order should include the members of the team on it and who's responsible for what. I would say that should include, maybe, a nominated GP and that the practice that the patient attends—if they don't attend one, then one should be found—is included in that treatment plan. I think that would be the simplest thing, so it's viewed as a team and that those people are working together with the patient and that, even in a community treatment order setting, the patient should have as much autonomy in planning their treatment and convenience for them, because that is going to make the treatment more effective, even if it's compulsory. I think those would be the two principles, really—that it's going to be team-based care, because it's more complex and so everyone in the team, and that should include GP primary care, should get copies and be actively involved in the care.

The CHAIR: I have another question about ADHD, which you mentioned in your submission, Dr Senior, and we've heard about the issues with people receiving treatment for ADHD and also adult diagnoses of autism in other evidence submitted to this inquiry. I was hoping you could speak to some of your experiences with patients experiencing that and what recommendations we could make to improve that.

TIM SENIOR: Yes, it's complex. If you take a life-course view, we have a lot of children diagnosed with ADHD. Currently our paediatricians—this is in Campbelltown, south-west of the city. In the city, our paediatricians are retiring. We are really struggling to recruit paediatricians that will bulk-bill or be in the public service. The GPs I work with, including myself, have been given special dispensation to continue prescribing stimulants for the patients of one of the retiring paediatricians. That's really unusual in New South Wales, so we're really grateful for that. That's worth watching, because Queensland do it, and that may be something that allows people access to care. At the moment that's only for established diagnoses and continuation of treatment. It's not changing doses, but that's a good start.

We have teenagers transitioning to adulthood who will need to find adult psychiatrists or physicians able to prescribe. We have no bulk-billing adult psychiatrists and very few adult physicians who manage this. The public system won't see them. The PHN psychiatrist is an explicit exclusion, so we are really stuck about how we actually get care for those patients. Even to start prescribing stimulants that then we might continue—at the moment, we're not allowed to continue. We see quite a number of people, where they look at their symptoms and think, "Maybe I have ADHD or maybe I have autism spectrum." But the assessments for those all cost several hundred dollars, which is way outside the price most of my patients can afford. So we end up being stuck about getting that assessment and starting treatment. We share places that—there may be somewhere in Wollongong that does slightly cheaper neurodevelopmental assessments.

But it's really unsatisfactory, and I think the recommendations that I would make would be we need a method of doing a comprehensive neurodevelopmental assessment or neuropsychiatric assessment that's available free or at very low cost for people who can't afford it. We need access to paediatricians and psychiatrists who will bulk-bill in the public system or will see them in the public system for free or very low cost and be able to manage adult ADHD and autism. And we need GPs to be able to, at the very least, continue prescribing stimulants when started by a specialist. And I would argue that GPs are expert enough to be able to adjust the doses for many of those medications. We do manage a lot of really complex medications and do it well and often in consultation with specialists. I think those would be the three steps I'd take.

Ms CATE FAEHRMANN: I was hoping you could expand on the impact of the lack of drug and alcohol and other drug detox and rehab services which was, I think, in your submission, Dr Senior. If, for example, there was somebody that presented to you with an ice addiction that was contributing, where would you be able to send that person if they wanted to get into treatment straightaway?

TIM SENIOR: That's a very good question. It happened to me only a few weeks ago. This is a really instructive story, actually. This is a person who wanted to get off ice on that day. We were really lucky in having a social and emotional and wellbeing team that has drug and alcohol workers with them. They were able to get them into detox, I think, two weeks later. That's really fast. Actually, when people make a decision like that, about that about wanting to stop an addiction, the time to intervene is now. So often, a normal length of time might be three or four months waiting for a detox, which—with putting people back in the circumstances that they respond to their stress by using drugs and all those triggers that they have had, lifelong, that provoke the use of drugs. We're putting them straight back into that situation, and by the time that the appointment comes up, their ability and desire to stop using drugs may well have faded or taken a different course.

This patient got in. She had a really good experience in detox. Inpatient detox arranged for her to have inpatient rehab afterwards, as well. So this was going really smoothly. She turned up for—and rehab, currently, is really difficult to get as well. The beds are not easy to get. She turned up. She'd left her glasses in the car. They decided that she couldn't read and write, so she couldn't consent to the program—couldn't sign the consent forms—and they sent her away back home. She was saying, "My glasses are in the car. I can read it." They said no. She said, "Well, read it to me then. I will sign it." And they said, "Oh no. You need to be able to engage in the program fully." She was fully able to, but they decided, for some reason, that they didn't want to. She went back into the community. She did really well, supported by our drug and alcohol worker in an assertive follow up-manner. She did really well, but it wasn't because of the rehab services; it was despite them.

I was really saddened and shocked by that story, but sadly not too surprised. Beds are really difficult to get into. Often they're quite good when you do, but the number is really low. Actually, what we would really like is the capacity to say, "You want to detox now? We can do it now." There are some really good programs for home detox from alcohol that may come through other drugs as well—not the more complex end of the spectrum, which is a bit more difficult—and it requires really good follow-up through the week. All the GPs where I work are part-time, so it requires really good coordination between us all, if we were going to do home detox over the week, and good monitoring by ourselves and by the nurses. It is doable. There are some really good programs for doing that. But it's not for everyone and it's not for the more complex detoxifications either.

The CHAIR: We started this session late so I'll allow one last question.

The Hon. SUSAN CARTER: I'm looking for a quick answer to a complex question. We've heard about the need for assertive care. Could you talk very quickly about how we balance assertive care with patient autonomy? For example, someone who is suffering presents to a carer and says, "I'm going to take my life." The carer then rings a mental health service, which speaks to the person struggling, who says, "No, I'm fine." Assertive care and patient autonomy—how do we find a balance between the two?

GRAHAM BRERETON: Assertive care is really about making yourself available. That speaks to the importance of actually being willing to knock on someone's door and visit them. They may send you away. That is, they may not recognise that they have a mental health problem. But if you're being assertive about it, you come back and knock again. It is really quite easy to say that the client refused services, but that is not addressing the problem of them not understanding their problem in the first place. Being assertive really is about being patient with the client's developmental process in understanding their issues. I guess that is one of the problems with community treatment orders, that it doesn't nurture that understanding.

The CHAIR: Thank you both very much for the time you've taken to prepare your submissions and to give evidence today. The secretariat will contact you regarding any questions on notice.

(The witnesses withdrew.)

Dr ANGELO VIRGONA, Chair, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists, affirmed and examined

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

ANGELO VIRGONA: Yes, I would. Thank you for the opportunity. I take the opportunity to pay my respects to the traditional owners, the Gadigal people of the Eora nation, and apologise for the events of the weekend, which is going to have searing consequences, I think, for members of the community. I'm really grateful for the opportunity to be able to talk to you today. I come to this with two hats on, really, representing the psychiatrists in the State. There are 1,400 psychiatrists and approximately 600 people training to be psychiatrists in New South Wales. But also I've been involved with a mental health alliance over the course of the last 12 months, which has come together to advance the cause of mental health in New South Wales, given the perilous circumstances that are faced here.

Before the last election we came together and were pushing the point that New South Wales has been really underinvesting in mental health for a long time. We are now the lowest spend per capita on mental health in the country. We've been rapidly overtaken by Queensland and Victoria after their royal commission and parliamentary inquiries and significant investments that emanated from those. We felt that it was really time that we put this on notice as a coalition of organisations. Too often in the past, I think, our sector has been fragmented and we've all come to people like yourselves asking for enhancements or investments in particular areas, pushing our own barrows. We felt that this was counterproductive and that we really needed to come together to present a single view about the state of play in New South Wales and what was required to fix it.

The CHAIR: Thank you very much. I will start with my own question. In your submission you mentioned a recommendation around a centre of excellence for trauma-related disorders. What are some of the current issues or barriers to good care being provided for those people who have experienced trauma?

ANGELO VIRGONA: Trauma is ubiquitous. We're seeing it more and more in people who are presenting for care—both for psychiatrists, mental health services generally and psychologists. We are hindered by a lack of psychotherapy resources for people suffering from these disorders. We know that psychotherapies of various types—evidence-based therapies—work for people with trauma-related disorders such as post-traumatic stress disorder and complex post-traumatic stress disorder. The availability of those therapies is extraordinarily limited. There's a limited numbers of psychiatrists who practise those therapies, and there are costs associated with it. Similarly, with psychologists who are skilled in this manner, there are only a few sessions of psychological therapy that's funded under the MBS. Being able to fork out the \$250-plus a session after their 10 sessions is prohibitive for most people suffering these disorders.

For many, because of the nature of the disorders they have suffered in lots of ways in their lives—and they often have really particular social problems—they don't have the income to be able to afford therapy, and there's a real dearth of therapy options in the public sector system. In the public sector system you've got sexual assault services for acute distress. You have community counselling services—that is available here and there but doesn't offer long-term therapy to people. Some mental health services in the State offer dialectical behaviour therapy programs, which is a treatment which was designed for people with borderline personality disorder. But most of the people diagnosed with that disorder could also be diagnosed with a complex post-traumatic stress disorder. The problems that have developed, resulting in the diagnosis of borderline, usually occur as a result of early life and cumulative trauma.

We wanted to turn a spotlight on this. NSW Health has funded Project Air at the University of Wollongong over the last decade. Their remit was really looking at providing education around borderline personality disorder as well as interventions. They have been behind what is called the Gold Card Clinic intervention, which is basically for those who are presenting to emergency departments with deliberate self-harm or suicidal ideation—being able to give them the opportunity to have follow-up after discharge from the emergency department. That's in place in New South Wales and probably has led to some reduction in re-presentation rates to emergency departments, but it doesn't offer any sort of long-term solution for people with these really complicated disorders.

We wanted to focus attention on this and perhaps the first port of call was to actually get a body of evidence together, get the experts together, develop a centre of excellence and do a similar job, I think, to what Project Air has been partially funded to do and that is to educate NSW Health staff and the broader community on complex trauma and also provide a tertiary level assessment and potentially treatment service as well. In Victoria they have—sorry, I have to remember the names. They have Spectrum, which is a much better funded service for those with borderline personality disorder, and Phoenix, which is also a service for people with

post-traumatic stress disorder. They are much better funded services in Victoria. People have much better access to these. They have the same problems with people getting ongoing therapy in the community, because therapy is going to take quite some time, but at least they've got those sorts of basics in place that we don't have in this State.

Dr AMANDA COHN: For those people who've experienced complex trauma, how relevant is it who the provider is of those psychological talking therapies? We've seen from the evidence to this inquiry that a lot of programs are funded separately in silos so people can access however many visits from one service or however many visits from another service. How does that impact the recovery of people who have experienced trauma?

ANGELO VIRGONA: Enormously. It's a dog's breakfast, really—the funding of services to people. We have people who may be able to get access to a number of services through the victims compensation system. Some people get access to psychological therapies through their NDIS package if they've been able to get an NDIS package related to their disorder and disability. Through the private sector services, as I indicated before, you get a limited number of sessions. I'm now working at the—Ramsay run a unit in Thirroul for women with complex trauma, essentially. What we found over the first year of that place—well, I knew this beforehand really. But it's really that you see people that have had repeated attempts at trying to engage in psychological therapies with people. Usually, because their session limit is reached and they can't afford it, that stops. Then they wait for the next crisis before they get another mental health care plan from the GP and start all over again. It's a retraumatising process for them, having to re-engage with somebody new and try to develop a trusting therapeutic relationship.

The Hon. WES FANG: You'd obviously be familiar with the "on the brink" report. Are you able to provide some insights as to what response you've had to it, particularly from the Government, since it's been released?

ANGELO VIRGONA: The "on the brink" report was the report that we commissioned before the election. We did a survey of all—we cast the net as widely as possible to people working in the mental health field in New South Wales, not only in the public sector but also in the private sector and the community-managed sector. We had about 1,400 responses. About 870 of those respondees actually gave us text about their experiences, about what was wrong and what they thought was needed to fix the issues in New South Wales. I think it was a report that grabbed some attention. We were pleased about that. The Government and Ryan Park, before the election, read the report.

We had three key recommendations in the report. They were that we needed to perform a gap analysis of mental health services in New South Wales—by that, what I mean is, for the State-funded services, we don't really have a sense of the quantum. We don't have a sense of exactly where we are, exactly what the models tell us we should have in terms of services and what the gap is. So we really wanted that analysis to be undertaken and that to be done in the first year of the next Government. We got an undertaking that there would be a gap analysis. Since that time we've had discussions with the mental health Minister and a gap analysis is being undertaken. It's not quite the gap analysis that we wanted.

I've got another hat. In my role as a representative of the alliance, I sit on the project team with department operatives and the Mental Health Commissioner and a consumer representative, who are charged with this gap analysis. The terms of reference have narrowed somewhat from the broader one, but we are still reaching out to the Minister. We will cooperate with anything that's being done to try to define what gaps there are and where the priorities should be. That's what we'll be doing—presenting the Minister with some priorities. But that does not mean that we don't do the comprehensive gap analysis. Because, without that, we can't do the type of serious service planning and prioritisation that needs to be done to see New South Wales catch up. I mean, we're so far behind at the moment and we really do need to catch up. It's going to take significant investment.

That was the first point—the gap analysis. The second point was that we need reform of the sector. You would've heard from Dr Senior and no doubt just about everybody else who has talked to you about what a hodgepodge of services there are out there, how it's impossible for people to navigate them. There are probably a lot of inefficiencies in the system as a result. We've got intake systems all over the place, assessment systems all over the place of varying qualities. How to bring some coherence to that is going to take some real serious thinking between the State Government and Federal Government. We see that as being really essential for the next Commonwealth-State mental health agreement.

The third arm is really talking seriously about investment. We know that in Victoria and Queensland, the governments there are levying companies with payrolls over \$10 million a year to provide additional funds. You are not going to see any reform of the sector in New South Wales by us doing pre-budget submissions and the Minister trying to eek another couple of percentage points out of the Treasury with each budget. This is going to require major investment and the order of magnitude in Victoria is around \$800 million a year. In Queensland they've committed to \$400 million to \$500 million a year extra; this is new funding into mental health. That's what

we're talking about in New South Wales. It's going to take something really significant to change the landscape and to provide the services that people deserve.

The Hon. WES FANG: So the budget that's just been released hasn't really seen a dramatic increase of a similar magnitude to what we've seen in Victoria or Queensland?

ANGELO VIRGONA: No, absolutely not. There's been no real new money in mental health in the current budget. We weren't anticipating that in this budget at all because we see this as a plan that has to occur over time. We've got to get the planning right first and determine the quantum and then work out how to reach that.

The Hon. WES FANG: Obviously the planning is important. But in effect the gap analysis is not what you would consider to be best practice at the moment. It's sort of a subpar gap analysis that's occurring at the moment, is that right?

ANGELO VIRGONA: This is a temporary thing to create priorities for investment. I think the more comprehensive gap analysis is a bigger body of work that'll take six to 12 months. We know that from the Queensland experience, where they did this and they were able to work out exactly how far they were behind in various areas and age groups and then they were able to prioritise who they were going to focus the investment on first.

The Hon. WES FANG: Have they given you a commitment to following through with the wider gap analysis as well? Or have they only committed so far to the more restrictive?

ANGELO VIRGONA: We haven't had a commitment to the broader analysis yet. But we're working on it. We're hopeful that we're going to get there.

The Hon. WES FANG: There's no commitment in relation to funding or additional funding for what priorities might be identified out of the gap analysis, whether it is a restrictive one or wider one later?

ANGELO VIRGONA: Yes. There's no commitment for funding at this point in time.

The Hon. WES FANG: You talked about the priorities. What are the priorities, do you think, for community mental health, moving forward?

ANGELO VIRGONA: I can tell you what I think. This is the problem. People like me and from across the sector have been going to the Ministers and saying, "This is what I think we need to spend money on. We need to do this or that." We haven't really had that sort of scientific analysis of the problem. So I'm loath to nominate things. I think, from the previous Government, we had great investment in child and adolescent services with the Safeguards program. That was really welcomed. We also had novel investment into headspace centres in New South Wales. I'll declare a conflict here. At the college, we led the charge with this one. I think, with headspace centres in New South Wales, people often complained that kids were being turned away, saying the problems were too difficult for the headspace staff or too complex for headspace staff to be able to handle. We had a lot of junior staff in headspace, very little input from psychiatrists and clinical psychologists.

We saw, in the fallout from COVID, that to invest quickly, to ramp up a service quickly to meet the obvious needs in the youth mental health space, headspace was the place to do it. The Government took the initiative and invested money across New South Wales so that there are psychiatric services available to all headspaces in New South Wales. Universities are now putting many more clinical placements in there, clinical psychologists, OTs, social workers, building the capacity of headspace, as well as GPs. The funding model for headspace previously made it difficult to attract people because it's a bulk-billing model. Very difficult to get psychiatrists or GPs to go and work in them. But this was a contracted model, which made it more attractive.

The Hon. WES FANG: Lastly, in general, how do you see the state of play for New South Wales perhaps versus other States? Where do you think that the priorities are? With both hats, acknowledging that you are here in two different capacities, in effect, I guess the college would have one view, but perhaps the alliance or the coalition which you're a member of as well might have a slightly different view. Do they typically align? Or do they have a different view as to the state of play within mental health services in New South Wales?

ANGELO VIRGONA: I don't think so. Since we've come together, I think people have a real appreciation of the viewpoints of the other parts of the sector. We see a need for more investment into a peer workforce and a carer workforce. We see the need for increased accommodation support through HASI, which has been a terrific success in New South Wales, but it needs major further investment. But I think the most pressing problem for all of us is really workforce. I think workforce is the elephant in the room when it comes to mental health. The National Mental Health Workforce Strategy was released last week. It makes for really sobering reading. The extraordinary shortfall in positions across Australia is just extraordinary. In New South Wales, it's

no better. We see a particular problem in, obviously, rural and regional areas. So I think that's going to take a real focus.

I'll give you as an example Campbelltown has been planning and building a new wing with mental health services accommodated there. I can't speak most recently, but until recently they hadn't had the funding to be able to actually open the extra space. If they did have the funding, can they get the workforce? It's extremely difficult to get psychiatrist trainees in New South Wales. I'm working with the AMA and ASMOF, communicating with the ministry and the Ministers' offices around the workforce crisis affecting psychiatry in New South Wales, but it affects the whole sector.

The Hon. WES FANG: Is that a Federal—it's a State conversation.

ANGELO VIRGONA: This is State.

The Hon. WES FANG: It's predominantly, I guess, a Federal issue, really, from a training perspective.

ANGELO VIRGONA: It's chopped up. From a university's perspective, it's a Federal view. If you want more psychologists, the Feds have to fund them, which they did do, I think, in the last budget. They funded another five or six hundred places, I think, for psychology undergraduates across the country, which is important, but it's nowhere near what's going to be required to meet the shortfall. In psychiatry the Feds fund a little bit. They'll fund some special training experiences, particularly in areas that are difficult to attract psychiatry. In rural areas they fund quite a few positions. But in metro areas, essentially, the State fund all the training positions, pretty much.

We're seeing a real difficulty with attracting new trainees to New South Wales. Victoria, probably, I'll exaggerate a little, but they had twice the number of people applying for psychiatry training posts in Victoria as we had in New South Wales. I think part of the problem is we have the lowest awards, employment awards, New South Wales, for trainees as well as staff specialist psychiatrists, so people are leaving staff specialist positions. They're getting harder to fill. We're relying much more on locums. We have an extraordinary number of locum advertisements at any one time in New South Wales.

The Hon. GREG DONNELLY: Thank you very much, Doctor, for coming along and your submission, which is very helpful. My question's very general in nature. You might take it on notice if you feel you need more time to answer it. But, if you can, answer it now. Specifically with respect to children and young people and the matter of mental health, in trying to help understand what's required in terms of both the individual clinicians involved and the time required to make a diagnosis of a young person who—I shall use the term—as a patient comes along with a mental health or supposedly mental health challenge, what are we looking at, not what that's actually happening in the way you've described how things are—very, in some respects, dysfunctional and underfunded et cetera—but what would it take, as a professional, as a minimum requirement or a minimum amount of time and investment to undertake that diagnosis to find the morbidities or comorbidities, just to give us a benchmark of sorts?

I mean it as a genuine question. I know it's almost theoretical in some sense. Obviously, with the dearth of resources and those coming forward for training and all these complexities that you've raised—take them as all valid—we, obviously, want to achieve an improvement, but achievement against what are the benchmarks or minimum requirements required that we should be trying to move towards?

ANGELO VIRGONA: It's such a big question. I'll take it half on notice. I'll give you half an answer. I think being able to provide a coherent, organised, multidisciplinary assessment of someone is really difficult. We're trying to do that, I think, with the Safeguards model in New South Wales so that kids are getting a more comprehensive assessment through that program. I think that that's the sort of thing that would be required across the age ranges, really. Who does it? Who's going to do that? This is the problem.

We've got from the GP who doesn't have time to see people to perform a comprehensive assessment, if they felt that they had the skills, through to psychologists, if you can access them now, psychiatrists, if you can access them now, the community mental health team, who will not really perform assessments of people from a diagnostic perspective unless there's some sort of crisis that's occurring in that person's life or they're being looked after under the Mental Health Act with a community treatment order. There are so many people. Pat McGorry called them the "missing middle". I call them the "missing severe" because if we say "middle", we think they have middling problems, but they do not. They have moderate to severe mental health problems, and these are the people who fall through the gaps such that they're not getting that comprehensive approach.

The Hon. GREG DONNELLY: With that comprehensive approach, is that generally accepted as the preferred, dare I say gold-standard model?

ANGELO VIRGONA: Of course. Yes.

The Hon. GREG DONNELLY: I take it as a given, but I want to get it on the record. That is seen as what we should be trying to pursue?

ANGELO VIRGONA: Without a doubt—a comprehensive, multidisciplinary assessment by a team of mental health professionals, including psychiatrists, psychologists and, depending on the range of disabilities that people are suffering, then it may include occupational therapists and social workers. Mental health nurses are often part of that picture as well. We do not really have functional, multidisciplinary teams beyond these now developed safeguard teams in New South Wales. People may take me to task in the older persons' realm. They exist too, but the teams aren't really big enough or funded well enough to be able to perform a service to a lot of people.

The Hon. GREG DONNELLY: The engagements with the person to examine, discuss, reflect and talk, to work through for that diagnosis—that takes a series of sessions? I know this sounds like a naive question, but it is just for the record so we understand what we're confronting here.

ANGELO VIRGONA: It depends on the person; it depends on the nature of the problem. Sometimes you can do a comprehensive assessment with somebody on your first meeting and you can do a pretty accurate job. For others, there may be difficulties for them with engaging and difficulties with trust, among other issues, and it will take a bit more time before you can come to an opinion. In psychiatry, I've changed my diagnostic impressions of people who I've been seeing over a long period of time. Nothing is set in stone. However, in most cases we can be pretty accurate early on.

The Hon. EMILY SUVAAL: Thank you, Dr Virgona, for making time to attend today and for your submission. I have two questions today. The first is with regard to the service integration that you talk of and, specifically, the models of integration in the context of the next Commonwealth and State mental health agreement. I wondered if you had thoughts or further commentary about what the models are and which is superior?

ANGELO VIRGONA: There's no idea about what's superior because the models really haven't been tested significantly. The Productivity Commission inquiry had recommended regional commissioning authorities where you would pool the funding from the State sector services with the primary health network funds. Primary health networks receive about 10 per cent of all the funds that the Feds spend on mental health services. So it's a reasonable amount of money. But I think if you compared their spend within a local health district with the local health district spend, it would be significantly less. Nevertheless, the idea was that those funds would be pooled, and then a commissioning authority would be developed that would involve the major stakeholders, but basically driven by the State, to look to provide services to a broader population than is currently being seen by the State sector services. That was one model.

All these models have excluded the MBS. There had been models in Aboriginal health where the MBS items have been included. What they'll do is for an area where there's a prediction around how much MBS should be delivered to that community—that's psychology and psychiatry—those funds would be pooled with the State sector funds to form one big pool of funds. Then a central group—the Aboriginal health corporation—would deliver services. I saw data some years ago on that for the Kimberley which was positive, but I haven't seen data in more recent years to know how that works. That may well be a model that would work in more regional and remote areas where there's a real maldistribution of MBS-delivered services. So they're not getting their chunk of psychology and psychiatry, and you have to make a population adjustment of them and say, "This is what they should be getting according to what everybody else is getting." That may be a model that works regionally and rurally. It probably wouldn't work in metro areas.

My take on this is that we need to perhaps identify two or three models, and we need to test them. I've been arguing that we've been in a state of mess for such a long time. Let's not continue to mess it up and come up with another half-baked proposition. Let's test some things out, out in the field, and see how they go, both in the metro and in the rural areas. That is my short answer.

The Hon. EMILY SUVAAL: As a follow-up, with the regional commissioning authorities that you spoke of, do you have a view as to who would be best placed to coordinate that, or are we setting up another body? Would it be through the PHNs or through the LHDs?

ANGELO VIRGONA: No, I think the LHDs know what they're doing when it comes to running things. COVID proved to us that the States do the heavy lifting, and they have got the experience of operating services and businesses. I think that you would leave it in the hands of the State but in close partnership. Obviously the Feds are going to have an engagement with it.

The Hon. EMILY SUVAAL: Thank you. That's very interesting. The second question was around the Productivity Commission report that you've quoted in your submission regarding the amount of working time

community clinicians spend in clinical contacts, which is 29 per cent. I wanted to get your thoughts about this. What are the reasons for it and how can it be improved?

ANGELO VIRGONA: The reasons are probably many. That 29 per cent wasn't everybody. I think that was one particular service that they focused on. But most people who are aware of the services would see there's a lot of time that isn't spent in face-to-face clinical care. They collect a lot of data. A lot of data is collected and nothing is done with it. That's what is done in mental health. When I was managing mental health services a decade ago, we were allocating time each day for the staff to make sure they put in the data about what they'd been doing for the day, because we were always under threat for not being funded if we weren't delivering. It never happened. We were never defunded if we weren't collecting as much data as the area health service or local health district next door. But nevertheless, everyone was in that mindset.

A lot of time is spent on risk management and ticking boxes to make sure that you've covered all your bases. The other thing is there's a lot of time spent in meetings and determining whether the service is going to see somebody or not. I've been in meetings where we've had half a dozen staff members sitting in a room for an hour. They talk about one client and determined that they are not going to see them. In all the time that they spent on it, the patient could have been seen and their problems dealt with. Maybe I exaggerate a little, but that sort of thing is not atypical. There's a bit of a siege mentality in community mental health services, because they are hammered. They are inundated with demand, and they've had to put the blocks up to be able to maintain coherence for the service. They may be some of the issues. I'm sure that somebody has written in a more scientific way about it.

The Hon. EMILY SUVAAL: It is particularly interesting based on some of the other evidence we heard this morning about the merit in having that assertive community treatment model and, indeed, the merit of treating someone in their own home and going up and knocking on their door.

ANGELO VIRGONA: Regarding the assertive treatment model, when I was a boy—we can all say this—we used to buy a whole lot of cars and we would be driving around in cars and we were doing a lot of home-based treatment. Now there's a lot less of it. A lot is it around work health and safety. There are places that you don't send your staff because the areas can be dangerous for them. A lot of work is done over the phone, increasingly. I've been in a situation where one of my patients has been admitted to the public hospital, they get discharged and they've got to have their mandatory follow-up after discharge. I said, "What happened?" and they said they got two phone calls. So there's a lot of phone call follow-up that's going on because of demand.

The Hon. SUSAN CARTER: If I could take you back to workforce. In your submission you talk about the aging psychiatric workforce. I'm trying to understand, is that aging in the public hospital setting or aging across all settings?

ANGELO VIRGONA: I think it's across all settings. The national survey said that there are—I've forgotten now, but there are so many psychiatrists over the age of 55.

The Hon. SUSAN CARTER: So junior doctors are not attracted to training in the specialty?

ANGELO VIRGONA: I think it's one of the difficulties. Because the services have been so under the pump and so stressful, when a junior doctor comes and observes them they see that it is a really stressful occupation and I think they get turned off. That's one of the issues I think we face in New South Wales. Victoria have mandated that all their junior doctors get rotated through a psychiatric term during their first two years of training as a junior medical officer. We don't have that in New South Wales. I'm going to counter the argument I made two minutes ago, but we know that the more exposure you have to doing psychiatry—having a term in psychiatry—the more likely you are to train in it and to see it as an option. We're missing out on that in New South Wales. We could do more with those postgraduate one and two terms in New South Wales.

The Hon. SUSAN CARTER: I also wanted to take you to the point in your submission where you talk about NSW Health not keeping live data on vacancy rates. Are you suggesting that NSW Health doesn't really understand where the vacancies are and what the workforce needs are at a particular hospital or in a particular health district?

ANGELO VIRGONA: Yes, I think. I'll be able to answer that question soon, I hope, because we've asked for this meeting with the ministry and Ministers about workforce. But my sense is that the issues are devolved to the local health district level. It's a local health district's problem to sort this out and there is not a sense that there is some central repository of data where people have a real sense of how many locums there are in New South Wales currently or how many staff specialist vacancies there are. They may know them, but I don't think that information is provided very much. What sort of visiting medical officer contracts are offered in New South Wales at the present time? I think the first step, like the gap analysis, is all about data. You've got to get the data right and then you can start planning appropriately.

The Hon. SUSAN CARTER: Can we set training targets without that sort of data as to who needs to be employed where?

ANGELO VIRGONA: Training targets in what sense?

The Hon. SUSAN CARTER: If we were trying to attract people into the specialty. Do we know how many psychiatric trainees we need to attract if we don't know where the vacancies are?

ANGELO VIRGONA: We know where the vacancies are for trainees, in a sense, because we have a role in the recruitment of trainees into colleague training. They come into the college but they're employed by the State, so it's a bilateral employment path, if you like.

The Hon. SUSAN CARTER: Does anybody know, for example, that at Bankstown Hospital they are two psychiatrists short?

ANGELO VIRGONA: The local health district will know that.

The Hon. SUSAN CARTER: But not the ministry?

ANGELO VIRGONA: Not necessarily. I don't know if they keep a live spreadsheet of what's happening at each of these places. I could be wrong and they'll be able to inform you otherwise, no doubt.

The Hon. SUSAN CARTER: A quick comment, if you can—do you think GPs have enough access to psychiatric training as part of their training so they can provide support? We're hearing today that they're very much front line.

ANGELO VIRGONA: Yes, of course they are front line. I think you'll find that there are GPs who have a particular interest in mental health. They will get further training. They'll do a master's in mental health. One has been available at Monash, I think, for the past 20 years. Some do a master of psychotherapy at Westmead because they want to work as a psychotherapist. It's not a very big number. There's also a collaboration that's happening between our college nationally and the college of GPs, where we're developing a diploma-level course for GPs to upskill in mental health. That's great; I don't knock it. But there's no point in doing it, unless you've got an MBS item that is going to work for the GP. The GPs aren't going to do it if they can't spend the requisite amount of time because the longer they spend with a patient, the less money they earn. Female GPs are the ones who tend to cop it most because they tend to spend more time with patients and often have a lower income as a result. That's the fix that needs to happen in GP land, to be honest with you, as well as the multidisciplinary care model being run out of GP surgeries with mental health nurses and psychologists.

The CHAIR: Thanks so much for your time today to give evidence and for the preparation of your submission. The secretariat will be in touch with you with any questions on notice.

(The witness withdrew.)

(Short adjournment)

Ms HELEN BOARDMAN, Registered Nurse, Clinical Nurse Consultant, NSW Nurses and Midwives' Association, affirmed and examined

Ms VICTORIA NORRIS, Registered Nurse, Perinatal and Infant Mental Health Service Nurse Manager, North Sydney Local Health District, NSW Nurses and Midwives' Association, affirmed and examined

The CHAIR: Thank you for making time to give evidence today. Would you like to make a short opening statement?

HELEN BOARDMAN: I'm here representing the NSW Nurses and Midwives' Association, so the views expressed are that of the union and not my employer. I've been working in psychiatry for the past 15 years, qualified for 13 of them. I've got a diverse background. I've worked in inpatient, acute, forensics and, for the most part, in the past seven years in community mental health.

VICTORIA NORRIS: I'm a registered nurse with 20 years' experience working in mental health in the community in outpatient settings across metropolitan Sydney. I've been a proud member of the NSW Nurses and Midwives' Association since 2001. For the past eight years I have worked in the specialty area of perinatal and infant mental health. I'm also a casual academic teaching, and hopefully inspiring, our future nurses in undergraduate nursing. It is a privilege to be here today and to be part of this very important inquiry. Today I hope you advocate for all mental health consumers, especially expectant and new parents who are experiencing mental ill health. I also hope to shed light on the inequality of access experienced by mental health consumers in the community in outpatient settings.

The CHAIR: I firstly say thank you, not just to the two of you but to the very large number of members who have put their individual testimonies in your submission. It's certainly a very powerful piece of evidence, and we're very grateful for that. My first question is about recruitment and vacancies. Your submission points out a number of different services with a significant number of vacancies. Why do you think that is? Why can't NSW Health recruit nurses to fill those positions?

VICTORIA NORRIS: The experience of working in mental health settings across metropolitan Sydney is that there is high rate of burnout and there is a lack of support for a lot of our frontline clinicians in the very important and very traumatic work that they do.

HELEN BOARDMAN: Regarding current nursing education in New South Wales and Australia, the degree is a general nursing degree, so our new grads are coming in to work in psychiatry with very little theory behind them. Perhaps they have only had a two-week placement in mental health during their training. Regarding the vacancies, we're not able to provide a staffing mix where senior nurses can provide support to the new grads. We'll often be very new grad or junior nurse heavy, with maybe one or two senior nurses on shift who, therefore, not only have most of the clinical responsibility, they have also have to provide mentorship to the junior staff, which obviously becomes untenable.

The CHAIR: To follow up on that, as I am sure you know, our role as the Committee is to write recommendations to the Government, NSW Health. What would you want to see in those recommendations about being able to recruit to fill those positions?

HELEN BOARDMAN: Definitely improved education in the area of speciality that is mental health. If you go to the emergency department, you expect an appropriately trained emergency nurse. If you go to the ICU, oncology, you expect your nursing cohort to have speciality training in their area. Whereas, there seems to be that's not an expectation in mental health. We really need to have special mental health and recognition that this is a speciality in its own right.

VICTORIA NORRIS: Also in the community and outpatient setting it's incredibly skilled work. Often the work that you do as a community mental health nurse holds a lot more autonomy and responsibility than it does when you work in the inpatient setting. Yet, in a way, because there's no shift work in the community setting, those community mental health nurses are paid less. They are getting paid less to do more skilled work. That's definitely an issue.

HELEN BOARDMAN: Especially when they are a registered nurse. Overseas there is often acknowledgement with a higher pay grading, but speaking to the autonomous nature and required level of expertise to provide that service independently, which doesn't exist in our current system.

VICTORIA NORRIS: Just another note, that living in metropolitan Sydney, where we need so many nurses and midwives and frontline workers, the cost of living is going up and up and it's becoming more and more expensive for the people that we want to work on these teams to live in Sydney.

The Hon. EMILY SUVAAL: Thank you both for appearing today. I declare at the start that I am currently a member of the NSW Nurses and Midwives' Association as well. I note part of your submission talks about the Transition to Practice Programs, also the work for supports and the ability to access specialist postgraduate education. Could you both advise us what, if any, specialist postgraduate education you have undertaken and your comments and thoughts about its availability and merit?

HELEN BOARDMAN: Because I trained overseas, I already have a specialist honours degree in psychiatric nursing. But since I've come to Australia I've completed my Master of Mental Health Nursing and have nearly completed my Master of Nurse Practitioner, which is due to finish next year.

VICTORIA NORRIS: As Helen was saying, here in Australia or here in New South Wales, the training for RNs, the bachelor degree is a general course. To work in the mental health setting ideally you would do a transition course into mental health nursing, which most of the LHDs offer, a program where you get support in that first year working in the mental health setting. I myself have done a graduate certificate in child and adolescent mental health. I was supported at the time doing that very much by my employer, and I think also I was able to get a scholarship. There's lots of scholarships available. But it is an added expense for our registered nurses to do any kind of graduate study. Also, a lot of graduate nurses have a lot of family and life responsibilities that make it really hard to do that extra study, to gain those higher responsible jobs that pay better.

HELEN BOARDMAN: Particularly when you're taking on tertiary education outside of the transitional program provided by the health district. We only have a set amount of study leave that you can take, which doesn't actually cover the—for example, one semester if I've got eight face-to-face days in uni, I can only take two of them as study leave. The rest of those days have to be completed on my rostered days off and you've got to take that into account with external commitments. I think that having increased paid leave to attend education would definitely be a good recommendation.

The Hon. EMILY SUVAAL: Tell us more about the benefit of additional studies. You mentioned there are a number of scholarships available, but there are still some costs involved to the individual. I imagine that comes in the way of having to access your own paid leave entitlements. Are there any other examples of that and is there anything that you suggest we do?

VICTORIA NORRIS: Any kind of financial support to gain further study and experience would be very welcome by registered nurses. Most registered nurses working in mental health are keen to learn more skills and to study more.

The Hon. EMILY SUVAAL: Do you think they currently have access to that additional education that's needed?

VICTORIA NORRIS: There's a lot of education provided in house within LHDs to increase capacity for our working mental health nurses. I don't think everyone's aware of the scholarships and the financial support that's available to them to study at graduate level.

HELEN BOARDMAN: There's also an inconsistency in the delivery of those programs every year. I know some universities, for example this year, are not doing the Master of Mental Health Nursing program because they can't attract the amount of people required to run the course. I couldn't speak to why we're failing to attract those people; I think it speaks more to mental health as a whole system is seen as a less desirable system to work in.

The Hon. EMILY SUVAAL: There was another submission, it may have been the college of psychiatrists, that mentioned the role of nurse practitioners and having an increasing role for those, an increasing scope. Ms Boardman, it sounds like you've undertaken a significant amount of additional study to get to where you are in that journey. Are you able to provide any additional comments on the role of nurse practitioners within mental health and what, if anything, we can do to better support, encourage and promote that and ensure that you can indeed work to your full scope?

HELEN BOARDMAN: From speaking to people who have already completed the nurse practitioner, there have been queries whether nurse practitioners are able to work to their full scope, or are being supported to work to their full scope within the health district outside of that and whether this is to do with Medicare and the PBS. I know that it has been spoken about in terms of State health funded as well. There are limitations on prescribing and whether you can prescribe as a continued treatment. Some of the treatments can only be continued as continuing care—i.e., already started by a medical practitioner. They are really common medications, second-line antidepressants.

If you've already prescribed a first-line antidepressant, given them a reasonable trial, and then you wish to start them on a different type of antidepressant, there are limitations on that second line, and this is medication

that most nurses who are undertaking their nurse practitioner—by the time they've reached that point, these are medications they have been using and been familiar with for over 10 years. Especially working in the community and being able to work as an individual practitioner, again really common medications such as depot medications, there are limitations on that, whether you can start it or whether it's going to be a continued medication. Then there's the issues between if you're working as a NP across both public and private, which pharmacies will dispense for which and the costs associated with that. It's a bit of a convoluted system and they don't all line up, and it would be good to have some streamlined guidelines. I think the other issue that's been put to me by some of the nurse practitioners is the collaborative arrangements with doctors and the need to have a doctor involved in the care delivery—whether that's a completely different speciality to psychiatry—which can place some limitations on our ability to work autonomously outside of the public system as well.

The CHAIR: I've got a couple more of my own questions. I was really interested in some of the stories told in your submission about community treatment orders under the Mental Health Act. As you would both know, they're supposed to be the least restrictive means of providing care to a person. I'm interested in your perspectives on whether that is the case on the ground.

HELEN BOARDMAN: I mostly work in crisis community mental health so I couldn't speak to the CTOs in terms of them being on a community mental health team. I've been asked to assist in CTO breaches so my experience with CTOs—I'm an accredited person under the Mental Health Act and have to make those decisions several times a week about delivering restrictive care as the least restrictive means of care under the Mental Health Act. I think it takes a long time, in your clinical judgement, to truly be able to make the decision to remove somebody's liberty and recognising that that's the only way to maintain safety. I would have to take that question on notice in terms of talking to my colleagues who do work in the regular community mental health teams about their experiences of community treatment orders—but I know that there is quite a lot of evidence to suggest that they actually don't improve patient outcomes longitudinally—and whether there are better ways of doing that.

The CHAIR: I'm quite happy for you to take it on notice. I suppose I'm interested because mental health service users and patients have told us about the loss of autonomy and the impact that has. I'm interested if there are instances where that care could be provided through less restrictive means and how we can support that.

HELEN BOARDMAN: I think the ability to deliver assertive care regardless of whether it's on a CTO or not, we don't truly have the capacity to do that in the public mental health service, given the huge caseloads and the increasing complexity and acuity of the patients that we have, with large vacancies and the fact that we are very junior heavy. I think it speaks to a bigger problem rather than just CTOs; it's the whole—if we could assertively support someone at home with adequate staffing and appropriate caseloads then could you argue that CTOs aren't the least restrictive, perhaps?

The CHAIR: Your submission talked about the New South Wales mental health access line. I was quite horrified to learn that that's been privatised in a number of local health districts. Could you expand on your experiences of that service?

VICTORIA NORRIS: The mental health access line is basically the central intake point for every LHD's mental health service. As in all mental health sectors, they're often very understaffed and have a lot of unskilled clinicians with relatively limited experience. Often the clinicians working on the mental health access line have not themselves worked, for instance, in different mental health settings. So they are triaging a call but then they don't necessarily have the experience to know what is going to happen to that call and what they can offer that individual.

The CHAIR: Just to clarify, is that a comment generally statewide about the access line or specifically the LHDs that are using the Medibank services version?

HELEN BOARDMAN: There's a huge discrepancy between the models of care of the access lines. Some LHDs will have the access line as part of the crisis team and it's staffed 24 hours a day. But even within that, there's a difference between LHDs who have a night shift that's purely on the phone—so if there is a crisis then they will have to send police and ambulance—and LHDs that have on-call at night, so they have the potential to go out. Then you have LHDs that can access patient records in real-time that belong to the health district. Then you have other LHDs where the triage line is manned by Medibank or other private providers who have no access to the health records, so they can't see the longitudinal history and they take every single triage as a new triage and then forward on to the appropriate team for follow-up.

The CHAIR: Picking up on something you've just said, I wanted to clarify that, in the LHDs that have better staffing overnight, there are crisis calls that can be managed by mental health clinicians, whereas in other LHDs they are being sent to the police.

VICTORIA NORRIS: Yes.

HELEN BOARDMAN: Yes. Or some of the health districts that are still staffed by Health staff can do phone counselling, phone triage and telehealth support. But if it's at a point where the clinician feels like it can't wait until the morning, then they would call police and ambulance.

VICTORIA NORRIS: There's some LHDs that have really great set-ups where the individual taking the mental health access line phone call is also part of the team that would respond to that, so of course that's going to be a much better outcome for the consumer.

The CHAIR: Absolutely. What I am trying to really clarify is that there are some LHDs that are sending police to mental health calls that, if the mental health team was adequately resourced, would be within the capacity of the clinicians to respond to.

HELEN BOARDMAN: Given that they've got access to the patient's history it doesn't mean that the police wouldn't get called. The mental health team may well call the police for assistance but that would be based on a risk assessment of how safe it would be for the mental health team to attend with or without police. It's not saying that police definitely wouldn't go but it's saying that if they did go it would be based on a clinical risk assessment and the judgement of the team.

The Hon. SUSAN CARTER: Thank you both very much for being here today. I have just a few questions in relation to training, and attracting and retaining mental health nurses. Before the change in nurse education to one that's more hospital-based, it was possible to elect to be a mental health nurse and train as that or as a general nurse. I understand that that pathway is still possible for midwives but it is no longer possible for mental health nurses, so if you're interested in being a mental health nurse you would do a three-year Bachelor of Nursing, a two year Master of Mental Health—

VICTORIA NORRIS: Sorry to interrupt. If you wanted to work in mental health nursing you'd do your undergraduate degree for three years and then you could go straight into a transitional mental health program—

The Hon. SUSAN CARTER: I suppose the point I'm making is that would be a general nursing qualification. If somebody is specifically interested in mental health nursing, and not really attracted to general nursing, the only pathway now is through a general nursing qualification. I wonder if you had comments on whether, as with midwives, if there was a special pathway available for people with a special interest in this area, that might attract new people into the profession and perhaps people who really wanted to stay in the profession?

HELEN BOARDMAN: I think it certainly might. It is still a model that happens in the UK where I did my training. We also had a degree that was 60 per cent practical and only 40 per cent in uni. I think that that gave us the opportunity to really feel part of the team. Our placements were a lot longer—the shortest one was six weeks long and the longest one was 12 weeks—so you became part of the team. You were able to truly become part of the patient's journey, even during your training, and you had an appropriate amount of autonomy in practice during your training. I think for people who truly have a passion for mental health that that is absolutely a good route for encouraging the workforce that wants to be there and is passionate about mental health.

The Hon. SUSAN CARTER: Ms Norris, do you have a comment about that pathway?

VICTORIA NORRIS: My personal opinion is that I think it's really wonderful to give that general nursing training to everyone. In my experience in mental health nursing for over 20 years it has been very worthwhile to have that general knowledge in physical health, because mental health consumers also have physical health needs. It's just good to have some awareness and perhaps some nursing experience of that.

The Hon. SUSAN CARTER: I am just curious why there would be a special path for midwives but we don't also at least give people the option of either training as a general nurse and then going into mental health care, or training from the beginning as mental health specialist nurses?

VICTORIA NORRIS: Yes. I can't speak to that. I completed my training in 2001 and it was like that then.

The Hon. SUSAN CARTER: We heard today some discussion about a role that perhaps mental health nurses might be able to play in assertive treatment, especially perhaps located in GP teams. Do you have any comments about that—subject, of course, to sufficient workforce?

HELEN BOARDMAN: Not just sufficient volume of workforce but sufficiently skilled workforce. I am 15 years into my career and now work autonomously in the community, but you would have to have a sufficient amount of experience to be able to work in those autonomous roles when, essentially, it's you making the decision with a person from a non-psychiatry background involved in the decision-making process.

The Hon. SUSAN CARTER: Thank you.

The Hon. WES FANG: Obviously, you're here representing NSW Nurses and Midwives' Association. Are you aware of any of the consultations that would have happened between the union and either the health Minister or the mental health Minister in relation to the reviews that are being undertaken at the moment into the mental health provisions in New South Wales? Does the union have a view as to how that's progressing and what, perhaps, the shortfalls are, what are the immediate requirements for the focus of the Ministers, and perhaps what might be a view of the longer term goals of what they think the New South Wales Government should be focused on?

HELEN BOARDMAN: I would have to take that question on notice.

VICTORIA NORRIS: Yes.

The Hon. WES FANG: Thank you.

The Hon. EMILY SUVAAL: I think it was Ms Boardman who mentioned the assertive approach as somewhat—I don't want to say an alternative, but being able to use that to its potential and thereby not requiring a CTO. Can you talk to some of the limitations at the moment in your ability to deliver that assertive model? You mentioned the case management approach and the case loads being quite high. The acuity of patients that you're seeing is getting worse. What could we possibly do to assist with that?

HELEN BOARDMAN: If we had a lower case load per one FTE clinician, the clinicians would be able to, hopefully, engage patients on their non-treatment goals. For example, I've heard from my colleagues that on our safe treatment teams there's often a lot of patients who are on depot medications—so either fortnightly, monthly, every three months—and sometimes that's the only time they can engage that patient. So, essentially, the team that's delivering their care, the only time they're engaging is when they're having medication that they don't want to have. But if those staff were able to work with patients on other things, or even meet for a coffee, which is as important as—I think nursing is an art and it's a science, so, yes, you absolutely need the understanding of medications, non-pharmacological therapies, being able to navigate your system, being able to talk to a multidisciplinary team, and all of those things, but it's also an art.

It's about being able to engage the patient. It's about being able to build a therapeutic alliance. It's about understanding who your patient is as a person and them understanding who you are to a degree, which is one of the principles of the therapeutic alliance. Being able to have an adequately resourced—I say a treatment team, but any mental health team means that they have the opportunity to engage the patients, not only for medication administration or the Mental Health Review Tribunal.

The Hon. EMILY SUVAAL: What's the current case load? You talked about a lower case load for an FTE clinician. What is the current case load and what should it be?

HELEN BOARDMAN: The last best practice guidelines I read are for a normal—so non-assertive—community mental health team. Guidelines are approximately, which I still think is high, 35 patients to one FTE. At the moment across the State some nurses are managing a case load of 80.

The CHAIR: Thank you both so much for your time to give evidence today. The secretariat will be in touch with you about questions on notice.

(The witnesses withdrew.)

DR VICKI MATTIAZZO, Deputy Chair, RACGP Rural Faculty, Royal Australian College of General Practitioners Rural, affirmed and examined

The CHAIR: Welcome. Thank you for making the time to give evidence today. For the record at the start of this session, I declare that I am a member of the RACGP but I was not involved in preparing its submission. Would you like to start by making a short opening statement?

VICKI MATTIAZZO: Sure. I'm here today on behalf of the royal college. I would like to thank the Committee for the opportunity to give evidence. The RACGP is Australia's largest professional general practice organisation, representing over 24,000 members, 10,000 of which are in rural areas. I'm the co-deputy chair of the rural faculty as well as the New South Wales-ACT representative. For the past eight years I've worked in rural New South Wales as a GP and practice owner, in our local emergency department, and more recently with the Royal Flying Doctor Service in Broken Hill and Far Western New South Wales. The experience I speak of today is firsthand and also reflects input from other GPs on the front line of health care.

General practice plays a vital role in the delivery of mental health care. Last year's *Health of the Nation* report revealed that psychological conditions were the most common reason to access GP services for the fifth year in a row and we expect this year's report, to be released in November, to be similar. Thirty-eight per cent of GP consultations included a mental health component. This demonstrates the central role of GPs in accessing services, especially in the provision of mental healthcare plans. The GP often acts as the first point of contact for the patient with the healthcare system but the relationship works both ways. I have had some of my most profound experiences as a GP when a patient has opened up about their challenges. This requires great courage on behalf of the patient and, as their primary healthcare provider, I see it as my responsibility that they get the follow-up they deserve. When this is not possible, it impacts on not only the mental health of the patient but also often on the GP, contributing to burnout—perhaps even more so in rural and remote communities, where resources are even more scarce.

Some things do work well. I was about to say the access line. It does work well in my local health district. But there are other things that I look forward to discussing, including the fragmentation of care through inconsistent communication between the mental health care teams and the GPs, or the "go back to see your GP" approach; the "missing middle", where patients with mild to moderate mental illness who cannot afford expensive private mental health care are increasingly denied access to mental health care services; limited access to specialist services for culturally and linguistically diverse, LGBTQI and First Nations communities as well as specialist services for postnatal depression, aged care and eating disorders; timely access to drug and alcohol services; and, importantly, rigid intake criteria excluding some patients with co-existing diagnoses—perhaps those with mental health, plus drug and alcohol, plus cognitive impairment. These patients often fall between the gaps. I look forward to answering your questions.

The Hon. SUSAN CARTER: Thank you for being here today. I appreciate it. I was interested in your submission where you were talking about some of the access issues for patients in rural areas. In particular, I noticed you were talking about the travel impediment. I wondered whether, just as a very practical thing, we should be looking at some sort of travel support for people in regional and rural areas to put them on an equal footing with their city counterparts access-wise.

VICKI MATTIAZZO: I think that would be very helpful. There are different levels of travel. For example, in the place where I have been working, it's a small community outside of a larger community about 60 kilometres away. A lot of the services are focused in the larger community. Especially for young people wanting to access services without their parents, it's really hard for them to get to those services because we have very little in the way of public transport. Thinking about access to specialist services, I know we have the IPTAAS scheme, which I think works really well for some things.

I noticed, when I looked into it, that I don't think we have availability for a lot of mental health support services and other allied health. For example, people can access IPTAAS for things like spinal clinics, cleft lip and palate clinics and other allied health services, but not so much for mental health. I think that would be really helpful. I certainly know patients in my community, especially LGBTQI community members, who have had to travel. I know someone who left our community and travelled seven hours to access appropriate services. To have some financial support for that would have been really helpful for that family.

The Hon. SUSAN CARTER: I'm wondering, too, whether there are actually diagnosis challenges. For example, if you are seeing one person with an eating disorder every two years—and I don't mean any disrespect—is it as easy to identify the issue that patient is presenting with if it's not usually presenting?

VICKI MATTIAZZO: Sure. It's a numbers game. Clearly if you're seeing a lot of similar conditions, you become much more skilled in recognising and treating those conditions. Certainly that's true. That's where I think being able to be alert to it is part of the bigger education question for GPs and other members of the team. But if I have got a question like, "I'm concerned about this person; I think we're dealing with an eating disorder here," or whatever it may be, being able to tap into and get advice from services easily would be very helpful. One of the things that is really difficult in the mental health space is being able to pick up the phone and getting some advice on the clinical hunches that you might have and working out the best pathways.

The Hon. SUSAN CARTER: Who could a GP call to get that advice?

VICKI MATTIAZZO: Sometimes it's a matter of knowing which services are out there, because we do have the access line and that works really well. But it is our only entry point into getting advice into the community-based mental health system. If we had other ways, like a centralised advice line, to be able to say, "I've got this patient. Are we able to talk this through and you can point me in the right direction?"—one of my big challenges is that we have very limited access to advice from psychiatrists. I can't think of any other area in my scope of practice where access to having a conversation with a specialist is so difficult. For example, if I had a patient with a complex heart condition, I may be able to ring their cardiologist, or even the cardiology registrar on call, and say, "Can I just talk this through with you?" Often they will be really helpful in pointing me in the right direction. It doesn't require a referral. It's something that could be sorted out in general practice. I can't do that with psychiatric services.

The Hon. SUSAN CARTER: That's very interesting. I have one last question, and you may not be able to answer it. But, for example, if a patient presented in Broken Hill with an eating disorder, would that patient be able to be supported properly in the community or would they need to travel to another location? How far would they need to travel to receive specialist support?

VICKI MATTIAZZO: I can't speak specifically for Broken Hill because I'm not familiar enough, but I can talk about my area in south-eastern New South Wales. It depends on the acuity. Certainly if we identify that the person is at physical risk then we would be able to liaise for that person to be seen in a hospital setting because there's a safety issue. When it comes to dealing with outpatient services, it's much harder. There has been priority given in our LHD to be able to access some more services for people with eating disorders, but I think that's a little inconsistent. Outpatient is very difficult.

The CHAIR: I wanted to pick up on one of your answers about how hard it is to access psychiatry. I am aware of some primary health networks that, with Federal funding, have provided a psychiatrist on call that GPs can ring. My question to you is, when those sorts of services are available, how much time does that take you outside of the consults? In the current paradigm, how would you be remunerated for that time?

VICKI MATTIAZZO: We wouldn't be. My closest referral hospital is actually in the ACT. It's Canberra. I think there's an hour between 1.00 p.m. and 2.00 p.m. where we can make a phone call to someone and someone may get back to us. It's difficult to access. But, yes, all of that time would not be remunerated from the point of view of the GP.

The Hon. EMILY SUVAAL: It's probably hard to say exactly but, as a rule of thumb, how much time would that be?

VICKI MATTIAZZO: Half an hour of phone tag plus a conversation—an hour? It would depend on the circumstance.

The Hon. EMILY SUVAAL: Thank you. That's important to articulate. There's obviously the issue of not being remunerated, but then there's the issue of time.

VICKI MATTIAZZO: Time. Then that's setting you back. You're taking the call, and then you're setting back your next patient that's coming in et cetera. Everyone gets frustrated with that.

The Hon. EMILY SUVAAL: I have a question. Thank you so much for appearing to give evidence today and travelling to be here. I really appreciate it. You talk about recommending that we adapt the mental health eligibility assessment in outpatient care clinics. I wondered if you could talk more about that and how that would work.

VICKI MATTIAZZO: It's an issue I've sort of canvassed a bit with some other GPs as well. I'm talking more from community-level mental health care, as opposed to hospital-based. Community-based mental health care is looking at acuity. Therefore, if people are not in acute crisis, it is seen as a chronic issue. This is then sent back to the GP for the preparation of a GP mental health care plan, and then the patient accessing a psychologist or whoever through that process. That is not always possible, especially in rural areas. It's really difficult. It's difficult in a lot of places—

The Hon. EMILY SUVAAL: Is this the access of a psychologist that you are speaking of now?

VICKI MATTIAZZO: Yes. Sorry not to be clear. Sorry, I have just lost my train of thought. Could you repeat the question, please?

The Hon. EMILY SUVAAL: I'm wondering if you could articulate how the mental health eligibility assessment in outpatient care clinics would help.

VICKI MATTIAZZO: I think it's all to do with resourcing; it's not to do with people not wanting to be helpful as much as they can. It's a resourcing issue. First of all, if there's not an acute issue, then it is not seen as a priority for the community-based mental healthcare teams. Also, there are issues where there are multiple diagnoses. For example, if a patient has coexisting diagnoses—and it happens more often than we would like—of mental health issues, alcohol and other drugs, often accompanied with a cognitive impairment associated with a brain injury perhaps, we often find that there is a conflict in who will take responsibility for that patient. Often nobody does. I can give you a couple of very clear examples of my own experience where perhaps someone has a mental health condition leading to social disruption, relationship breakdown, alcohol and other drug issues, a lack of inhibition and perhaps assaults where they have sustained injuries, such as a brain injury—cognitive impairment, lack of judgement, more alcohol, and then the cycle continues.

It's really difficult to get a service to take responsibility for the overall case management of that complex situation. So in some situations the mental health team might say, "We need to address the drug and alcohol issue first." The drug and alcohol service will say, "Well, it's a mental health issue," and they don't want to engage. They won't engage because they don't have the judgement to say, "Yes, this is a priority." Rehab for their brain injury won't participate because they see it as a mental health issue, so they go back to the GP. Sometimes I found myself thinking that perhaps there are two likely outcomes for this patient: Either they're going to end up in prison, and that may be the only place they get help; or they will end up dead through misadventure. I have often felt quite desperate to know how to pull things together, as the primary caregiver in that situation, and to know how to help that situation. That's where I think case management for complex coexisting comorbidities is really important.

The Hon. EMILY SUVAAL: You talk about the care coordinators or specialist care coordination teams across LHDs. That sounds like that's what you are speaking to there.

VICKI MATTIAZZO: Yes.

The Hon. EMILY SUVAAL: What's the impact on people like yourself in the absence of that occurring? You talk about yourself feeling, professionally, like there could be two outcomes for that patient. How does that impact you?

VICKI MATTIAZZO: It's devastating, it's frustrating and it takes a lot of time. Once again, it's often unpaid because there are a lot of phone calls and there is a lot of googling to try to work out the best pathways. But it's disheartening and I think it contributes to burnout.

The Hon. EMILY SUVAAL: We heard earlier in evidence today about the over-representation of female GPs in particular in that category.

VICKI MATTIAZZO: Sorry, just to add one thing, I also contacted a colleague of mine who works predominantly in emergency departments in rural areas, and GP based. That sense of who is managing the situation, especially where there are coexisting physical and mental health issues—because we know that people with mental health issues are at higher risk of complications from medical conditions. But sometimes engaging mental healthcare teams to collaborate with the emergency departments and with GPs to help avoid this cycle of readmission is very frustrating.

The CHAIR: I would like to follow that up, because in the submission you talk about RACGP members' frustration with not being able to access the information they need to be able to support people, for example, after discharge from an inpatient admission, or when they have been transferred from another service, or they've moved from another service or another area. What information do GPs need access to to be able to support people with mental health issues?

VICKI MATTIAZZO: Timely discharge summaries, particularly that include clear and up-to-date information about medications that may have been changed during an admission or during a service provision. We do get them eventually, but we often see the patient before we get the paperwork.

The CHAIR: We had evidence earlier today from the NSW Nurses and Midwives' Association which, in a beautiful moment of interdisciplinary collaboration in its submission, talks about the need for patients experiencing mental illness to have access to a GP, particularly for physical health needs and for that holistic

patient care. One of its suggestions is embedding GPs within community mental health services, or finding another way for patients who don't have a regular GP to actually access a GP for free. What are some ways that the New South Wales Government could actually enable that and make it a service that the GP would want to work in?

VICKI MATTIAZZO: In a community healthcare model?

The CHAIR: Either within the community mental health service or some kind of alternate model to provide people with access to a GP for free.

VICKI MATTIAZZO: Now, with the MyMedicare changes, patients are encouraged to enrol with a general practice, and that will allow them to access higher rates of bulk-billing incentive payments, which are more likely to incentivise GPs to bulk-bill if they are registered with that GP or that general practice. So that's in the private sector. When it comes to having GPs embedded in mental health facilities—in, like, a community health model—I would probably have to consult with my colleagues around that. But I think those models do exist. I suppose it's a matter of good professional support, remuneration and training.

The CHAIR: Please do take that question on notice.

VICKI MATTIAZZO: Sure. We'll take that on notice.

The Hon. WES FANG: Thank you for appearing today. We heard earlier evidence around the provision of medication, such as ADHD medication and the like, and the restriction that's placed upon GPs around either the provision of further scripts or even changing the medication and the dosage required for that patient, and that perhaps there's a way of alleviating and reducing the workload on psychiatrists and psychologists by not requiring that sort of work to be headline work for that psychiatrist, but perhaps it's something that could be done with GPs. I think it makes quite a bit of sense, but that work would need another billing number from Medicare because it would be quite complex, I'd imagine, and time-consuming for the GP. Do you have any thoughts around that sort of work being progressed into the GP space and, if so, the barriers of having that put onto GPs and what the advantages might be and how we can relieve that burden?

VICKI MATTIAZZO: A couple of thoughts. I have seen where it can work really well, but it depends on your relationship with the other people in that multidisciplinary team, including the psychiatrist. I have certainly worked with psychiatrists where we've had excellent relationships via telehealth co-consulting and good communication with letters whereby it's quite streamlined and we can say, "Yes, this is the dosing. You are right to go for a year with these prescriptions." It can work quite well, but it depends on your relationship, once again, and your communication pathways as part of a team.

These issues are complex. If prescribing is going to move into the realm of general practice, we need to make sure that we have adequate training and time to address those complex issues appropriately, or else we are putting the patient in danger and also putting ourselves on the line. With appropriate training and support from our specialist colleagues, I think it's a model worth looking at, but to do it without that would be increasing risk.

The Hon. WES FANG: That's the practical aspects of feeling comfortable around the provision of those drugs to a patient, but there's also the impact on the business or the income of the GP. There's also an impact on the psychiatrist's income as well because it is reasonably quick or quicker when you've got somebody who's well known to them being re-prescribed what they have or with a slight alteration. How do you see that being managed? What would be required from the GP standpoint to make it not necessarily a profitable exercise, but certainly not a negative in the way that you conduct your practice? Also, with the training, I imagine that's also going to impact your business or income, and that might also need some assistance. How do you see that working as well?

VICKI MATTIAZZO: Once again, I might need to take a part of that question on notice. We do have some provision now with longer consults; we now have level E consults that are available to us, which will last longer than 60 minutes. That does assist us in some ways to make the longer and more complex consults more sustainable. In terms of training around that, we'd have to go back to the college and say, "Do we have some appropriate training pathways to allow GPs to do this safely?"

The Hon. SUSAN CARTER: I note with interest that in your submission you indicate that in rural and regional areas the use of amphetamines is now becoming a bigger issue than the use of alcohol. If a patient came to you and said, "I have a drug problem. I want to detox. I want to go into rehab", are there local facilities? Would they have to relocate? What sort of delay would there be in being able to facilitate that treatment?

VICKI MATTIAZZO: A long delay. We do have some community-based drug and alcohol counselling services, which are very helpful. But if a patient came to me ready—and this is certainly a very frustrating situation—you want to be able to act so that you're ready with that patient. Unfortunately, there are often delays of several months before you can access detox programs, and sometimes the patient is recommended to just keep

using until we can get services to them. A few times I have used DASAS, which is a specialist advisory service. For example, I have a patient who may be safe to detox at home and I've had some excellent advice over the phone from that service where it's been safe to do so. That has worked really well. But if a patient wants to access inpatient detox, then the delay is often quite long.

The Hon. SUSAN CARTER: Are the services available in the local community—

VICKI MATTIAZZO: No.

The Hon. SUSAN CARTER: —or do they have to travel outside? In terms of rehab after detox, is there then a delay between those steps?

VICKI MATTIAZZO: I think that's a little bit more streamlined because there's often a lead time in and people are often in detox for a number of weeks. Therefore, when they come out, there's been discharge planning. For those situations, our drug and alcohol services have not been too bad. But where there's that kind of sudden "I'm ready", that's often difficult to access.

The Hon. SUSAN CARTER: But you're talking about an extended time out of the community away from family supports?

VICKI MATTIAZZO: Yes, most definitely. Local hospitals are very reluctant to accept people for detox.

The Hon. SUSAN CARTER: Is there a difference in terms of accessing alcohol services as opposed to drug services? Or are the wait times basically the same?

VICKI MATTIAZZO: I'd have to take that one on notice. I'm not sure.

The Hon. SUSAN CARTER: Again you may not be able to answer this, but do you think it would be possible to resource hospitals to be able to do detox in the community? Or do you think that would be a case-by-case discussion?

VICKI MATTIAZZO: I think it would be a lot of resources. It would be great if you look at it from a patient-centred point of view. There would need to be appropriate staffing in the hospital to be able to manage that. But once again, as you alluded to, the outpatient follow-up would also be really critical so that the patient didn't relapse.

The Hon. SUSAN CARTER: In relation to staffing, we've heard some interesting evidence earlier today in relation to the difficulty of maintaining staffing levels in Sydney because of increasing cost of living. I'm just wondering whether that's having a compensating benefit in regional areas, with more staff moving to regional areas, or whether there are still major staff attraction and retention difficulties in regional areas?

VICKI MATTIAZZO: We still have staffing issues, and accommodation is still an issue in our community, that's for sure.

The Hon. SUSAN CARTER: So you would think accommodation is the biggest barrier to attracting new staff?

VICKI MATTIAZZO: I think it depends on which communities you're looking at. Certainly in the area that I'm most familiar with, accommodation is probably the number one thing that is preventing people from making that move.

The Hon. GREG DONNELLY: Thank you very much for coming along. In the matter of children and adolescents with mental health matters and the need to see one for receiving some advice and potentially treatment—in the context of your opening statement you indicated that now more than ever before there appears to be this trajectory where there's this increasing engagement between the community at large with their GPs over matters of mental health. Is that also the case with respect to children and adolescents? Or do they bypass GPs and go straight to places like headspace, for example, to seek out that first engagement? I'm just wondering whether the statement you make is an across the board or it's a demographic according to age categories or subcategories?

VICKI MATTIAZZO: The numbers that I gave you would be an across the board, and I don't have the breakdown of individual demographics within that. I think it depends a lot on where you live. In rural areas, the general practice, even if the GPs within the general practice may change—because we know that there are resourcing issues with GPs as well—the general practice is usually the stable factor. Services come and go. So I still think that in rural areas, in particular general practice would be the first point of call for a lot of younger people—or their school counsellor perhaps. General practitioners would be the ones who would be able to prepare

then the mental health care plans to allow people to access the subsidised or the rebatable Medicare item numbers with the psychologist.

The Hon. GREG DONNELLY: On the matter of the school counsellors, that dynamic between schools with school counsellors and they are doing their best to try and guide and advise young people, do they, through that guidance, encourage the young person to go and engage with the GP? Is that how that connection comes about?

VICKI MATTIAZZO: Yes, we often we will get people coming in to see us, either independently or with their parents, on the recommendation of the school counsellor. It's often to access the mental health care plans as well.

The Hon. GREG DONNELLY: This is my final question; it might have parts to it. In terms of children and adolescents presenting today to GPs in that route we just discussed, are there some broad categories of areas which are presenting themselves as, dare I say, at this point in time and at this moment really quite focused in stimulating or creating these mental health anxieties or concerns? Is that too broad a question to even ask?

VICKI MATTIAZZO: It's a broad question, and I don't have any numbers in front of me. But if you just want my personal, anecdotal experience—

The Hon. GREG DONNELLY: Anecdotal, sure.

VICKI MATTIAZZO: I think anxiety is a really big issue for younger people. I suppose, as GPs, we are seeing what I referred to in my opening comments as the missing middle.

The Hon. GREG DONNELLY: If I had time, I was going to raise that because it was a key point, yes.

VICKI MATTIAZZO: So lower acuity and more chronic. Certainly eating disorders—a lot—anxiety, and self-harm, I would say, in that younger population would be the points that come to mind to me.

The CHAIR: I know from my own experience that GPs are provided quite a lot of training and face quite rigorous exams in terms of their knowledge and ability to care for patients experiencing mental distress or mental health issues. Some of the evidence that we've received from patients, from people with lived experience, does talk about some people's negative experiences with GPs or feeling rushed or dismissed. I'm interested in your perspective on, I suppose, what the barriers are. There's obviously something stopping GPs from being able to provide the level of care that they're trained to do and potentially what the New South Wales Government could do to address some of those.

VICKI MATTIAZZO: Time. Yes, time and patient numbers, resourcing, being able to—I think perhaps some of the negative experiences come around feeling rushed. Like I expressed in my opening statement, it has taken a big step for the patient to come to see you about something and you want to be able to give them the time to be able to access the services that they require, but that's not always possible when you are as rushed as you are. That may often translate to the patient—well, not often but sometimes to the patient as feeling rushed or, perhaps, not validated. I'm not saying that as an excuse, but maybe that's a contributing factor.

I think awareness and expectation building about we're not necessarily going to get this all sorted in one session, that we need to rebook and that we need to develop a relationship to be able to manage the issues that you have come to me with and also having an idea of what services are available that I can tap you into. I think it's really difficult because the services do come and go. It's hard to stay current and up to date with what's out there. It would be really helpful to have some more centralised information that's kept live so that we can tap our patients into the services that they're coming to seek.

The CHAIR: My last question is about telehealth. One of the terms of reference of this inquiry is looking at the risks and benefits of telehealth. I know GPs suddenly developed huge experience of telehealth during the pandemic. What's your experience in, I suppose, how that can be done well or what some of the risks are?

VICKI MATTIAZZO: We're very grateful to see that the longer consult telehealth numbers have been approved with MyMedicare. We're grateful that now telehealth can last longer than 15 minutes. I think that a lot of people, particularly in rural areas, like telehealth because it helps them access services that they would otherwise have to travel a long distance for, but I don't think it replaces face-to-face medicine. That's our overwhelming response from the community: It has its place, but it doesn't replace face-to-face consultations.

Having a hybrid system where there might be some face to face as well as follow-up through mental health is really helpful to some people, but many people do like it. One issue, particularly in rural areas, is that some item numbers are restricted to video telehealth and that can be very clunky, especially where there is poor reception. If it's a patient that you're very familiar with, the need for video telehealth may be questionable. But sometimes the restriction on video telehealth for some items is frustrating.

The CHAIR: Thank you very much. The secretariat will be in touch with any questions on notice.

(The witness withdrew.)

(Luncheon adjournment)

Ms KYLIE COVENTRY, Head of Policy, Australian Psychological Society, before the Committee via videoconference, affirmed and examined

Ms ANITA MCGREGOR, Forensic Psychologist, Member of the College of Forensic Psychologists of the Australian Psychological Society, before the Committee via videoconference, affirmed and examined

Ms SAHRA O'DOHERTY, Acting President, Australian Association of Psychologists Inc., before the Committee via videoconference, affirmed and examined

Mrs AMANDA CURRAN, Chief Services Officer, Australian Association of Psychologists Inc., before the Committee via videoconference, sworn and examined

The CHAIR: Welcome to our next witnesses, who are with us by videoconference. Would the Australian Psychological Society like to start by making a brief opening statement?

KYLIE COVENTRY: Yes, we would. The Australian Psychological Society is pleased to have the opportunity to provide evidence at this public hearing today. We would like to commence by acknowledging that we are meeting on the lands of the First Nations people of Australia and pay our respects to their Elders past and present. Our submission to this inquiry was written from the perspective of a professional association and from a practitioner viewpoint, keeping in mind the experiences and feedback we receive from the clients we provide services for. Today I have Anita McGregor joining me to provide evidence as a member of the New South Wales section of the APS College of Forensic Psychologists, a practising psychologist and key contributor to our submission.

The APS commends this inquiry into outpatient and community mental health care in New South Wales. Outpatient community mental health services are essential for people living with serious mental illness. Support from these services aims to prevent future episodes of mental illness and subsequent hospitalisation while facilitating recovery. It is therefore critical that all people with mental ill health have equitable access to appropriate services to attain optimal wellbeing.

Psychologists play a key role in providing community mental health services and supporting people living with mental illness, along with their families and carers. We do so by providing outpatient community mental health care through State-funded mental health services, non-government organisations and federally funded programs such as the Better Access initiative and the NDIS. Psychologists also provide private mental health services.

The recommendations in our submission focus on strengthening support for vulnerable populations to navigate outpatient community mental health services to receive the right care at the right time; increased mental health outreach services, particularly in rural, regional and remote New South Wales; funding to encourage psychology students to complete professional practicums in rural and remote areas, and partnerships between rural and remote community mental health services and universities to bolster the mental health workforces in these locations; ongoing access to efficient and effective online and telehealth services, with all members of the community having the necessary resources to facilitate these services; a deeper consideration of the intersectionality of disadvantage as being integral to any proposed solutions to improving equity and access to community mental health services; and, finally, an integrated, holistic and early intervention approach to outpatient and community mental health services to ensure equitable access to appropriate mental health care for all who need it in New South Wales. Thank you.

The CHAIR: Thank you. Is there an opening statement from the Australian Association of Psychologists?

AMANDA CURRAN: There is. The Australian Association of Psychologists Inc represents psychologists Australia-wide, and we appreciate the opportunity to provide advice and recommendations to the Committee today. In addressing the issues, we must draw attention to the larger issues present in the mental health sector which contribute to increased pressure on the public system. In the review of the Better Access scheme, cost was cited as the number one barrier to accessing treatment. To address the issues of equity and accessibility in the public sector, we recommend broader reforms and implementation of targeted initiatives to reduce barriers to care, particularly for under-served communities. This includes recommendations from the February 2023 McKell report, which states that the mental health emergency will persist unless out-of-pocket costs are lowered and the workforce is increased.

AAPI recommends increasing Medicare rebates to \$150 for all clients of all psychologists and allowing provisional psychologists to work under the Medicare system. Allowing provisional psychologists through the last phase of supervised training to offer rebates under Medicare could introduce approximately 8,000 mental

health care professionals to the workforce, representing a 22 per cent increase. That could occur rapidly, with a resultant increase in access to services for residents across New South Wales. There is also inadequate treatment currently available in the private sector due to the Federal Government's decision to halve the subsidised psychology sessions under the Medicare Better Access scheme post-COVID. We urge the reinstatement of the additional 10 sessions. Left at the current maximum of 10 sessions per year, the public sector will continue to experience increased pressure and the community will remain largely under-serviced.

The availability of mental health services—especially in rural, regional and remote areas—is a critical concern. Online and telehealth services have proven to be valuable tools for increasing access to mental health care, particularly in remote and under-serviced areas. But AAPI acknowledges telehealth is not always the most appropriate option, and we urge the Committee to review our recommendations for boosting the rural and regional workforce. This can be achieved by supporting and encouraging psychologists to work in regional and remote locations through financial incentives, training opportunities, rural loading, covering relocation expenses, subsidised housing, reducing education debt to those that commit to work in rural and remote areas, and employment programs for provisional psychologists within these communities.

Students who do placements in these communities are three times more likely to work in similar-sized communities after graduating. To promote accessibility and cultural safety, it is imperative to develop culturally appropriate mental health services. Collaborating with First Nations leaders, CALD community representatives, LGBTQIA+ organisations and disability advocates is crucial to ensure that services are tailored to the unique needs of these communities. Additionally, hiring diverse mental health professionals from a variety of backgrounds, reinstating diverse study and training pathways for psychology that will encourage diversity in the profession and providing cultural competency training will enhance the quality of care delivered. Thank you.

The CHAIR: Thanks to all of you for making the time to give evidence today. It is really valuable. We'll now go to questions from the Committee. Mrs Carter?

The Hon. SUSAN CARTER: Thank you all for being with us today. My first questions are to Ms Coventry. I'm interested in paragraph (b) of your submission, where you point to limitations in executive functioning or general cognition and the impact they have on organisation and self-regulation, which presents a need for support to navigate services. The examples you give seem to be drawn from a correctional framework, but do you have comments on whether that same need for assistance with navigation exists for other people seeking to access mental health services?

KYLIE COVENTRY: Yes. I think, absolutely, it would also apply to other people seeking mental health services.

The Hon. SUSAN CARTER: For all groups other than those who are receiving support from DCJ, do you have any suggestions as to what form that might best take? Is it somebody in their family and friends who is nominated as a navigator? Is it a mental health care nurse? Do you have any ideas as to who that navigator might be, if we were to recommend that type of role?

KYLIE COVENTRY: I think there are two things. I think, one, that it would be important to have education and training for the mental health workforce around the impact of the self-regulation and the impact that mental health illnesses have on that [inaudible] functioning. I think it's probably not a one size fits all; it may depend on the person and it may depend on the service. I think this is definitely a role for the peer workforce. I think people with lived experience have a role to play here in terms of supporting people to [inaudible]. I think it would be important to try not [inaudible] more pressure on families but that it would be good to have that role as something that [inaudible] within the system—within mental health services [inaudible] there's a definite role for peer [inaudible] and their lived experience.

The Hon. SUSAN CARTER: Sorry, there's just a couple of sound issues at this end, so I might repeat what I think I've understood you to say. I believe what you've said is that the navigator role isn't a one size fits all, but we should perhaps look to a peer workforce because they may be best placed to walk with somebody navigating through the system. I believe you also said that there was a need to educate the mental health workforce with respect to some of the organisational difficulties that people suffering from mental health issues may have. I'm a little bit surprised by that, because I suppose I would have assumed that a mental health workforce would have been aware of some of the organisational and other deficits that people with mental illness may have.

KYLIE COVENTRY: I think broadly speaking, yes, they should be. But I think that it would also be helpful to provide that training and remind people about why [inaudible] sort of support is required.

AMANDA CURRAN: I think what often happens is that some of the behaviours exhibited by people who are severely unwell might be perceived as noncompliance, aggression or a lack of want to engage with services and they are often exited. Because services are so under pressure, they are often exited from those free

public systems because of that difficulty with engagement. That's where we've found that a peer workforce has been trialled in the defence areas—people who have exited the defence forces. Connecting with a peer worker has helped them engage with mental health services of all kinds. They give that additional perspective of what the challenges are for that person engaging. It might be that they're highly medicated; they can't get out of bed in the morning; or they might be experiencing psychosis and be very paranoid about services. Having been someone who has lived experience can assist them to get to that mental health service rather than slipping out of the system and not being picked up adequately.

ANITA MCGREGOR: I'm being evacuated. I will return when I can. Apologies.

SAHRA O'DOHERTY: I just wanted to add to Amanda's comment. It often comes down to a funding issue. As a treating psychologist myself, it is very difficult to provide treatment, case management and advocacy without the adequate funding. When we look at existing community mental health services, they might have distinct or designated roles for each person. If there is a dedicated case manager or advocacy service, that's where the client who is actually benefiting from that service would get the support that they needed. That would be then differentiated from the treating role—someone who is a treating mental health professional.

The Hon. SUSAN CARTER: I think that what we've been talking about is the fact that often people who are mentally ill might need someone to help walk them through the system and help them access various clinicians or other appropriate healthcare workers. Just one other question, if I may, directed to Ms Coventry. I was interested in your comments in relation to the role that schedule 1 to the New South Wales Health Records and Information Privacy Act 2002 plays in disrupting continuity of care. I suppose there is always that tension between clinical need but also autonomy and privacy of the patient. I wondered if you could just talk a little bit more about that tension and the best way you see to resolve that?

KYLIE COVENTRY: Unfortunately I think Anita would have been best placed to have provided that answer.

The Hon. SUSAN CARTER: Okay.

KYLIE COVENTRY: We could potentially revisit it when she has returned. But I agree there is an innate tension between privacy, confidentiality [inaudible] and the need for sharing of information [inaudible] so that services can [inaudible] coordinated and integrated. Again, I think that, with appropriate support, a case manager [inaudible] to assist that information sharing directly from the patient and from other services, where possible, with the patient's consent could be helpful.

The Hon. SUSAN CARTER: Thank you. Perhaps when Anita is available, she can add a bit more to that.

The Hon. EMILY SUVAAL: I'll start with a question to the Australian Psychological Society, but others should feel free to answer if they have thoughts on this. I noted at the end of your submission your reference to patients "currently spending extended periods in long-term psychiatric facilities" and the difficulties that exist with placing those people in the community, but also around the recent discussions associated with the NDIS and the reduction, if not removal, of psychosocial disability from the NDIS. I wondered if you could expand on that further and what, if any, likely impact that may have on people in New South Wales?

KYLIE COVENTRY: The NDIS currently is focused on the functional capacities of participants. There seems to be a gap in terms of understanding that people who have severe mental illness have functional incapacity associated with that, at times, and so need a really high level of support, and if that support isn't provided through a system like the NDIS then it does create [inaudible] families and for other community-based services.

Our recommendation is that psychosocial services [inaudible] remains within the NDIS in recognition of the functional capacity requirements that people with severe mental illness might have, and that services are better integrated. We're not saying that it should be all NDIS but that people should have access to the NDIS in addition to community-based services so that the care that they're receiving is helping. The NDIS provides a level of support that I think community-based services are not able to, in terms of looking at—

The Hon. EMILY SUVAAL: Sorry to interrupt. How would you see that integrate well between the community-based services and the NDIS? We've heard about the importance of care integration and the integration of services being provided by different organisations. How would that occur?

KYLIE COVENTRY: One of the things that the NDIS is looking at as part of the review that we made a recommendation [inaudible] review was the need [inaudible] support coordinators within the NDIS. I think, too, that systemically and culturally there needs to be a recognition that they all need to work together rather than being siloed. Having somebody who could coordinate that, whether it be from within the NDIS or within a

community service, is really important—so that case managing model: somebody, again, to walk through the system with the person who has the mental illness.

The Hon. EMILY SUVAAL: Ms Curran or others, did have you anything to add on that one?

AMANDA CURRAN: I think that currently, because of the changes to the NDIS, there is quite a significant lag between people being an inpatient and being able to get the appropriate assessment of what their actual needs are in transitioning them out. There has been some project work done to try to address that issue. But without something being named and sort of sectioned away, for all those individuals who have the acute, chronic, long-term mental health conditions there won't be adequate cover. There is not cover through Medicare services for these individuals. There is a housing crisis that's really not going to assist in getting them housed in the community. Without supported housing, often that transition from hospital to community is not achievable for some of these people who have been in long-term mental health hospitalisation. We understand the need for NDIS to change and to be financially viable for a long period, but there needs to be something put in its place if that is closed because there is nowhere else for these people to go.

The Hon. EMILY SUVAAL: Welcome back, Ms McGregor. My second question was around the access to services for individuals with forensic history, which I notice that you've included in your submission, and the services that currently exist through the University of New South Wales forensic practice clinic. You noted the exploration of amendments to the health privacy principles. How would you see that working in practice given some of the sensitivities around that information and loosening up, I suppose, the principles at the moment?

ANITA MCGREGOR: I'll speak to this. I don't know if I can speak confidently around some of the changes. By speaking as a forensic psychologist of over 30 years who has worked in the community, I will say—and I apologise because I don't know what evidence has been given up until now—our clients generally have a lack of general access to mental health care plans, to NDIS, to substance abuse rehabbed housing because if they have any kind of legal issues going on, they are often limited. We are often faced with situations where we have clients with multiple complex issues and we are often trying to go and deal with clients with those kinds of complex issues. I think that it has to sometimes be specialised teams that have specialised knowledge on how to manage some of the issues around scheduling.

The CHAIR: Now that Ms McGregor is back, I wonder if we return to Ms Carter's question that was asked in your absence.

The Hon. SUSAN CARTER: I was interested in the comments that you made or the observations made in the submission in relation to the challenges of receiving adequate information about a patient and those challenges actually arising from protective measures in the form of the requirements of the privacy Act and the balance between protection of privacy but obtaining accurate information so the patient can be treated properly. I wondered if you can talk about that tension a little bit and what you see as the way forward.

ANITA MCGREGOR: I wish I knew the way forward. In some respects, as forensic psychologists we can only do our jobs when we have the information. We're often asked by Corrections as forensic psychologists to do offence-related treatment. Without understanding what the offence is, we can't do our work. We can't do an adequate risk assessment. We can't look at the specific factors that are associated with offending, for example. So I appreciate that there is a tension. We generally, as forensic psychologists, are very knowledgeable about what information we require and we are very, very clear about how the best way to go and access that is. We're finding that sometimes systems are pushing back for us to access that information and we are working towards memorandums of understanding. We're working towards better working relationships. It is a long and difficult process.

The Hon. SUSAN CARTER: You wouldn't have any specific recommendations that you could suggest that we could look at making?

ANITA MCGREGOR: We are in the process of working with the Department of Communities and Justice to go and have some of those memorandums of understanding. Any support that we could get in forwarding that and making it some kind of priority just means that we have a safer community at the end of the day. I think we can do our work easier without having those kinds of barriers. It just makes it that much easier. Again, we can be very clear about what kinds of information we need, but having that road paved a little bit would be very helpful.

The Hon. SUSAN CARTER: Perhaps if you could take it on notice and provide us with further details of the type of information that you think is required, that might be very helpful for us.

ANITA MCGREGOR: I'd be delighted to.

The Hon. GREG DONNELLY: Mine's a general question. Thank you all very much for participating. It's just a general question in regards to children and adolescents. It's a broad question about your thoughts about the factors—plural—feeding into the causes of mental health morbidity. Obviously, we've heard evidence thus far about thoughts in regards to this and also submissions, but as peak bodies—and I know it's an umbrella sort of question—your thoughts about those factors that are feeding into the mental health issues. Start with either organisation, I don't mind. If everyone would like to answer or one from each organisation or whatever is preferred.

KYLIE COVENTRY: I think there are a number of factors. I think the impact of COVID-19 is a factor now too. I think climate change is another factor, the impact of social media, and I think there's a general awareness among young people these days around mental health that there perhaps hasn't been in the past. It also has an impact in terms of their own thinking about it. We strongly advocate for school-based programs to focus on building resilience in young people as an [inaudible] early intervention method.

AMANDA CURRAN: I think when we've got a mental health system that doesn't adequately fund early intervention services for young people, we're going to end up with significant strain on acute mental health services. There's a real need for adequate funding of Medicare sessions, so increasing the rebates so that children can be seen at no cost. We need to also look at how many sessions are available and where sessions are supplied as well. Providing services to children in schools is of crucial importance so that when they're experiencing those life stressors, and we're talking big issues here for children—parental separation and divorce, abuse and neglect—they're likely to be picked up in a school system.

But currently there's not adequate services available in schools to provide that support and there are inadequate services outside of schools to provide that support as well. If we get in there early and support people, then we've set the scene for the rest of their life. I think that there are multiple issues across socio-economic status, cultural and linguistic diversity—all of those need to be taken into account when we're looking at the trajectory of mental health across somebody's life span. I don't know, Sahra, if you have anything else that you'd like to add there on that?

SAHRA O'DOHERTY: Absolutely. I think that we take the whole-of-family approach—the whole-of-community approach. In the AAPI, we're looking at these sorts of issues. We can't just be looking at early intervention. Obviously, as Amanda was saying, early intervention is definitely the key. We also need to look at things like increasing programs for families and parents. We know that there is an increase in demand for perinatal depression and anxiety support in people who recently had children—things like expanding NDIS to include family support, or even under Medicare funding. Again, I feel like a lot of this does come down to funding. We need to be ensuring that the whole of the family is able to be supported adequately. It isn't always the job of the school to be providing a lot of those supports. And, let's face it, schools are under-resourced and underfunded, particularly in the public sector. But we need to be looking at what community supports can be targeted at families, particularly of young kids, in order to prevent the mental health burden coming out later on as adolescents.

What I know from my experience working in places like headspace is a lot of young people are being referred to headspace where it might actually be an inappropriate service for them. They might be not meeting that criteria of mild to moderate presentations, and then they are cross-referred on to the community adolescent and child mental health teams, where they are understaffed and overburdened and they are not able to see those young people. What we're seeing is more awareness, but not a lot of support. We need to have more of that wraparound holistic support, particularly, as I said, for families.

The CHAIR: I have a few questions to do with the terms of reference around equity. In the submission from the Australian Psychological Society, I noted a comment about the staffing or the skill mix in community mental health services that are leading to exclusion criteria. Could you expand on that? What recommendations could we make around the staffing of community mental health teams to be able to broaden inclusion criteria for those services?

ANITA McGREGOR: I think again, it's the specialisation—just generally, the workforce in the community, I think, as everyone has noted, needs to be more diverse and more specialised. Unfortunately, especially our psychology workforce is becoming more and more specialised. There are currently nine endorsements plus a generalist way of becoming a psychologist. Unfortunately, the lay of the land in Australia is that there's a preponderance of clinical forensic psychology training. Most of the other endorsements are being limited and some of the other kind of specialised training is being limited as well. We're getting a very vanilla kind of training in our communities and in general. I think that this becomes an issue kind of Australia-wide in some ways as well, about how we are educating the public about what psychologists do and advocating for what psychologists do. Because without that specialised training, we're going to get very vanilla community health centres and we're just going to miss a lot of the needs of the community.

The CHAIR: Thank you. I can see Ms O'Doherty nodding along with parts of that answer. Would you like to comment on that as well?

SAHRA O'DOHERTY: I'd love to, thank you. I absolutely agree with what Anita has just said. We need to be looking at broader and more diverse industry and training pathways for psychologists. I'll note that the 4+2 pathway, which is one of the main registration pathways, has recently been retired. That included two years of supervised internship and placement for provisional and early career psychologists. When we look at the current level of masters training in Australia, we're actually excluding a lot of diverse populations from entering into the field when we're needing to commit to full-time training and no ability to work. We're seeing a lot of psychologists who are coming in from wealthier socio-economic areas, from Anglo-Saxon backgrounds, not CALD backgrounds, so we're really lacking that diversity in the profession, which then of course trickles into who is able to adequately serve particular diverse and marginalised areas of the population.

The CHAIR: Thank you, that is really helpful. I also wanted to talk about the mental wellbeing of the mental health workforce itself. We've heard lots of evidence about burnout of workers on the front line and how complex and emotionally difficult some of this work can be. We've spoken with GPs, psychiatrists and nurses earlier today. I'm interested in your views on clinical supervision to actually support mental health workers. What does that look like for psychologists, and what should it look like for the workforce more broadly? How can we do this well?

ANITA MCGREGOR: Can I speak to that? I'm actually one of the AHPRA supervision trainers, so I think I speak to this with a bit of experience. Psychology is one of the only professions where supervision is a requirement. Unfortunately, it is only about 10 hours a year that is required, but I think it is still better than nothing. In fact, right now, as we're speaking, I'm actually teaching a class on self-care and I'm having the students actually do an exercise on self-care right now, because it is such a huge part of what we do and is so required. I've had so many conversations in the last couple of years about how COVID didn't just devastate our communities, but it devastated the community of psychologists as well. It is terrifying in some ways when we think that there's these really sometimes very broken psychologists who are still trying to reach out and help a broken community. It's just really hard because we recognise that we're facing situations where there's just long waitlists and services that are underfunded. I just watch my fellow psychologists continue to reach out, despite the issues that they're facing.

The CHAIR: To follow that up, what sort of resourcing does a good clinical supervision program actually need?

ANITA MCGREGOR: More than 10 hours a year. Often in systems—and I'd like other people to go and comment on this as well—you have line administrators who are also doing your supervision, and so it makes it sometimes an unsafe place for psychologists to go and actually get that supervision. Some kind of support for psychologists—part of their pay package—to go and be able to seek external supervision or external support would be really helpful.

The CHAIR: Ms Curran, go ahead. I can see you have your hand up.

AMANDA CURRAN: Thank you very much. There was research done by the ANU last year that AAPI supported around burnout and the mental health and wellbeing of the psychology workforce. I'll be happy to provide that study to you. What we're finding across the psychology profession is that people are dealing with their own burnout by reducing work hours and then, of course, that is leading to financial insecurity. It would be really wonderful if we could see additional financial resourcing of that supervision so that people can get the adequate support that they need to continue to work as many hours as they need to. We saw New South Wales and Victoria psychologists struggle the most, and that is because of the longer periods of lockdown that they have experienced.

Just to follow up on a comment that Anita made about having a line manager provide your supervision, we contributed to the headspace early careers model where they have arranged for someone in a different site to provide supervision of early career clinicians that are employed through that program. Ideally, that sort of approach would be taken so that you've got someone completely impartial but of the same profession as yourself that can provide that supervision, training and emotional support to psychologists. We've seen that some workplaces are providing additional funding for supervision. We'd like to see that rolled out across the NSW Health service and potentially across the private practitioners, who are doing a lot to prop up that system at the moment as well.

The CHAIR: I would really appreciate if you could send through that study that you mentioned from the ANU. I think that would be of great interest to the Committee.

KYLIE COVENTRY: I just wanted to add to what Amanda was saying about that ANU study. Also, it focused on the impact of natural disasters on psychologists, particularly those who live and work in the

communities that have been affected by the recent fires and floods in New South Wales, and the impact that that has on them in terms of their own personal lives but also in terms of their professional lives in trying to support the community they live in, which also brings me to make the point that the Australian Psychological Society has a Disaster Response Network that provides support to frontline workers in disasters. We run it in partnership with the Red Cross and I think that that provides a really good model, at least for that initial support for frontline workers but including those who might be experiencing the impact of natural disasters in the communities they work in.

The CHAIR: I'm interested in the APS submission as well. You mentioned the benefits of telehealth, particularly in that post-disaster context. I was wondering if you could expand on that. In what context or in what settings is that useful and what are the risks as well?

KYLIE COVENTRY: I think it's particularly beneficial again in regard to what we've just been talking about, where psychologists who are not involved in whatever natural disaster may have occurred can provide that support via telehealth. For example, with our DRN—our Disaster Response Network—we sometimes have people on the ground, but primarily the support is provided via telehealth. The benefit of that is that those who are affected don't have to provide that support. It can be supported by people outside of that community.

ANITA MCGREGOR: I think especially in regional and rural areas telehealth can be excellent and people who have difficulty in transportations, so people who have disabilities, those kinds of issues—it can be very, very helpful. The limitation, however—and we found this actually during COVID working with forensic clients—is that often people couldn't get privacy. Sometimes they didn't have access to devices to internet—like adequate, stable internet. And also the issue around cost sometimes—people having to go and pay for the internet use and those kinds of things. We actually found quite a few limitations. There are a number of limitations as forensic psychologists in doing assessments via telehealth. While I think it can be really, really helpful and used as a tool to support and augment some of the things that we do, we do have to recognise that there are some significant limitations in its use as well.

The Hon. SUSAN CARTER: In relation to supervision and provisional registration and barriers to diversity of people entering the profession—anybody who feels interested can comment—it's my understanding that, quite understandably, there is more supervision required for provisional psychologists. To what extent do you think the provisional psychologists having to meet the cost of that themselves is a barrier for some people pursuing registration?

AMANDA CURRAN: For provisional psychologists to fund their own supervision—amounts to \$25,000 or so every year. For every 17 hours of physical work that they do, they have to have one hour of supervision from someone who is senior in the profession. It's really quite a significant financial burden and a lot of our provisional psychologists—to start out they're doing voluntary roles because there's no scheme for a paid placement currently. Well, I won't say "there's no"; there are very limited opportunities for those paid placements. So it is quite a financial outlay for them. Often, with the pathways changing, they've had to pay \$35,000 for a masters degree on top of what they've already done as well. At the outset, they're really financially troubled. We've had provisional psychs needing to get food hampers and support for buying petrol and things like that. They really should be better supported throughout the system, so that that's not impacting on the care that they're providing to the community. Because they are the future of the profession, it's really important to support them adequately.

ANITA MCGREGOR: I think it's important to note that there are two training paths for psychologists. One is the 5+1 that kind of replaced the 4+2. With that, you are often paying for your own supervision through that sixth year. If you're doing like a two-year masters program, often the placements are unpaid but the supervision is paid for. Although the financial burden can still be large, even though they have—the program that I'm within at UNSW, there are Commonwealth-supported placements. All of our students are in Commonwealth-supported placements. There's still a huge financial burden in trying to go and get through two years of a full-time program often without being able to go and have any paid employment. You really require incredible support or support of family or something to go and get you through. So placements can really vary where they're paid or unpaid and whether the provisional psychologist has to pay for supervision or not. The model varies and it's important to note that.

The Hon. SUSAN CARTER: I just wanted to pick up a couple of themes from earlier. One was, I suppose, the privacy autonomy theme. I also pick up from some of the questions from my colleague Mr Donnelly and also statements, Ms Coventry, in your submission in relation to the role of families, who are often the first to notice symptoms of mental illness, and their ability to seek treatment for members of their family. Cohort—let's say 14 to 20.

Families understand that there are mental health issues. The young person may or may not have the same understanding as the family, also bearing in mind the comments in the same submission about limits in executive

functioning or general cognition—but also, I suppose, the difficulty sometimes with families speaking to healthcare practitioners for or on behalf of, or getting information about treatment of, a 14- to 20-year-old. What are some of the issues around how families can best support the young person in distress and how they can be recognised as partners in supporting the young person in distress?

KYLIE COVENTRY: Again, I think it's really important, and I think we said in our recommendations [inaudible] education and training for mental health workers and mental health services around the role of family, so that balance between involving the family and understanding [inaudible] but also not putting the pressure on them to be the only [inaudible] for the family member who's experiencing mental health disorder. Then I think that that's where people with lived experience can be really important, both in terms of peer [inaudible] but also in terms of parents [inaudible] and carer organisations [inaudible] supporting families. So, even if it's something as [inaudible] as mental health, being aware of [inaudible] carer support services and giving family information about how they can access that [inaudible] so that again it's seen as [inaudible] and it's a wraparound service rather than something that's just provided to the person [inaudible] who's experienced mental ill health [inaudible] and that the mental health system [inaudible] the family and provides the [inaudible] with that support.

The Hon. SUSAN CARTER: I will just repeat that, because again I'm having some sound issues. Is it a correct summary if I say that it would be useful if members of the mental health profession were educated and more aware of the position of the person presenting with symptoms, in the family, the role that the family can play in supporting and helping them and supports that that family may need to be able to fulfil that role?

KYLIE COVENTRY: Yes.

ANITA MCGREGOR: I just wanted to add to that that I think every psychologist in this room would probably agree that we get requests on, probably, a relatively regular basis about asking about what resources are available to friends and family and those kinds of things. One of the things that I have noted is that helping GPs, potentially, having information about what resources are available is really helpful. One of the other things that I was just thinking about is that, in the clinic that I'm part of, we run quite a unique not-for-profit group. It's a free group for carers of loved ones who have mental health issues, usually around emotional dysregulation, because often the parents and carers of people who have mental health or cognitive issues or those kinds of things have such limited support, and so being able to support the families with information and resources is really key, often, to helping the person who's having the mental health issues.

The CHAIR: Thank you all again so much for your time today and also preparing your submissions. The secretariat will be in contact with you about any questions on notice.

(The witnesses withdrew.)

Dr EVELYNE TADROS, Chief Executive Officer, Mental Health Coordinating Council, sworn and examined

Ms CORINNE HENDERSON, Principal Policy Advisor, Mental Health Coordinating Council, affirmed and examined

The CHAIR: Thank you so much for taking the time to give evidence today. Would you like to start by making a short opening statement?

EVELYNE TADROS: Yes. Thank you, Chair. The Mental Health Coordinating Council thanks the Committee for the opportunity to provide evidence. As the peak body for community mental health organisations in New South Wales, we represent non-government organisations who support people with mental health conditions to live well in the community, by delivering psychosocial supports and rehabilitation services. We provide leadership, promote legislative and systemic change, and develop capacity-building resources to assist the delivery of quality services.

Central to the recommendations outlined in our submission is that any review of equity, accessibility and appropriate delivery of public mental health services should be informed by an appreciation of the impact that NGO services offer to consumers. They work collaboratively with public services to provide person-centred wraparound care and support to meet both needs and personal aspirations. The Mental Health Coordinating Council highlights that, when appropriate non-government services are available at the right time in the right place, there are fewer demands on public services. People require fewer inpatient admissions and outpatient services, leading to a reduction in public health costs overall. We strongly recommend enhanced funding for NGOs, channelled through a reallocation of funds generated by cost savings in the public services.

Our key priorities for our submission suggest that clear evidence from the HASI CLS evaluation in 2022 demonstrates their effectiveness from both a cost-benefit as well as an individual, family and community perspective. For example, hospital admissions for HASI clients due to mental illness saw a reduction of 74 per cent over two years. This is compelling evidence. Likewise, step-up step-down prevention and recovery centres that aim to support transition back into the community from hospital or provide extra support at times of crisis or vulnerability have been shown to be very effective. Unfortunately, there is limited access to these programs, particularly in rural, regional and remote areas. Evaluations have shown longer term outcomes of better connections with family, employment and community. Unfortunately, there are only five step-up step-down programs in New South Wales. The introduction of 19 Safe Havens in New South Wales is also an important initiative, providing a place to go when people feel distressed or have suicidal thoughts. We need much more crisis interventions to emergency departments across the State.

The last thing I'll also add is the opportunity to extend all mental health and suicide prevention service funding cycles to a minimum of three to five years to increase recruitment, retention, evaluation of services, and continuity of care for patients. We've seen that the Commonwealth has been able to deliver some contracts that go from five plus five—five years, with an additional five, pending performance. We'd also encourage that. Thank you.

The Hon. SUSAN CARTER: Thank you very much for being here today, and thank you for your work. A theme we've been exploring today is the difficulty for a lot of people to navigate their way through the system. In fact, you touch on that when you talk about the need for awareness and alignment of existing services. I wonder if you have any thoughts. I notice your support for peer workers. I wonder if you have any thoughts—happy for you to take this on notice, because it's not something that's been specifically addressed—about whether or not it's beneficial for people moving through the system to have somebody to assist them, to navigate, locate, direct, access, make appointments for them so that they can benefit for the services that are available and, if so, whether that person should be a peer worker, whether they should be a mental health trained nurse, whether it should be a trusted friend or family member but someone recognised by the system—just if you have any thoughts about that role of navigator.

EVELYNE TADROS: Yes, absolutely. The New South Wales Mental Health Commission have done work in the peer navigation space. It is absolutely something we would support and recommend, and that can also be delivered by peer workers. The navigation allows for that access and information about the various services. We've done our workforce survey for the CMO sector. We do it every three years or every two years, and the next one will be released hopefully by the Minister at our AGM on 16 November. The last survey demonstrated that 14 per cent of the CMO workforce included peer workers. There is absolutely a role for peer workers to play, and we would support the peer navigation. I'll turn to my colleague. Have you got anything else to add?

CORINNE HENDERSON: As part of that program, it involves quite extensive training to assist competency in that space. As part of the cert IV, which is something that we have developed with the commission,

there is a specific qualification that enables peer workers to understand, themselves, how they can do this work. That's incredibly important because you can't be a navigator if you don't know how to build capacity of the people you're working with to later do that for themselves. It's about not only building the capacity of the peer workers themselves, but then building the capacity of the people that they work with.

The Hon. SUSAN CARTER: Would you have any idea what the cost of completing that cert IV is, both in terms of money and time, and how many places are available and where it is available to be completed?

EVELYNE TADROS: The Mental Health Coordinating Council also delivers training as a registered training organisation. Many of the scholarships available for the certificate IV in peer work are available through scholarships. It's a partisan agreement with the Commonwealth and the State. Some of it comes from the Ministry of Health. Most of it is run through scholarships. If I can take it on notice, we can provide the specific numbers, if it wasn't included as part of that scholarship, of what the cost would be.

The Hon. SUSAN CARTER: I'd be grateful if you could, and perhaps also locations and geographically how accessible it is. I'd be very grateful if you could provide that information.

EVELYNE TADROS: Absolutely. I can answer the latter part. We offer the program all throughout New South Wales. Because of COVID, we had to move to remote learning. It is absolutely available all throughout New South Wales and is being picked up all throughout the State as well. That's an easy one.

CORINNE HENDERSON: When we complete our workforce survey, which is halfway through at this point in time, if you were interested, we can certainly provide you with that.

The Hon. SUSAN CARTER: I think we'd be very interested, thank you. I have one more question on this, if I may. It sounds to me that as part of the development of this certificate IV program, you've mapped all the services that are available so that people can navigate their way through. Am I understanding correctly what is contained in this?

EVELYNE TADROS: That might be a bit ambitious. On our website, as I'm sure many organisations do, we have programs and services that you can access, but it is important that we reflect on the myriad of systems and services that are available to mental health consumers or people in need of support and their carers. There isn't a one-stop shop in any of the systems that you look at. It's not like we have a MyAgedCare.com or MySchool.com. I don't think there is anything as simple as that. Through our training we generally tell people the service offerings and where can you go to look for information. But there isn't that one-stop shop.

The other thing that we do as part of our registered training organisation is deliver a suite of professional development programs. We've just put on scope the peer work leadership program. We also do things like safe storytelling and a whole range of programs that support peer workers generally as they progress throughout their journey of being a peer worker.

CORINNE HENDERSON: Added to that, it's not just about where to go but to understand the breadth of the system and what it is somebody might need. That's the first stage—being innovative and creative and thinking quite laterally about what somebody might need, and then finding where might be able to provide that service.

The Hon. SUSAN CARTER: I have one final question, just to understand the concept of peer worker. Is a peer work anybody who has suffered with mental illness or is it more precise? Is it that someone who has experienced depression would walk with somebody who's currently experiencing depression, or somebody with an eating disorder would walk with somebody currently experiencing that? How is it that we think about peer workers?

EVELYNE TADROS: It's very mixed and varied. It is probably not as succinct as that. It is just someone with a lived experience. Sometimes they have training under their belt formally, and sometimes they come with their lived experience alone. Someone with lived experience of schizophrenia could work with someone with an eating disorder. It's a perfect match if you've got a peer worker with an eating disorder who works with someone who's experiencing issues around eating disorders now. That's the perfect match. It is about drawing on their strengths and drawing on a peer worker's experience to say, "This was my experience, and this is how I got to where I am." It's the tools that the peer worker has learnt that they're able to share with the person who is immediately experiencing a mental health challenge.

The CHAIR: I was interested that in your submission you made a recommendation around suicide prevention for carers. We have heard from carers through the inquiry that they would like to be more involved and better resourced to support the people with mental illnesses that they're caring for. I'm interested in what that might look like in terms of who could deliver it, whether it's face-to-face training or whether this is an online module. What do you see suicide prevention training for carers looking like?

CORINNE HENDERSON: We don't do that training. Mental Health Carers NSW do a lot of that work around supporting carers. We can't speak specifically about what might be included, but we were just sharing the sentiment that being a carer is something that really needs support at a number of different levels, not just respite but maybe to help people understand what somebody they love is going through, which they may not quite understand. So it's supporting people at multiple levels and helping them not to develop their own mental health issues, because that's something that carers talk a lot about to us—how they experience their own mental health issues because of the very experience of being carers.

The CHAIR: I'm also interested that in your submission you noted that Australia has very high rates of use of community treatment orders under the Mental Health Act, which are high by global standards. I'm interested in what insight you can offer into why that might be or what alternatives might be that we can recommend.

CORINNE HENDERSON: It's very interesting. If you look at it internationally, there are many western countries that don't have CTOs at all. The question is how they manage people with complex mental health issues. Does this mean there is more chemical restraint? There's a lot of literature, and I think we refer to some of the literature in our submission that may well be worth looking at, and we can send you some more if necessary. CTOs can be extremely useful and a lot of people are greatly helped by them, but they are not a safety net in lieu of community services. Very often treatment teams become very risk averse because they've lost somebody to engagement in the past, and so a CTO is put in place as a safety net. That's not really what is envisaged under the Act, which is quite clear that it's about the least restrictive care that's safe and appropriate.

What we advocate—and obviously we're the peak body for community managed organisations—is that if treating teams were able to feel more assured that there were the services in the community that they could work with to support somebody, a CTO wouldn't be necessary. That doesn't mean they aren't sometimes necessary. But that's one of the reasons we believe that there are more CTOs than possibly there needs to be. Sometimes people have been on CTOs for decades because they have a history of appearing unsafe in the past, and it has continued because of that safety-net attitude to CTOs. People deserve to be given a dignity of risk and, at some point or other, if they seem safe and stable for quite some time, to come off their CTOs.

EVELYNE TADROS: Notwithstanding that some people are going require CTOs, prevention is better than cure, which is we why we would argue that if we get people earlier on in their time of need, we're stopping them from entering the emergency departments or getting that support too late. That's why we would advocate for more support in the CMO sector.

CORINNE HENDERSON: In relation to that, one of the things we strongly advocate for is supported decision-making to be part of the core skill for the mental health workforce, so that people can work with consumers to assist them to make more appropriate decisions for themselves so that they can capacity build to work better with the people who are aiming to support them.

The Hon. EMILY SUVAAL: Thank you to both for you appearing today and for your submission, which detailed some 27 recommendations for our inquiry. Obviously not dismissing the importance of all the recommendations, because they're all important, but do you have a top three in terms of importance or impact? Maybe they're listed in that order, I'm not sure, but what would those be?

EVELYNE TADROS: The one-two-three would probably be the top three I used in my opening statement. We're recommending increasing HASI/CLS by 2,500 in the first year and increasing them to 10,000 within four years, at a cost of \$365 million. I know the Ministry of Health is working with David McGrath on a psychosocial research project, which is to identify the need within New South Wales to help potentially inform the tender. That tender round finishes in 2025, so we hope we can tag on a few extra packages there. The second is around step-up step-down. We're recommending an extra 130,000 places for people to access residential programs that minimise the risk of hospital admission in New South Wales.

CORINNE HENDERSON: One of the issues around step-up step-down is, because there are too few of them around, it tends to be step-down for people who are coming out of hospital and need a smoother transition into the community. What we need is for people to be able to step up as well so they don't end up in hospital. It's really critical that it works both ways.

EVELYNE TADROS: Recommendation three is to extend all mental health and suicide prevention service funding cycles to a minimum of three to five years. The reason we say that is because it provides continuity of care for the consumers or people with lived experiences, as well as for the workforce. Throughout the inquiry we've already heard quite a bit about the workforce being burnt out and the churn that is happening. If we can sustain people in their contracts then they're more likely to stay with us. Our workforce survey also identified that a quarter of the mental health workforce is in the CMO sector, and that is increasing by 6.5 per cent per annum. So we need to be continuously investing in the workforce, including in the CMO sector.

The Hon. EMILY SUVAAL: How many CMOs do you represent in New South Wales? What's the number?

EVELYNE TADROS: Over 80.

The Hon. EMILY SUVAAL: What role do they have in looking after—we've heard them called the "missing middle"—moderate to severely unwell people in New South Wales? What role, if any, do CMOs have? Are they properly integrated with NSW Health to do that?

EVELYNE TADROS: Many of them are funded by NSW Health; some of them are funded by primary health networks; some of them are funded by the LHDs. They deliver a myriad of programs. Some of them are national organisations that cover all of Australia, and then there are others that just cover New South Wales. The ones in New South Wales might be for pockets of regions, or they cover the entire New South Wales area. What was the second part of your question?

The Hon. EMILY SUVAAL: Are they properly integrated within NSW Health?

EVELYNE TADROS: I would argue that because of the funding criteria, they've got an eligibility criteria that they often have to adhere to. The eligibility criteria for many of the programs can be a little bit restrictive in terms of integrating. There are opportunities to increase that integration between out of hospital and into hospital, and even rehab and detox—I know that was spoken about earlier today—so that that cycle of care for a consumer, regardless of the condition or the issue that they're facing—providing that holistic, trauma-informed approach is still something we need to continue to work towards.

CORINNE HENDERSON: In the wake of the NDIS, a lot of our members provide NDIS services. Some of the services that they previously supported no longer exist. There is that missing middle there, to some extent, because there are almost no block-funded programs for people to drop in to reduce social isolation. So there is definitely a missing middle there, where people are working with people at the quite complex end of mental health.

The Hon. EMILY SUVAAL: So it's fair to say that the CMOs, in terms of looking after that moderate to severe level of distress, aren't properly equipped to do so?

CORINNE HENDERSON: I think moderately severe to severe, rather than right at the bottom end of the scale. They are often looking after people who have become quite stable in the community. They may have long-term mental illness but are well, are coping quite well in the community and enjoying their lives et cetera. A lot of the support goes to people with those continuing conditions.

EVELYNE TADROS: I think it's also dependant on the program. If you look at PCLI, which is the Pathways to Community Living Initiative, stage 1 was long-term patients in long-term care who moved out into aged-care facilities. They were the over-55s who have had long-term mental health. They moved into aged care and they have been stabilised in that. It depends on the spectrum and what you're looking at, but there is certainly more opportunity for us to engage more. I don't think I need to preach to the converted, but the 2020 Productivity Commission identified that there were about 50,000 people in New South Wales who needed support. So even back then we were identifying huge needs for support. We've obviously been impacted by COVID and higher cost of living, so you've had all these issues exacerbated for people generally in the population, as well as those already having mental health challenges to address. It's exacerbating the issue, yet we're not necessarily coming up with the additional programs to support it at pace.

CORINNE HENDERSON: Which is why one of our recommendations is around a payroll levy.

The Hon. EMILY SUVAAL: Yes, I noticed. That came up this morning earlier in evidence.

CORINNE HENDERSON: We know there's no more money really there or to take away from something else. This additional funding could be, in the same way as in Victoria, specifically allocated to the sector, which we think would be a very good solution to the issue of money.

The Hon. EMILY SUVAAL: I'm sure the Treasurer will be pleased to hear that. In terms of the recommendations, one of the others that you mentioned was recommendation 18 around the peer workforce:

Provide support and resources for the Lived Experience (Peer) workforce and create employment pathways, workforce readiness and industrial protections.

Could you elaborate further on that? What, if any, industrial protections are there currently? What do we need to do in that space?

EVELYNE TADROS: I think it's quite inconsistent, how peer workers are paid. Some fall under enterprise agreements, some fall under SCHADS, some under the health agreement. I know that peer workers are

calling for a consistent instrument that would support them and help them throughout their journey. In terms of training and pathways, that's why the MHCC sought to get the peer work leadership on scope. We just had the peer certificate for peer work. We've now got peer work leadership because there's a recognition that once you get in as a peer worker, there's not far to go beyond just being a peer worker, so they've added that leadership scope. We also need to scope it out and see that it's sustainable for us as an organisation each time we bring something new on scope.

CORINNE HENDERSON: We have been supported considerably by the department to provide scholarships to the sector, but training and education are not generally part of funding for particular programs. Unless there are scholarships available, people can't receive training, and quite a lot of organisations are not able to train their staff. We do provide a few things that we can that are freely available online, like a very brief supported decision-making module that was funded through an NDIS grant, that anybody can have a look at. But real, live training is something that costs quite a lot of money. There's also a problem with backfill. Whilst somebody is doing some training, there needs to be someone to replace them. These are all financial issues that CMOs find difficult to manage.

EVELYNE TADROS: The only other thing I'd add is I think once upon a time peer workers would have been nice to have. If we've got some extra money in the budget we'll go and employ a peer worker. Now it's like it's a must have in any tenders, any opportunities, any new business that a CMO applies for. It needs to be front and centre of their bid and you actually work everything else around it. That means more funding for CMOs because you've got to have your clinicians, you've got to have your caseworkers, you've got to have your case coordinators. We're talking about peer navigators and we're talking about peer workers, but you only get a certain amount. You have to try to shuffle the deckchairs to make it work.

The CHAIR: You commented in other related matters about the challenges with the comorbidity of mental illness and addiction to alcohol and other drugs. We heard some evidence about that earlier today as well and you've commented on the service delivery environment being quite siloed. We also heard today the frustration that some supported living organisations exclude people who use drugs and that was contributing to some of that complexity. What recommendations would you have for us for how we can do better to support that particularly complex group of clients?

CORINNE HENDERSON: I think that it will be useful to see what comes out of the drug summit and out of the AOD strategy, because certainly when we were involved with the consultations around that it was clear that the AOD sector saw that mental health should be part of the work that they do. We haven't seen the strategy, I believe it sits with the Premier and Cabinet at the moment, but we need to look at that to see what is being suggested.

EVELYNE TADROS: I think the challenge, as you may well be aware, is that all the systems operate quite separately; homelessness operates in its bucket, you've got child adolescent health. One thing that we would really like to call for is obviously a joint—a bit like a COAG at the national level. We need a little New South Wales COAG where all departments that are trying to support in this space are actually working together. We did see it with the MHDA once upon a time, where mental health and drug and alcohol were one unit and obviously at a different point in time it separated out. There needs to be some intergovernment relationships at that ministerial as well as—and we've seen that with Minister Jackson's portfolio at the moment where she's got homelessness and mental health in the one portfolio, but also getting the departments that are associated working in that same way.

CORINNE HENDERSON: There has been some co-commissioning through the PHNs of programs that work with people with coexisting conditions and that's obviously a great move. But it's dependent on what's going on in each of the LHDs and what their priorities are according to the demographics. It would be great if it was something much more universal across the service system, because from what is seen—for example people coming before the tribunal, you could say, just off the top of my head, probably about 70 per cent of people who are in the mental health system have a coexisting issue. That cannot be dealt with while they are in hospital there; they have to go into hospital and do that separately. There needs to be more integration in that area.

EVELYNE TADROS: And just more services generally. I know if you look at the homelessness system, if someone comes across with, dare I say, just homeless or at risk of homelessness and doesn't have drug and alcohol, mental health, they're likely to get in easier in a homelessness service than someone who also comes with a mental health and an AOD issue. There just needs to be generally more support offered in all the streams of support that are required.

The Hon. GREG DONNELLY: Take it as read from the submissions we've received and the oral evidence presented by witnesses that there is a percentage of children and adolescents experiencing mental health challenges because of their domestic family relationship issues, whatever they might be, just use it as a broad

matter. The ability of parents and/or guardians to be directly involved in supporting and assisting the adolescent or child, perhaps it's not there, it's fundamentally dysfunctional, sadly. From evidence from other submitters, discussion around anxiety, for example, is a burden that a lot of young people carry today. Some of the earlier witnesses went through some other examples that affect children and young people, irrespective of their family circumstance.

What surprised me from evidence that we've received thus far is the issue that parents and guardians just don't feature at all in any of the reflections. It's as if they don't exist or they are invisible, or perhaps even worse, may not be inclined or feel well suited to be able to deal with issues. I would have thought as a first line of defence those at the most intimate relationship level, the family level—an ability to assist parents at those very early stages to identify at those early stages and start perhaps to understand and even lead on to possibilities of seeing professional support. It seems to be almost obvious to me. Am I missing something there?

EVELYNE TADROS: No, not at all. I think you—

The Hon. GREG DONNELLY: I don't think I have seen the word "parent" in any submission. I stand to be corrected. I find that quite extraordinary.

EVELYNE TADROS: I think it falls under the umbrella of carer.

The Hon. GREG DONNELLY: Carer, perhaps, yes.

EVELYNE TADROS: A lot of the time the parent might be just classified as a carer, rather than a parent. I do agree that there are obviously lots of children and adolescents, whether it's a parent or a carer or a guardian, who the parents and guardians often require support that are not potentially getting it and the first line of defence is school, your GP, headspace, and, unfortunately, police and the justice system. We were talking outside during lunch that often the young people have to enter the detention centre or adults have to enter the corrections centre before they get Justice Health engaged, and that's when they actually start to see their support needs addressed. I think that probably just falls under carer.

CORINNE HENDERSON: I think with child and families, well child and young adolescent services, families are always involved if they are there. That's very much part of the way that they work therapeutically. It's not my area of experience or not something that our organisation's primarily working in that area. We have organisations that have headspace programs, but that's about it.

EVELYNE TADROS: Our CMOs would absolutely map out who the carer and support networks are for individuals as they approach. Whether it is Head to Health, whether it's headspace, as they approach on the incoming questions that would be answered, "What's your support network like?" and you would start to map that out for each individual so that you could actually draw on that support, because often people are feeling isolated. "Who would you go to if you needed help with ...?" "Oh, I'd go to my favourite teacher." "I'd go to my aunt." "I'd go to my uncle." You start to map that out for the individual so they can draw on those supports. Because sometimes it's not mum and dad; it might be the aunt or the uncle or the neighbour or whatever it might be.

CORINNE HENDERSON: Sometimes with headspace services, young people, part of the problem from their perspective is the family and actually they want that privacy and they want to be able to go to a service that is not going to involve their parents. I think that's respected.

The CHAIR: Thank you for your time, both to prepare the submission and to give evidence today. The secretariat will be in contact with you with any questions on notice.

(The witnesses withdrew.)

(Short adjournment)

Ms DEB WILLCOX, AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health, affirmed and examined

Dr BRENDAN FLYNN, Executive Director, Mental Health Branch, NSW Ministry of Health, affirmed and examined

Dr MICHAEL BOWDEN, Acting Chief Psychiatrist, NSW Ministry of Health, affirmed and examined

The CHAIR: I welcome our next witnesses, representing the Ministry of Health. Would you like to make a short opening statement?

DEB WILLCOX: Yes, thank you. I begin by acknowledging the traditional owners, the Gadigal people of the Eora Nation, and pay my respects to Elders past and present, and acknowledge any Aboriginal people here or online this afternoon. This was, is, and always will be Aboriginal land. What a weekend it's been. I also want to acknowledge the individual and collective expertise of those with lived and living experience of mental ill health and certainly their families, carers, loved ones and extended community. We take the voice of our consumers and their families and carers very seriously in NSW Health. They're integral partners to everything we do. I thank the Committee for convening the inquiry into these incredibly important issues and for asking us to appear. I acknowledge the fact that the Committee opened its hearings with consumers and consumer groups.

In 2020-21 NSW Health provided around 3.4 million community mental healthcare service contacts to almost 150,000 consumers. Our services in the New South Wales public health system are obviously part of a much broader ecosystem, as they say, of healthcare delivery in the State, but we are really focused on those experiencing severe, enduring and complex mental health issues in New South Wales. We deliver our services through a network of mental health services provided by our local health districts and our specialty health networks, and through a number of our affiliated not-for-profit and non-government organisations, who are incredibly important partners to us as well. We provide these services, in the context of community mental health care, in hospital outpatient clinics, non-hospital community mental health services such as crisis mobile assessment and treatment services, day programs, outreach services and consultation liaison services. Our aim is to give every individual the right care at the right place at the right time.

It's important that we contextualise the care that we provide against the broader mental health sector. The Commonwealth Government has a large role to play and all of us share responsibility for mental health policy and the provision of care for people living with mental disorders. Through the Medicare Benefits Schedule the Australian Government funds consultations with specialist medical practitioners, GPs, psychologists and allied health practitioners. The National Disability Insurance Scheme funds support for psychosocial disabilities and the Primary Health Networks funds other primary mental health services. We work really closely with the Australian Government. We really want to make sure that consumers don't slip in between our services; that connection and integration is a real priority for us. In addition, we have the bilateral schedule on mental health and suicide prevention that was signed in 2022, and it forms part of the National Mental Health and Suicide Prevention Agreement between our governments. Again, it looks for a cohesive approach and better integrated support for people, particularly near a suicide.

In New South Wales the Minister for Mental Health, the Hon. Rose Jackson, has requested advice from us to look at the gaps and opportunities, particularly in the area of community mental health. The Minister has asked that we complete this body of work before the end of the year. The aim of the report is to be a source of advice to the Minister to assist with priority setting and support any potential future investment decisions. I realise the Committee has heard probably a little around the gap analysis today. We are doing this in lockstep with Catherine Lourey, the head of the New South Wales Mental Health Commission; Dr Angelo Virgona, who is representing The Alliance; and Tim Heffernan, who's come in his role as a person with lived experience, but he is also the deputy commissioner with the Mental Health Commission.

We are working closely with The Alliance, local health districts and networks and our partners, including the Official Visitors Program, to make sure we capture as much feedback from the sector as we possibly can. At a State level I think it's important that the Committee is aware that mental health, as you know, is not just a responsibility of the health system. We work very closely with our cross-agency partners. Our secretary, Susan Pearce, chairs the Mental Health Taskforce which is represented by Education, Regional New South Wales, Planning and Environment, Aboriginal Affairs, Communities and Justice, Police, Housing and Health. I've probably inadvertently left somebody off but it includes a large group of senior officials. We talk about cross-Government collaboration and priority setting and how we can work together.

The taskforce looks at the complex and joint work, as I said, particularly in areas around homelessness, recidivism and creating mentally healthy workplaces. Within the ministry ourselves we have a couple of

governance structures that go to specific priority areas, including the Aboriginal Mental Health and Wellbeing Strategy Steering Committee and the Eating Disorders Steering Committee. We work with the Department of Communities and Justice on the New South Wales Housing and Mental Health Agreement.

In relation to our workforce, obviously they are critical to the care of our citizens. Their relationship is not just one of providing care; it's a therapeutic relationship. I think through this Committee previously on other topics I have talked about the difficulties around the workforce that the whole country is experiencing since COVID. Our secretary chairs a national workforce taskforce, with all States and Territories represented, looking at what sort of things we can be accelerating collectively to try and improve our workforce shortages. We are mindful that in terms of psychiatry there are some particular issues and the workforce team within the Ministry of Health is very focused on this. We are also mindful of the regional and rural dilemma. It is a much harder environment, and it is harder to attract and retain, so they're a source of separate focus for us. We have the Health Workforce Plan, a 10-year plan, and we've just received the new National Mental Health Workforce Strategy, which was literally released on 10 October.

Finally, I think it's important to just very briefly mention to the Committee what our consumers are saying about us. The YES survey—the Your Experience of Service survey—is a nationally developed questionnaire designed to gather information from consumers. In 2021-22 just over 21,000 consumers contributed to the survey and 78 per cent of them said their care was "excellent" or "very good". The bit that was the most great to hear is that the domain around respect was the highest scoring, which is aimed to understand whether we provide a welcome environment where they are recognised, valued and treated with dignity. The same survey was completed by our Aboriginal consumers and they rated their care "excellent" or "very good"—around 69 per cent—and carers rated it similarly. Obviously there's room for improvement in all of those results but they're a great source of information for us to prioritise and understand what the needs of our mental health consumers are. I finally want to acknowledge the staff in our system who care for our mental health consumers and their families and make a special mention of our peer workers. I thank the Committee again for inviting me here today. I will hand over to Dr Flynn.

BRENDAN FLYNN: I thank the deputy secretary and the Chair. I also acknowledge the traditional owners of the lands that we are meeting on today, the Gadigal people of the Eora Nation, and pay my respects to Elders past and present and any people joining us today who identify as Aboriginal. I want to acknowledge the individual and collective expertise of those with a lived and living experience of mental ill health and suicide, and those who love or have loved them and care for them. I want to briefly talk about the community mental health system in some introductory remarks and then finish up as quickly as I can. I want to describe the way the care is delivered and what some of the challenges are. NSW Health community health teams—and they're the ones that are delivered directly by NSW Health—cover every corner of the State and consist of multidisciplinary teams. That includes nursing staff, allied health staff, medical staff, peer workers, Aboriginal mental health clinicians—there are some other disciplines there as well. They are highly trained and they provide a high standard of quality care.

Our submission has expanded on important underlying principles of care that those teams adhere to. Those include making sure that the care is person-centred, that it is orientated towards an individual's recovery as they define it and that it is always informed by trauma-informed care principles. There are many pathways that can lead to care within a NSW Health community mental health team. They include the emergency department, general practitioners, private mental health practitioners, other medical specialists, community-managed organisations, families and carers, and some individuals self-refer as well. Referral from external agencies through to NSW Health is usually done via the mental health line that you've heard about earlier today.

Presentations are triaged according to clinical acuity. High-acuity presentations include individuals who have significant symptoms that are usually related to severe or enduring mental illness, or whose symptoms place them at immediate risk to themselves or to others. We focus on consumers with a high clinical acuity and complex care needs. We know that some individuals are referred to more appropriate services. Examples of those include Commonwealth-funded psychology services under Medicare or sometimes community-managed mental health organisations. But we do recognise that there are challenges for accessing care in public community mental health services in New South Wales and also difficulties navigating that access and navigating even once you get into the system. Community care is delivered differently, depending on the needs of the consumer. For example, sometimes people may be seen by the intake part of a community team or the care coordination part, or sometimes the rehabilitation team.

An increasing emphasis is placed on assisting primary care providers managing the often very significant comorbid physical care needs of mental health consumers. We know that physical care outcomes for the people that we care for are significantly worse than the general population. Some specific programs for populations that are impacted by inequity in health outcomes include access to Aboriginal mental health services, LGBTIQ+

services, perinatal services, and communities that are culturally and linguistically diverse. Those are important services that we offer. Individuals who have experienced trauma, violence, abuse and neglect are overrepresented amongst the people that we see and the people that we serve, so it's really important that we offer integrated approaches around that. Towards Zero Suicide is an important suite of largely community-based initiatives that add to the general work that the sector does and are specifically targeted at reducing the rate of suicide in New South Wales.

Community treatment orders, or CTOs, are implemented for some consumers by community mental health teams. This is a legal order made by the independent Mental Health Review Tribunal or by a magistrate, and it sets out the terms under which a person must accept treatment, which may include medication, psychological support and counselling. The rationale for a community treatment order is that it's less restrictive than hospitalisation and that it does allow a cohort of people who otherwise may be hospitalised to be cared for in the community. But I do point out that we are aware of submissions to this inquiry advancing the view that CTO use in New South Wales is problematic. I think it's very important at that stage to emphasise that the principle of least restrictive care always applies, and that means always preferencing voluntary community treatment over a CTO when possible.

We acknowledge that we can always do better to improve the services that we provide. This inquiry has heard in submissions about individuals who have not received the care that they have every right to receive and the tragic outcomes when that happens. That's a very significant piece of work that all of our clinicians do in terms of reflecting on any circumstances like that and asking ourselves: What can we do to prevent any similar outcomes, and preventing, if they were implicated, any gaps in care? Recent tragedies in New South Wales have highlighted the issue of how best to respond to an individual who may be experiencing a mental health crisis. The police, ambulance and clinician early response team, or PACER, is an innovative mental health co-responder model that supports New South Wales first responders when attending people who are experiencing a mental health emergency in the community. Police can activate the mental health clinician as a secondary response and then that clinician, if it's safe, can come onto the scene, assess the person's mental health needs and, ideally, organise appropriate care.

PACER currently operates in 17 police area commands, largely in metropolitan Sydney and in the peri-metropolitan area, including the Central Coast. Rural and regional local health districts have adapted the PACER model and it's complemented with virtual technology to enhance access. The initial results of at least one of those programs are very impressive. PACER is not a one-size-fits-all solution to these issues and we're looking at a range of other options to strengthen care for people who experience mental health crises. NSW Health is committed to working with government and non-government partners as well as communities, consumers, families and carers to meet these challenges and improve health outcomes for all people in New South Wales who experience mental ill health. We look forward to assisting the inquiry with today's hearing.

The CHAIR: Thank you so much for the time you've taken to prepare a very detailed submission and also to speak to it today. It's incredibly valuable context for the Committee to understand some of the work that is already being done and to help us frame our recommendations in a way that is going to be helpful for all of the people we're collectively trying to care for.

DEB WILLCOX: Thank you very much, Chair.

The CHAIR: I have a number of questions. The first one is about the peer workforce. In your submission you mention the 27-team review by the Chief Psychiatrist that recommended the development of a peer workforce framework, which is currently under development.

BRENDAN FLYNN: Yes.

The CHAIR: What progress on that has been made so far? What kind of a time frame do you have for its completion?

BRENDAN FLYNN: I might take this question. The answer to that is that the peer workforce framework is still under development. The last update I have around that is I understand there have been some meetings with the Minister and industrial organisations looking at what some of the award provisions may be for potential peer workers in that space. New South Wales has approximately 200 peer workers working in local health districts and specialty health networks. I know the inquiry has heard in submissions today the value that's placed on that workforce by consumers and services. There is significant work to do, I think, even once that framework is finalised to make sure that our peer workers feel supported in terms of their educational needs and in terms of looking after their health while they do that important work.

The CHAIR: Thank you. My second question is for Ms Willcox. We've heard a lot about the workforce pressures and challenges from yourself and from other organisations. I'm interested if you can tell us how many vacancies there are currently in community mental health services across New South Wales?

DEB WILLCOX: I'll have to take that on notice, Dr Cohn. I don't actually know that exact figure. I am aware of concerns raised around the lack of live data or live workforce information. We do have a division within the Ministry around people and culture that has a workforce division that monitors, particularly in terms of a health workforce, modelling and planning and understanding how we maintain a pipeline and where the pressure points are. We work with the colleges and the universities to ensure a flow of students. Our local workforce directors in our local health districts are the ones monitoring their vacancy rates, and certainly there is reporting into the Ministry so we can see where hotspots are, or where we have a good feel because of the work with the colleges and the like.

We know psychiatry is a significant problem at the moment. Many are going into the private sector and we are struggling to attract into the public health system. Whilst I can't give you that immediate figure, I think it's important for the Committee to understand there is a sort of overarching governance at a ministry level in terms of workforce strategy—how we recruit, retain, the industrial settings are right, dealing with issues around locums, which is happening at a national level and at a local health district level. The workforce and mental health teams would be looking in particular at their workforce to maintain that they manage their vacancy rates, and escalate as required, but I can come back to the Committee with that figure.

The Hon. SUSAN CARTER: Can I follow up on that? Just to confirm, you're saying that the ministry has centrally available figures about who is where in the workforce and who isn't where in the workforce?

DEB WILLCOX: We know by local health district the components of the workforce. We know that there are so many doctors, so many nurses, so many allied health, corporate and the like. We can see that. We work with the local health districts. I don't have workforce in my portfolio, I might say. But, having been a chief executive in a local health district, I know the relationship with the ministry. There are common areas, it would be fair to say, across the country where we are struggling with workforce. Psychiatry is relevant to this Committee, but there are others.

The Hon. SUSAN CARTER: You know what the workforce is, but do you also have a figure of what the workforce should be? For example, could you say, "In this local health district, we would expect to have 35 doctors who are emergency department specialists but currently only have 30, so we're five down"?

DEB WILLCOX: It would change. It would not be a static figure. It would depend on activity and occupancy. But, yes, as a broad principle, if you've got a hospital that has an emergency department, a maternity unit and a geriatric ward, you would know the full-time establishment required for you to run those services 24 hours a day, seven days a week. A local health district would know how many vacancies they had on any given day.

The Hon. SUSAN CARTER: Would the ministry know?

DEB WILLCOX: I will take that on notice. My understanding is, yes, the workforce vacancies would be reported through the ministry workforce division.

The Hon. SUSAN CARTER: If you could take it on notice, I'd be grateful.

DEB WILLCOX: I'm happy to do that.

The CHAIR: I appreciate you taking that on notice as well. You might have to take my next question on notice as well. I was quite horrified to learn in testimony earlier today about the experience in local health districts that have contracted the access line out to Medibank services. It was the Nurses and Midwives' Association that spoke to some of the issues that has caused. Are there any other services listed in your submission that have been contracted to private providers in some or all LHDs?

DEB WILLCOX: I might refer to Dr Flynn on this one. My understanding is that Medibank has been running that service for many years and that there is no policy from the ministry to outsource any further mental health services to the private sector. The Medibank solution one is one that has been longstanding, providing this service. It's not something new.

BRENDAN FLYNN: I would add that I'm not aware of anything in our submission that is delivered by a private provider. There are lots of partnerships with not-for-profits and community-managed organisations. There are small pockets in the State health system where there are private-public partnerships and those sorts of arrangements. But we don't have any others like the mental health line and those districts that have chosen to do that that come to mind.

The CHAIR: You've mentioned partnerships with primary care throughout your submission, which I am delighted to see as a former GP. What formal systems do you have in place to ensure that information is being shared in a way that supports follow-up—especially, for example, after an inpatient admission—while also respecting the privacy of patients?

DEB WILLCOX: One of my clinical colleagues is probably best to talk about how that works.

MICHAEL BOWDEN: I'm happy to respond to that. We have got very clear policy around the transfer-of-care guidelines, which are very detailed in terms of the expectations on services in engaging external providers and also community mental health providers. If a person is within an inpatient setting, there's an expectation that the follow-up will all be arranged before they're discharged and that there is collaboration between the agencies that are being referred to and the treating service.

Equally, if somebody is currently in community mental health care and is being discharged from that care and their care is being transferred elsewhere, that includes quite a lot of detail about the type of information that needs to be included in a discharge summary, for example, and in treatment planning around risks and risk assessment, but also safety planning and details around medications, including what medications are prescribed, what the side effects are and what the alternatives are. There's also expectations around the timing of discharge summaries. Discharge summaries are expected to be ready at the time of discharge from the service and communicated directly to the receiving service.

The CHAIR: I'm pleased to hear that those protocols are in place. We heard evidence earlier today from the Royal Australian College of General Practitioners that GPs frequently complain that they are receiving discharge summaries after they've seen the patient for their follow-up appointment. Has the department or the ministry undertaken any audits to see how that protocol is being followed on the ground?

MICHAEL BOWDEN: Not that I'm aware of.

BRENDAN FLYNN: I know that local health districts and networks do audit. I've been involved in that previously, but I'm not sure that's held centrally.

DEB WILLCOX: We could follow it up with the college anyway. We meet with them regularly, so I'm happy to follow up with them and see what we can do to clarify that.

The CHAIR: Thank you very much. I have got more questions, but I'm aware of how much time I'm taking up. Perhaps there are questions from the Government.

The Hon. EMILY SUVAAL: Thanks to you all for appearing today. My question is around how the integration of care with primary health networks across the mental health continuum is occurring, particularly around ease of navigation into clinical services and entry pathways. Have you got any comments on that?

DEB WILLCOX: Again, I'll throw to my clinical colleagues. There are a number of navigation pathways that we've built between the primary care sector and ourselves, but I'll leave it to the clinical teams. They're much more able to describe.

BRENDAN FLYNN: I'm happy to respond to that. It is a little bit different between different PHNs, but I think the key part of it is sitting down with the relevant local health district or network and doing that regional planning. I know that many of the PHNs are using an evidence-based, systematised triage system, which is the IAR tool that you may have heard about earlier in this inquiry. Generally, that is designed to either identify somebody with relatively high acuity who needs specialist mental health services, or perhaps somebody who should see a clinician in what has been termed, if you like, the "moderate" space, or can be managed sometimes non-clinically. I'm not sure if that answers the question, but I thought it was important to mention that there are primary health networks using systematised tools to help deliver people to the right place.

MICHAEL BOWDEN: I'm willing to add to that. We do actually have physical healthcare guidelines for mental health consumers. That was developed a couple of years ago. Again, that's available to all of our services, and people are expected to follow those guidelines. Those are aimed at recognising the high levels of morbidity in people who have mental health problems—physical morbidity and physical illnesses—and also to ensure that their physical health needs are not only recognised but also managed appropriately, in collaboration with GPs in particular.

The Hon. EMILY SUVAAL: I wonder if you could also speak to how the emergency assessment is going and the ongoing linkages to care in the community through those PHNs.

BRENDAN FLYNN: I think clinicians across the whole spectrum are good at identifying whether the individual they're seeing needs an emergency response, whether that's someone who is already in ED or someone who is seeing a long-term counsellor in a CMO-type picture. The emergency response, though, won't necessarily

come back through a PHN service because it tends to denote higher acuity and, therefore, that person tends to end up either immediately referred via the mental health line to a community mental health team—which is a preference, if that's possible—or there is a small cohort of individuals who need, essentially, a hospital response. I'm hoping that answers that. It depends where the emergency assessment is done.

The Hon. EMILY SUVAAL: Dr Flynn, you referred to the alternatives to PACER in regional and remote areas that have been trialed in your opening statement, and one of those that had the results of the trial that were quite promising. I wonder if you would care to expand on that and tell us a bit more?

BRENDAN FLYNN: Yes. In Hunter New England—and this is my previous role, but it's very much not my work but other people's work up there that's been very successful—essentially the clinician assistance of police is very difficult in a very large part of the State. HNE, as you know, goes right up from Newcastle past Moree. There is a system that's called "mental health first responder" that uses virtual technology, and in this case it's an iPad that is carried by both ambulance and police. It allows them to—if it's safe, if it's appropriate, and generally if the consumer is agreeable to it—rather than transport that person to a declared facility, rather than take a police or ambulance crew out of town, that person can have a brief assessment and work out what their disposition should be.

This service has assessed roughly 130 people in the last 12 months and something along the lines of 111 people have been diverted from ED, which is really significant. It's over 80 per cent. So it's early days. It has taken a lot of very good collaboration from police and ambulance colleagues. The people at HNE have done, I think, a really good job in getting it going. It's early days, but the initial figures are very promising. It's also a benefit to the community because you don't want to take a first responder crew out of a small town, only to have someone be assessed in ED and have that person need to find their way home.

The Hon. WES FANG: Thank you for appearing today. I'm not sure if you were following the evidence that was given this morning, but in relation to the capacity review that the Minister's asked for, Dr Virgona effectively said that it was, to paraphrase, an inferior review to what he was actually hoping would be asked for after the election. Do you have a view as to the review itself, but also what may be asked for at a later date, to actually provide a broader and better overview of what the capacity is, given that somebody as eminent as Dr Virgona, and given his position within that review, was critical of the way it's been framed at the moment?

DEB WILLCOX: I will pass to Dr Flynn because he's been working more closely on the details of the review. We are working closely with Dr Virgona and the alliance and, as I mentioned, the commission. I am disappointed that he feels that way. Our view is that, firstly, the Minister is very keen to get a gap analysis. What we need to do around that is, obviously, consult with the key groups, and certainly our LHDs, on where the services have been provided, and get a sense of the landscape: where we think we've got demand issues and where we might have service issues. That's what we really need to understand. We also need to have a look at what our NGO and other partners are providing in a particular region. So we try to get a holistic, helicopter view of what's going on in local health districts.

That won't be the be-all and end-all of this review, but this gap analysis is what the Minister's asked for with a view to us getting that finalised by the end of the year. Now, there are many tools and datasets and there is information that we will want to go more deeply into as we do a broader strategic plan for mental health services. We will continue to work with the alliance and with the commission, but I think what we will get over the next couple of months—people have been working really well together, and really cooperatively—is a high-level overview of where the system is at and where we think we need to put our attention. Then we can go into more detailed data analysis over the coming months to really firm that up. Brendan, do you want to add to that?

BRENDAN FLYNN: I don't have a lot more to add to that; I think that's a really good summary. The alliance has publicly asked for a very detailed piece of work using some of the tools and, in particular, it's interested in the National Mental Health Service Planning Framework. Our task at the moment is to provide the Minister with the advice that was asked for and then, down the track, something that the Ministry of Health is doing anyway is looking at what services are provided and how that matches against tools and other jurisdictions. We will continue to keep in contact with the alliance and relevant stakeholders, and there are many.

The Hon. WES FANG: But we're talking about some of the most experienced minds that are involved in the New South Wales mental health space. Given that the Minister hasn't actually asked for the work that they believe is required, are we not setting ourselves up, perhaps, for failure here—in that what we're doing is what's quick, but potentially not what is the most thorough? Therefore, what we're doing is, effectively, having to go back later on to re-examine this, which is ultimately just going to lead to delays and more cost.

DEB WILLCOX: It's a pretty detailed piece of work, and the teams have been working closely and meeting probably about every fortnight, with a lot of work going on in between. We will get good guidance out

of this work because we're going straight to the source, our local health districts, to get a handle on their service position and, again, what their demand and access issues are. We'll piece that together to give us a service map around, again, where our community services are running well and effectively, and where we think we need some realignment or some prioritisation. The deeper work will go to performing our strategic plan for the ministry over a longer period of time. But I wouldn't want the Committee to think that just because we've been working on this for a couple of months already—it will be almost a six-month piece of work—that it's a rushed or simplistic piece of work. It will be very thorough and will give us a very good view of the services across the State for the Minister.

The Hon. WES FANG: Would you agree that to have a stakeholder as prominent as Dr Virgona criticising the breadth of the gap review speaks to the issues, and that then leads to a credibility issue around when you hand down this—I will say—"interim" review? Obviously you foreshadowed that there will be further work. Does that not provide the community with some scepticism as to how detailed it actually is, how thorough it's been and whether you've actually looked at the right things or not?

DEB WILLCOX: I might let Dr Flynn talk to the detail on that because you've been working closely with it.

BRENDAN FLYNN: I think the key thing to remember here is that this work needs to be done anyway—this first part. So there is no point having data without a narrative. What we're hoping is that we go—and what we're working on at the moment is really considered and comprehensive discussions with lots of service providers, with the involvement of consumers and the involvement of the Mental Health Commission. Many of the valuable advocates in the sector in New South Wales are involved. Even down the track, as we use some of these planning tools, they won't mean a lot without knowing what our consumers think, without knowing what a lot of our partners think—Health Consumers NSW, Mental Health Carers NSW, the AMA, the Mental Health Coordinating Council. We need to know what they are seeing on the ground. My thoughts about it are that it's important work that needs to be done, and then there's also some of that more technical work that we will do in any case.

The Hon. WES FANG: The Minister talked a big game when she took over the portfolio, but, like I said, I have never seen criticism of—and there have been a lot of reviews. Since Labor came into government there have been a lot of reviews. That's been acknowledged by everybody. But to have a capability review undertaken, where some of the main stakeholders are already critical that you're actually not targeting the most thorough bits of work here, makes me think that the process is perhaps undermined by a Minister who wants this work rolled out quickly, as opposed to being thorough. Given that the budget's just been handed down and effectively there is no additional funding for services or work around this capability review, it also seems to me that it is really a half-baked effort on behalf of the Minister, and that you as bureaucrats are trying to actually—

The Hon. GREG DONNELLY: I'm loath to take a point of order, but at the table we have important—

The Hon. WES FANG: You don't have to run defence for her, Greg. It's alright. She's big enough to—

The CHAIR: I need to hear the point of order as the Chair, thank you.

The Hon. WES FANG: Sorry.

The Hon. GREG DONNELLY: We have witnesses at the table representing NSW Health. You're editorialising, as you know full well.

The Hon. WES FANG: I didn't realise.

The Hon. GREG DONNELLY: And you're inviting them to make judgement about the Minister.

The Hon. WES FANG: No, I wasn't.

The Hon. GREG DONNELLY: You know that's completely inappropriate. The way this works is you put a question and you invite an answer. But having such a long run-up with editorialisation, ultimately taking it to them passing judgement about the Minister, you know that's out of bounds.

The Hon. WES FANG: I'm sorry, Greg, I'll try and keep my questions succinct like you do.

The Hon. EMILY SUVAAL: I encourage you to do so.

The Hon. WES FANG: Given that the Minister hasn't advocated for any more money for this review, is it basically just trying to—

The Hon. GREG DONNELLY: Point of order: You don't know that, do you?

The Hon. WES FANG: No, the budget has just been released and there's no extra money. That was the whole point of my lead-up to the question. I asked the question: Was there any extra money identified in the budget?

The CHAIR: There has been quite a long run-up. Could you please ask a question that's appropriate for a public servant?

The Hon. WES FANG: I'm coming up to the crease. The arm's here; it's going to be bowled over. The question is: Have you been provided the additional resources required to have a thorough review or is this just trying to cobble together the funds that you've got at the moment and being hamstrung by a restrictive set of parameters when really you should be looking at a much broader picture here?

DEB WILLCOX: The Minister has asked us to work with the alliance, the commission and our partners to establish a gap analysis in relation to community mental health services across the State. We are doing a thorough review engaging with consumers and the alliance, as Dr Flynn mentioned, and talking to the local health districts and accessing data and information about service need. We will do a thorough and appropriate report for the Minister on the basis it's there for her then, and the Government, to make priority decisions around investments should they become available. We have the resources internally to do a very thorough piece of work. We consider it to be important work, and from the centre of mental health point of view this is the sort of planning work you'd expect an agency to do because it's our job to actually set the policy and strategy for mental health services across the State. We will work very closely with the alliance and pick up on some of the issues that have been raised. They're a very important partner and we have the hugest respect for Dr Virgona and a good working relationship, so thank you for bringing that forward.

The CHAIR: I have one last question of my own, which is to the PACER program. As you've pointed out there is rightfully a lot of angst in the community about police responding to mental health emergencies. I appreciate that the PACER program, to the limited capacity that it exists, has received a lot of positive feedback. I am really interested to hear about what is happening in Hunter New England. That's really important evidence. What I'm interested to know is if the ministry is aware of or has looked into emergency responses in other States—for example, South Australia or the ACT—where the police are a secondary response to ambulance or health rather than a primary response?

BRENDAN FLYNN: I'm happy to take that. The answer to that is yes. PACER is a very well appreciated model where it is offered, and as we've used the example of Hunter New England it's very difficult to use the same model across the State geographically. We are aware that the police are very interested in other sorts of models in addition to PACER because of those concerns. We're getting good feedback around the first responder program, but in particular we have recently had senior staff travel to Queensland to look at a service that's called the Queensland police radio model, which is much more universal. It provides a mental health clinician in the Brisbane radio control headquarters which allows for immediate advice to police officers as they go about their day-to-day work. That's just one example. We are having continuing meetings with the police, and I think it's fair to say that everybody's very concerned around what's happened in the last few months, and that only makes it more important that these conversations and potential new initiatives are progressed.

The CHAIR: It is really heartening to hear that the ministry is doing that work of investigating what other innovative solutions there might be. But specifically to my question, have you been examining models where health or ambulance provide the primary response with police as secondary based on risk assessment?

BRENDAN FLYNN: We haven't visited other jurisdictions around that yet. I am conscious, and I think it has come up on day one of the hearing, around the ACT model. I think that we have to be very open in terms of discussions around what can we do that is in response to what has happened recently in New South Wales and are there better ways to do it. I certainly wouldn't rule it out, but we haven't specifically investigated any non-police initial responder models at this stage.

The CHAIR: We're out of time for today. Thank you again so much for your time to give evidence. The secretariat will be in touch about questions on notice.

(The witnesses withdrew.)

Mrs MARJORIE ANDERSON, National Manager, 13YARN, affirmed and examined

Mr SHANE STURGISS, Chief Executive Officer, BlaQ Aboriginal Corporation, affirmed and examined

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

MARJORIE ANDERSON: I can tell you about 13YARN.

The CHAIR: Please do.

MARJORIE ANDERSON: It is a crisis line that has been designed by the community and developed with the community, and delivered by Aboriginal and Torres Strait Islander people 24/7 nationally. The line was developed in response to Aboriginal people wanting Lifeline for Aboriginal and Torres Strait Islander people. Lifeline underpins our technology and also our expertise. We have 46 crisis supporters at the moment. I must say, today's probably not the day for me to be sitting in here—the Monday after the referendum. Our calls are way up because of the referendum and Aboriginal people's disappointment in that. We are a culturally safe space and we deliver our services without judgement and confidentially. Aboriginal people have trusted us from the very beginning. We've been around for about 18 or 19 months now and we've taken about 36,000 calls.

SHANE STURGISS: I acknowledge the traditional custodians of the land on which we are today, our Elders and ancestors. I extend that acknowledgement to our LGBTQ+SB community, our sistergirls and brotherboys Elders and ancestors that have lived horrific lives but have been able to provide us today a platform from which we elevate and continue on their fight. BlaQ is the New South Wales peak organisation for LGBTQ+SB Aboriginal and Torres Strait Islander people, a national service provider and the Australian representative to ILGA World for the Oceania region. An Aboriginal community-controlled organisation, BlaQ holds responsibility to its community first and foremost. The Aboriginal community currently is in despair, as I sit here today. The events over the weekend, with the loss of the referendum to recognise Aboriginal and Torres Strait Islander people as the first people of this land, will have ongoing significant impact to the health, wellbeing and lives of an already vulnerable community. I am heartbroken, and I find it difficult to hold my pride of what it is to be a citizen of this country or any trust in parliamentary process.

When addressing the mental health need of the intersection of community that identifies as LGBTQ+SB and Aboriginal and Torres Strait Islander, the levels of complexity increase. Compounding this, there are access needs of our regional and remote communities and the impact of colonisation on First Nations people. The decades of neglect, abuse and government-initiated policy to harm both LGBTQ+SB and Aboriginal and Torres Strait Islander people need immediate attention to bring better outcomes. The addressing of health and mental health needs for the intersection of queerness and culture is lacking at all levels of government and in health. The recent New South Wales LGBTQ+SB health strategy failed significantly to mention and support the needs of Aboriginal and Torres Strait Islander communities, and the New South Wales Aboriginal and Torres Strait Islander health plan fails in addressing the needs of our LGBTQ+SB community. Now, more than was needed even as recently as a week ago, our First Nations LGBTQ+SB people are needing better outcomes, better service provision, better access, better post-crisis support and better funding for grassroots services. Always was, always will be Aboriginal land.

The CHAIR: Thank you so much for your statement and for your very frank comments, which are much appreciated, and for all of the work that you're doing to provide First Nations communities with mental health support. It's such important work. My first question is very broad. As I'm sure you know, our job as a committee is to make recommendations to government to improve mental health care in New South Wales. What recommendations would you like to see us make to make those services culturally safe for First Nations people and for First Nations LGBTQI people?

MARJORIE ANDERSON: My first comment would be to do things with the community rather than to the community. When we were developing 13YARN, we ensured that we had the diversity of the community represented in our workshops. We had the Stolen Generation. We had Elders. We had youth. We had urban Aboriginal people, and rural and remote Aboriginal people. We had the LGBTQIAP+ community. We had mental health professionals. We had those with a lived or living experience of suicide and its consequences. We ensured that the diversity of the community had input into our service. That's why, I think, our service has been trusted by the Aboriginal community.

I think when government talks about co-design, they go into the community and co-design has got perimeters around it. They say, "We're going to co-design with the community, but it's got to fit within this policy or that policy", instead of going to the community with a blank sheet of paper and saying, "What will make a difference in this community?" and then going away as public servants and making that fit the policies. I went in

with a blank sheet of paper. I had no preconceived ideas on the values, what the service would look like, what the service would sound like and what the help-seeker experience would be. I got all that from the community. That's where the Government really have to understand that we need to be doing things with the community, instead of to the community or at the community.

There are a lot of gaps out there with mental health services, and the mental health services that are out there are very complex. We had somebody come up to us and say, "Look, I've been seeking help for my issues for years and never went in the right door." There should be no wrong door with mental health services. She rang 13YARN once, got an appropriate referral, and her life has changed. Why does it take a phone call to 13YARN to get the help that they need? This is why our service is so important, because of the complexity of the mental health system. But there should be no wrong door that people enter when they need mental health help.

Also, the long waiting lists, especially with ACCHOs, because they're not funded well enough to provide mental health support to the community. So they've often got really long waiting lists. It's really hard to tell somebody in crisis, "You might have to wait 12 months for support or help", and it makes our job harder because we have no referrals to send people to. We've really got to make sure that those gaps are looked at and that they're looked at in the Aboriginal space, and we work with the community to fill those gaps where we identify gaps.

SHANE STURGISS: I concur. It really is as simple as that. First Nations people know how to support First Nations people. We value the importance of kinship and we value the importance of culture, which is something that lacks from any government or health-driven service, because it doesn't connect in with community. Even as an Aboriginal community-controlled organisation, I wouldn't make a statement on behalf of community without consulting community. I wouldn't go into another State or Territory of this country without connecting with the landholders of that land first to advise them of the services I wanted to provide to their people to connect in with them and to actually ask them what it is that they need in their areas, in their geographic locations.

The Government tends to have this holistic view or homogenous view that Aboriginal people will all fit this one little policy or this one little service provision, regardless of their need or regardless of their geographic location. When you are looking at regional and remote communities, very different needs and accessibility to that of metropolitan communities. The thing I think that's needed is for government to actually listen and to consult. I know that at the moment it's not a great thing, because communities are feeling really over-consulted at the moment, but it needs to be done with care and compassion. It doesn't need to be done with a white saviour mentality. It doesn't need to be done with a homogenised aspect: You're Aboriginal. Therefore, this is what you need. You need to ask us what we need. You need to provide us the supports, resources, funding and access for our regional and remote communities that don't have access to health services directly in their townships. They also don't have access to online support services because they're not digitally included. There are multiple elements of accessibility that are failing our communities in regional and remote areas in this country.

The CHAIR: Are you aware of in-person services that have done this well? Are there successes that we could model on? I know 13YARN talked about ACCHOs and who you refer to if someone rings the service or needs a follow-up on in-person consultation. Which services are going well? Who do you like to refer to?

MARJORIE ANDERSON: I'm trying to think of a service that's well funded in New South Wales. I really am, and I'm struggling. I'm really struggling to come up with somebody who is funded well enough to meet the needs of the community.

The CHAIR: That answer speaks for itself. I might change the question, then, slightly. You mentioned ACCHOs, for example, whose waitlists are too long. Are there services that are providing competent and culturally safe care but are under-resourced?

MARJORIE ANDERSON: I think the ACCHOs are providing culturally and safe care, but they don't have enough clinicians. There are not enough Aboriginal clinicians in New South Wales. Australia-wide, there are not enough Aboriginal clinicians. I think we need to go back to the very beginning and really start to do some work on attracting young Aboriginal people into clinical work and supporting them through university—maybe not put a big HECS debt on them to go through university—and really support Aboriginal people to go through university on scholarships where we're going to build the clinical workforce. That's the problem. We're all fighting over the same clinicians.

SHANE STURGISS: Just adding to that, there are services out there that are well funded. They're all mainstream services, and this is where part of the problem lies. It's that mainstream white services, bigger organisations that have the grant-writing teams attached to them, have the means to be able to put in submissions to get these big funding grants, and then they're commissioning out to smaller Aboriginal community controlled organisations to deliver their cultural competencies for a very small amount of money—a tokenistic amount of money—to deliver a majority of their contract when it comes to cultural compliance.

This money needs to start going straight to the organisations, and access to this money and the funding submissions for smaller Aboriginal community controlled health organisations and Aboriginal community controlled organisations. I'm not a health organisation but the work that we do supports our mob, so it needs to be easier for us to have access to this. We need to stop funding mainstream services to actually then tokenistically rely, for small amounts of money, on Aboriginal community controlled organisations to deliver their competencies.

MARJORIE ANDERSON: Yes, I would concur with that. It's not only the ability to write the grants; it's the onerous reporting as well. The smaller organisations get the smaller grants, and a lot of the grants are eaten up with administration, so very little lands on the ground because they've got to pay somebody to do the reporting, because they don't have that in-house capability. So we've got to think about different ways of funding smaller Aboriginal organisations to deliver on-the-ground services and look at place-based services to ensure that the people in that area are getting serviced by people in that area, and stop the onerous grant funding and stop the onerous reporting. I find that even with 13YARN—I mean, we're funded by the Federal Government—the reporting is really onerous, and it's difficult.

The Hon. GREG DONNELLY: One of the challenges that has come to us over the course of the inquiry through the submissions and the evidence thus far is the shortage of professionals in the community at large and in the State at large who are capable of delivering diagnosis and then the support and care that follows with respect to mental health issues. The best practice that's been described to us for mental health issues is a multidisciplinary team of people working around the individual who is suffering from the mental health experience.

That multidisciplinary approach has been put forward as the best practice to deal with mental health issues. Is it your submission that that approach cannot work or doesn't work for Indigenous people who have mental health issues? Are we looking at a quite different model to deal with those matters, or do we just need to make the orthodox approach that I've described more Indigenous-friendly, if I can use that phrase? The submission essentially is that we have to set up a parallel system across the State, and that's the only way to fundamentally deal with the matters that you bring to us this afternoon.

MARJORIE ANDERSON: Well, if we want to close the gap, we have to deal with things differently. The difference when dealing with Aboriginal people is that we don't see ourselves as individuals as much. To work holistically with an Aboriginal person with mental health issues, it's really about working with the family and the community as well. The family and the community know how to support that person and give that ongoing support. I know there's confidentiality with treatment but, with support services, we must be working with the families, extended families and communities of these people. We need that approach of having multiple people working on the same case, according to what's needed by that person. But listen to that what that person wants as well, and make sure that it's Indigenous led. I know that we don't often have the Aboriginal clinicians, but make sure that it's Indigenous led so that it's culturally safe for that person. That would be my advice.

SHANE STURGISS: Yes, I completely agree. Thank you. A way forward, particularly for less accessible areas and regional and remote communities, is that kinship care. It is important.

MARJORIE ANDERSON: Yes.

SHANE STURGISS: It's not about treating an individual. You know, "It takes a whole village" is the saying, but in Aboriginal communities that's genuinely the case. We don't have access to privileged education systems, and historically that hasn't been the case. We don't have the generational wealth to be sending our young ones into great schooling and education processes. It all impacts and feeds into each avenue of this. But where I think we could see really positive results is resourcing communities, not just treating individuals.

When I say resourcing communities, I mean looking at that kinship care—looking at a respected person within the community and actually having them trained. If it's a regional or remote community, train them up not as the health professional but as the liaison, as the contact point, as somebody who's trained up well enough to be able to deal with the community that they live in. Then they're the liaison to know where to get the supports. They know where to then access and when crisis points are being triggered and need to be actioned. I think that's probably a better resource. A cost-effective as well as a more gentle and humanistic way of dealing with our communities, particularly regional and remote communities, is ensuring that individuals are being trained up to deliver services for their own communities.

The Hon. GREG DONNELLY: Let's take the point well made about community integrity being very important to Indigenous culture. Does orthodox treatment by psychologists and psychiatrists have a ready application to deal with mental health issues within Indigenous communities, or is that looked upon as being something we know little about and don't have confidence in, and therefore have a reluctance to engage with?

MARJORIE ANDERSON: I think a lot of mistakes are made because they don't have culturally appropriate assessment tools. There are assumptions made by psychologists and psychiatrists when they're dealing with Aboriginal people, instead of listening and learning. I find, with all due respect, that most of the psychologists and psychiatrists that I've dealt with have got very blinkered views on how they deliver their services and won't think outside the box on how to really take on board people's culture and what's best for that individual. They've got very blinkered views, and it comes from their university training. I've actually talked to the Australian school of psychologists about the fact that they're so concerned about their ongoing registration that they're too frightened to try and do anything differently, and so we need to change that.

The Hon. GREG DONNELLY: What would doing something differently involve? Sorry to interrupt, but what might that possibly look like?

MARJORIE ANDERSON: I think that because the assessment tools aren't appropriate, they don't give the appropriate treatment. It's really hard for an Aboriginal person to open up to a non-Aboriginal person as well, so they might not be getting to the crux of the issue because the tools they're using are not the tools that are appropriate for that person. It's something that Dr Clinton Schultz, who works for Black Dog, talks about all the time. He talks about his frustrations working in the industry and not being able to do things differently, so maybe somebody you should talk to is Dr Clinton Schultz.

Going back to that community training, too, there's a really good training program that has been developed by Dr Maree Toombs, who was working out of UCQ and is now in Sydney University. It's called I-ASIST training, and it's training for communities to look for and understand mental health issues in their community that might lead to suicide and how to help those people. So that's something that could be rolled out across New South Wales. But, unfortunately, they're not funded at the moment to deliver as much training as they would like to deliver.

The Hon. SUSAN CARTER: Thank you both for being here today. I just want to pick up on some comments from my colleague the Hon. Greg Donnelly. I was really interested when you were talking about the need not just to see the person but the person in the context of family, kin and community. Is it your experience that non-Indigenous mental health services ignore the role of the family?

MARJORIE ANDERSON: Yes, absolutely. One of the reasons why 13YARN was developed is because they said, "Look, we ring Lifeline and it's a great service. Lifeline is a wonderful service and it saves lives, but we have to educate the person on the end of the line about our family, about our culture, about our community responsibilities, about our family responsibilities before we can get the help we need. When we ring 13YARN it's another Aboriginal person or Torres Strait Islander person on the end of the line so we don't have to do that." When people see non-Indigenous clinicians, as well, they really have to educate that person. When you are in crisis, that's exhausting and triggering and often makes things worse. It's really about that education process.

I've been working with Headspace. One of the things they're doing is because they can't find Aboriginal clinicians, they're training their clinicians in a culturally safe way and then they're putting clinical and cultural supervision on those clinicians so that Aboriginal people can get the counselling they need from Headspace. I've been talking to Beyond Blue about how to really change the way they do things to assist the Aboriginal community. Tomorrow I'm having a meeting with 1800RESPECT on the same thing. If we can change a lot of these organisations to provide culturally safe help, Aboriginal people are going to be safer.

The Hon. SUSAN CARTER: I wonder aloud whether we might all be safer if we all recognised our role connected to other people and connected to families.

MARJORIE ANDERSON: Yes.

The Hon. SUSAN CARTER: We should be learning and changing all of our systems in that way.

MARJORIE ANDERSON: It's interesting because Lifeline are telling me that they're learning so much from 13YARN in the way we do things because we do things so differently. They're looking at the way they deliver services and looking at how they can better their services using 13YARN as a guide.

The Hon. SUSAN CARTER: A different question, and something we've been talking about a lot today, is the difficulty for people with mental health issues to navigate their way through the system and the need, perhaps, to have somebody who can walk with them. I was listening to you and the example you gave of the woman who tried to access many services. She contacted you and you could navigate her directly to where she needed to go. I wonder to what extent you think that 13YARN fulfils that navigation role for your community? Would there still be a benefit of having other people involved in a navigation role for people who are mentally ill?

MARJORIE ANDERSON: I believe there should be no wrong door. If an Aboriginal person walks in your door and you don't deliver that service, find out who does and refer them on. Don't just say, "We don't deliver that service." I see 13YARN as a bit of a front door to the industry—but it's still really hard. I'm a grandmother of a transgender young person who is 11. Most of that counselling doesn't start until 12. She has been going through this for a number of years, telling us since she was three that she was a girl. Trying to find the help for—I work in the system and I had trouble finding the help needed for my transgender granddaughter. If I'm having trouble, imagine somebody in Wilcannia trying to find services, or in Bourke or Brewarrina. If I'm having trouble in Sydney; imagine what they would go through.

The Hon. SUSAN CARTER: If we did explore recommendations around trying to assist people with mental health issues by providing some type of navigator or somebody who could walk with them, for Indigenous people should that be an Indigenous person, or could it be any person who was sensitive to Indigenous issues?

MARJORIE ANDERSON: It needs to be an Aboriginal person. I think any service delivery to Aboriginal people should be Aboriginal-led. Even if there are clinicians involved, the skill that the Aboriginal person in that room has far outweighs your university degree and they need to be treated with that level of respect. Often you find they have an Aboriginal liaison officer and they're down the bottom of the tree. But what needs to happen is that Aboriginal services to Aboriginal people need to be led by Aboriginal people—and I mean led. Understand that that ability to do that is a huge skill and should be remunerated properly as well. That would be my advice. I do not have non-Aboriginal people working on 13YARN at all.

The Hon. EMILY SUVAAL: Thank you both for coming along today. I recognise the importance of you doing so and that it may have been quite challenging. I wanted to put that on record and acknowledge you both for that.

SHANE STURGISS: Thank you.

The Hon. EMILY SUVAAL: In terms of 13YARN first, you mentioned you're federally funded. Feel free to take this on notice if you don't have the information at hand, but I wondered if you have the detail of how many calls were from within New South Wales of those 36,000 calls you said you received?

MARJORIE ANDERSON: I read that this morning. Over half. It's over 15,000 as at 2 August. New South Wales is the leading State for calls received. Queensland came second, but Queensland is starting to overtake New South Wales. In the last three months Queensland has been the State that's utilised our services more than any other State. But over the 18 months it has been New South Wales.

The Hon. EMILY SUVAAL: Have there been any trends in that? Have you noticed that it's been increasing—obviously there are probably cyclical patterns and it's only been 18 months, but—

MARJORIE ANDERSON: I wish there were cyclical patterns! Then I could work out my workforce management much better. We can get days of 178 calls and the next day get 41. We're not seeing any noticeable patterns now. The only patterns we are seeing are that when there's big community events, such as the Aboriginal Koori Knockout, our numbers go down because all the mob are together. Survival Day, all the mob are together and our numbers go down. Christmas time, mob get together—our numbers went down. We're seeing those sorts of patterns. But we can have a week where we get 41 calls, 68 calls, 126, 173 and then 41. It's a bit up and down at the moment.

The Hon. EMILY SUVAAL: I appreciate that as a program that's been operating for only 18 months it is early days in terms of that data as well. We heard earlier in some of the evidence given the importance of face-to-face care. With 13YARN, it obviously is a phone line. I wondered how you find the ability to refer people or whether or not you're able to then get that face-to-face care, or whether you have comments on that.

MARJORIE ANDERSON: Yes, that's what we refer them to. We're crisis supporters. We're a non-clinical service. When we refer people, we're often referring people to a clinical service, or we might refer them to a men's group or women's group. People ring up for lots of issues. But we do a lot of work face to face as well as a team. The Aboriginal community would not have trusted us if we hadn't been out in the community talking about 13YARN, showing them who's running 13YARN and showing them that we're not gammon—we're not a service that is run by non-Aboriginal people. We've been out in remote Australia. We've been out in urban. We've been in every State in Australia sitting down with the community and telling them about 13YARN. Face to face is the most important thing when it comes to Aboriginal people. We wouldn't have people ringing our line if we didn't do that.

For example, we went up to Barunga, up in the Northern Territory and, after our visit to Barunga, our calls from the Northern Territory quadrupled. So that's the importance of face to face with community. But when people do ring, we de-escalate, we try and empower and then we refer to ongoing services. We always say, "You

know, if you feel like this again, you can always ring us back." A lot of people do ring us that have their safe plans in place and are already seeing somebody. But they might get triggered in the middle of the night and use 13YARN to calm them down and to empower them to get through the night so that they can go and link in with their services the next day. We get a lot of calls like that.

One thing I will say is we get calls from inside mental health units—where people are not feeling good inside mental health units and they don't like the treatment they're getting within mental health units. So we get calls, and we also get calls from people in hospital as well—normal hospital, not mental health units. You know, they just don't like the way they're treated within these units. They feel unsafe.

The Hon. EMILY SUVAAL: That is really devastating to hear. Mr Sturgiss, did you have anything to add?

SHANE STURGISS: I would just say that face-to-face support service is a preferred methodology, but then, within community, there's also, I suppose, that element of shame, where a more anonymous service like a telephone service is the preferred method. Ideally, for your healing aspect, in person is fantastic, but, for crisis management, it doesn't necessarily have to be. It's more that post-crisis care support that needs to have that face-to-face element to it.

The Hon. EMILY SUVAAL: We heard a bit about ACCHOs in the evidence so far in the inquiry. Could you both speak to your own ability to refer, or to linkages or integration that might occur there and whether they are currently set up to deliver that mental health care or community mental health care.

SHANE STURGISS: I genuinely would have to say that linking in is difficult. When you are looking at Aboriginal community controlled organisations, they are so under-resourced. I'm a national service provider with international coverage in the Pacific Islands, and we established that with three staff. We currently run on six staff doing a national service provision as a State peak body with no funding. We have no local, State or Federal funding to run our operations. And I sit on seven different ministerial State and national strategy committees. So to link in with other services is difficult when you are looking at Aboriginal community controlled organisations, because your time is spent delivering the services to your community.

You don't really see or hold the importance into looking at that broader picture. That's wrong. You see the importance in it; you just don't have the time to facilitate it. I think that's where the issue is. They're all under the pump. Then, when it comes to these funding pools, because they're usually quite small for ACCO services and particularly health services and mental health services, they tend to then become combative and they're competing for that same little pocket of money. So the idea of working collaboratively to do that means, if we linked up together to apply for a pool of funding, we're sharing that little bit of money that's coming towards our way. We aren't able to do that, fiscally. So there are major inhibitors when it comes to linking in with other services. Our coalition of Aboriginal peaks, of which I'm a part for New South Wales—we meet regularly. We cross collaborate with a lot of things.

Again, even for me as a State queer cultured service provider and the lead for that, every other—we would sit across every portfolio in government. We would have queer mob everywhere, in everyone's portfolio, but we have no portfolio of our own. We have no LGBTQI+ SB portfolio. When I am sitting in those collaborations, I know that there are experts that relate directly to that portfolio. There's the Aboriginal Legal Service, Aboriginal Medical Service, employment services and education services that speak directly to each of those Ministers, and I let them take the lead on that. Very rarely do I have an option to have a voice in those forums, because I don't have a platform which I can bounce from.

MARJORIE ANDERSON: I think we link in with ACCHOs quite well. NACCHO sits on my advisory board. But, again, they're so under-funded. And what happens is the need out there is so great that when you have an ACCHO, they expect that ACCHO to be all things to all people. Even 13YARN has been—tried to be—dragged into supporting people in parliamentary inquiries, and we're not counsellors; we don't do that. Or coming out following suicide in communities—that's a postvention service; we don't do that. Because the need is so great, when you're a well-respected Aboriginal service, people want you to do everything for them.

What you end up doing is spreading yourself very thin and not doing anything very well. That's what happens with a lot of these ACCHOs. They spread themselves really thinly and run on the smell of an oily rag. It's not my area of expertise, but this is just me viewing what's happening out there. And I know, after being chair of many, many Aboriginal organisations throughout my life, it's robbing Peter to pay Paul all the time.

The Hon. EMILY SUVAAL: We heard about the importance of care coordination in keeping people with a mental illness well, and it strikes me that the ACCHOs are set up in the community, and they would be the best equipped to do that. But if they have to apply for and cobble together different buckets of money to do so, that's problematic.

MARJORIE ANDERSON: It is, and a lot of Aboriginal people deliver service to the community unfunded. And that's never counted. You know, I came from housing. I was in the Aboriginal Housing Office, and they're saying, "Why are Aboriginal community housing organisations more expensive than non-Aboriginal housing?" I said, "Because they actually look after the house and the tenant." You know, they don't just collect the rent. To be perfectly honest, they do a lot of things that they're unfunded for. So we have to consider that.

There are Aboriginal people out there working for minimum wage that are working lots of hours a day. When we go home from work, that doesn't mean we've finished work either, because we're seen as the organisation we work for. So, if somebody else in your organisation does the wrong thing and somebody knows you, it's your fault. They will come up and complain to you about it. So it's difficult for people to live and work in communities and really have that work-life balance as well. That needs to be recognised.

The CHAIR: I am interested in your comments about calls to 13YARN reducing on days when there are events of cultural significance that bring people together. I think it speaks to the social determinants of health that there are things other than health that impact our health. Should we be looking at funding that kind of event, or how we can support those kinds of connections to reduce reliance on mental health services?

MARJORIE ANDERSON: I think when mob get together as a community, they forget about the issues that they face day to day like the cost of living at the moment or inappropriate housing in New South Wales. We don't have enough housing. There's overcrowding in remote communities. There's not enough money spent on maintenance. The land council houses need to be bulldozed and rebuilt. We are just spending \$50,000 on a house and you can't see any difference because it's just making it safer. And also access to health services—all those things that are day-to-day struggles for Aboriginal people. When we get together at the knockout, people forget about that and they just enjoy being together with their mob. I think if you wanted to fund any cultural get-together, you should be talking to the community about that. If you're seeing areas where you really want to get some mental health services in there, go to that community and ask them what they want to do. Say, "What do you want to do?", and they'll tell you.

The Hon. GREG DONNELLY: On that point, because I think it's a very important point, is what may be proposed as necessarily important for that community group within Indigenous culture possibly quite different from what may well be seen by another community? Can there be real variance?

MARJORIE ANDERSON: Oh, absolutely.

The Hon. GREG DONNELLY: So the variance can be quite different?

MARJORIE ANDERSON: Absolutely. I remember we put out expressions of interest to supporting Aboriginal tenants and it was going to be co-designed with the community and delivered within the community. The things that we got were nothing to do with housing. It was really about bringing people together—like community gardens in housing complexes and things like that. It was more about the social and emotional wellbeing of the tenants rather than the housing themselves. It was interesting, because we thought we'd get better electricity or better lighting, or better this or better that. But it was things like community gardens that people wanted to deliver, or visiting programs for Elders who live alone. It's really important that we look after Elders who do live alone and not build those things like they had in Redfern—that skyscraper that they put all the Elders in. I couldn't believe it when they did that. Half the time the lifts were out and people were trapped in their units.

The CHAIR: Mr Sturgiss, did you want to jump in on either of those questions?

SHANE STURGISS: No, I'm fine, thank you.

The CHAIR: One of the terms of reference of this inquiry is looking at alternatives to police for responding to mental health emergencies.

MARJORIE ANDERSON: Oh, yes, I would like that.

The CHAIR: There's a large number of different pilot programs happening in different parts of New South Wales and in different States. At our next hearing, we will be looking at some of those alternatives. From your perspective, what a better model might look like for a queer First Nations person who rings 000 in a mental health emergency. What would a good, culturally safe response to that call look like?

SHANE STURGISS: Again, that would be something I could take on notice, because within culture, if we're speaking for community about what they want, we always engage community and we do a consultation. Even as the CEO of the organisation, I don't have the capacity to speak on behalf of the communities on all topics. That's something I'm happy to take on notice and put a submission in for. But, ideally, just to say that Aboriginal and Torres Strait Islander people have an inherent distrust of government, of police, regardless. Too many times we've seen, and we have been the victims of, very public abuse by police. Having police show up for it, in regard

to a mental health crisis or a psychosis, is a triggering element, which I think we could all agree on. It's not necessarily—that's not a secret. But the way forward from that and the better outcome from that is something that I would need to make sure that I was giving the correct information and consult the community on.

The CHAIR: We would really appreciate for you to take that on notice, and we look forward to hearing that response once you have been able to do that consultation.

MARJORIE ANDERSON: This is something we discussed ad nauseam when we were developing 13YARN, because the approach at the moment is, when we know somebody is in danger, 000 must be called and there's a police response. We hate doing that. We often ask, "Is there somebody else in the house with you?" And, if there is, "Get them to ring an ambulance." That often brings a better response than ringing the police. We've heard things, over the phone, escalate when the police arrive. One of the things we do is try to talk to the help-seeker and say, "Look we've had to ring the police because you've got a plan. Can you put whatever you've got in your hand down? And when the police arrive, open the door. Let them see that you've got nothing in your hands." Because we want them to be taken away safely and dealt with properly. Sometimes that will work, but sometimes, as soon as they see the police, it's an escalation because of that mistrust that Shane spoke about.

We've talked about this ad nauseam, on how we could do it differently. The general consensus, from those with a lived experience particularly, is if an ambulance service turned up instead of the police it would be a better outcome because there is a trust in the ambulance service that is not there with the police. We have seen younger police often have a different approach to the older police. We had a young man one time, when our 13YARN crisis supporters up in Dubbo were out to dinner, who was going to jump off a bridge. His actual psychologist heard about it and went down there. The police wouldn't let the psychologist talk to him. We had 13YARN crisis supporters down there and they weren't allowed near him. His mother came down; they kept her back. And the younger police who were there in the beginning had him settled down, but it was when the old police sergeants turned up and it was the heavy-handed thing that it just escalated.

They ended up arresting him and throwing him in the back of a paddy wagon, and the whole community was distressed. My 13YARN crisis supporters were distressed. Everybody that was involved in that was distressed. They say, "This is why we don't trust the police." It is because we get those heavy-handed old sergeants come in who want to flex their nightsticks, and it's just a terrible outcome for everybody. But the younger police seem to have a different approach. I'm not sure if the training has changed, but they seem to have a different approach. It depends on personality as well, with police, but I don't think they get enough training around dealing with people who are in psychosis or people who are having episodes of mental health issues.

The CHAIR: Those are really distressing stories, but it's really important evidence.

SHANE STURGISS: I think that's probably the key point to take away. The police have a very specific function in the community—to keep the peace. Ambulance and mental health workers have a very specific role in caring for community. If everyone just did their job that they're actually allocated, then that would be great. And if that means putting more resources into mental health ambulance paramedic teams, that would be money better spent than training and educating the police force in mental health and psychosis.

The CHAIR: We have a few minutes left. Are there questions from any Committee members? No? With the couple of minutes left, is there anything you would like to add that you haven't had the chance to tell us?

SHANE STURGISS: No, I think I'm good. Just the time frame for the consultation that I will undertake—when did you want that back by?

The CHAIR: The standard for questions on notice for parliamentary committees seems to be 21 days. That being said, this inquiry hasn't got a fixed end date for reporting yet, and it is expected to run well into next year. I think I can speak on behalf of the Committee by saying we would accept that next year.

SHANE STURGISS: Excellent, because I wouldn't get mob together to get back to me within 21 days in this current environment.

MARJORIE ANDERSON: No, not now.

SHANE STURGISS: So thank you very much.

The CHAIR: Thank you. That's really appreciated. The secretariat will be in touch with you if there are any more questions on notice. Thank you so much, again, for the time you have taken to share your experience and your expertise with us today. I hope that we can use that to make better healthcare services for everyone in New South Wales.

MARJORIE ANDERSON: Thank you for hearing us.

(The witnesses withdrew.)

The Committee adjourned at 16:40.