REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

CORRECTED

At Macquarie Room, Parliament House, Sydney, on Monday 30 October 2023

The Committee met at 10:00.

PRESENT

Dr Amanda Cohn (Chair)

The Hon. Susan Carter (Deputy Chair)
The Hon. Greg Donnelly
Ms Sue Higginson
The Hon. Cameron Murphy
The Hon. Emily Suvaal

PRESENT VIA VIDEOCONFERENCE

The Hon. Wes Fang

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

My name is Dr Amanda Cohn and I am Chair of the Committee. I ask everyone in the room to please turn their mobile phones to silent. Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside 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 COOPER SMEATON, Individual, affirmed and examined

The CHAIR: Welcome, and thank you for making the time to give evidence today. Would you like to start by making a short opening statement?

COOPER SMEATON: Yes, thank you. First of all, I would like to also acknowledge the traditional owners of the land on which we meet today and pay my respects to Elders past, present and emerging. Good morning, Chair, Deputy Chair and Committee members. I am here today after making a submission to this parliamentary inquiry. Sadly, I bring the news with me of the passing of an amazing soul and loss to my community, who sadly completed suicide on 1 October this year. This has furthered my determination to speak here today. Today I will be dedicating my evidence and appearance here today to Kahi Simon, and I extend this to Kahi's family, some of which are here today.

My first point of discussion I would like to take the opportunity to speak to is to the care and treatment of Kahi, to which I have been told from his mother, Kelly, who is here witnessing today's proceedings along with her husband and members of Kahi's extended family. Kahi unfortunately became another soul lost to the critically important and saddening statistic that suicide is higher in Indigenous communities, and then higher again in males. Mr Simon was treated specifically in the Hunter New England Local Health District between Taree and the Newcastle area. I would like to take you to his treatment in the Manning Base facility. This was extremely damaging to the welfare and state of mind for Kahi.[1]

In regards to a number of issues, a few of the key issues found here was the fact that Mr Simon was able to escape and exit care due to being moved to a non-secure ward because of the renovations in the secure unit. Even after he expressed to his treating team that he could not control himself, he was able to escape from the non-secure unit and was found to have attempted an overdose of more than 40 individual valium—this being his first attempt at taking his own life. Mr Simon and his family felt that his care was rushed and that they could not express the overall care concerns due to the fact that they weren't listened to in the first instance when he was able to escape after he expressed the exact statement, "I don't trust myself." This is extremely troubling for families, and I feel should be of the highest importance to fix. Mr Simon was discharged from care from a video consultation in which he expressed he did not feel that he was happy with—nor did his parents. He was not given the committed communication from the social worker that was told to the family he would receive, and nor did his family receive any ongoing community care.

The New South Wales community should know that the New South Wales health system and its people is one that works with a great sense of responsibility and genuine care for the people of New South Wales. But I believe that this is also a system that is under extreme pressure and that cracks are starting to show. If you look at the history of coronial findings that have had to include quite basic and standard operating procedures and obvious care recommendations, it is very difficult to not look past that and the fact that we have a significant care issue in the mental health sector of the New South Wales health system. Examples of this extreme pressure include the overwhelming ramping in trauma centres that should be staffed and resourced better, and the lack of responsibility that has been shown in regards to the discharge of extremely vulnerable and mentally ill patients, who have in turn ended their lives in the hours after presenting at an ED and not receiving critical and urgent care in the first instance.

The privatisation of mental health facilities that are looking to care for a so-called stable patient because they can't handle a patient who has, prior to admission, expressed suicidal ideations, is what you could call a sense of care discrimination. Mr Simon was denied the opportunity to enter a private care facility due to the fact that a non-medically qualified receptionist informed his mother he was not a suited patient as he was expressing suicidal ideations. This was the trigger for Mr Simon to complete suicide and cause the most severe pain for his family and to his community. This all stems from a complete lack of resource management and funding by State and Federal governments alike.

I'm not pointing the finger at any party and/or Government Ministers. This is a systematic harm issue that needs clear and concise discussion and response, with first being the funding to people at the forefront of where and what this is happening, patient-to-staff ratios and more accountability and acknowledgement of crucial and damaging coronial and statistical evidence that shows change is needed. I thank you for your time today. Again, I wish Kahi a peaceful rest and that he knows his death will not be in vain.

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[1] In correspondence to the committee received 21 November 2023, Mr Cooper Smeaton, Individual, provided a clarification to his evidence.

The CHAIR: Thank you so much for that statement. I want to acknowledge your loss of Mr Simon. Thank you so much for sharing that experience with us so that we can all help to make mental health care better for other people in New South Wales. It is really wonderful to have that story.

COOPER SMEATON: Thank you.

The CHAIR: My first question is very broad. As you probably know, it is the job of this Committee to write a report to the Government with recommendations of what we could or should do differently. I think you touched on a couple of those in your opening statement, but what would you like to see as our top recommendations for change?

COOPER SMEATON: I definitely think the overall care aspect of patients when they present at an emergency department is looked at as a strong sense—as identifying what the cause of the presentation is and then specifically having a sector that looks after mental health. And I understand there is. I understand there are consulting psychiatrists and psychologists and clinical nurse specialists. But I definitely believe that when you look at the coronial findings over a wide period of time, you see that there is an unfortunate number of patients who have taken their life after presenting at an ED and not being provided adequate care. I believe that this should be something that is looked at, and that a responsibility after attendance is looked at by the New South Wales health system as something that they have to own.

The CHAIR: Thank you. That is very helpful and very specific. I will go to other members of the Committee for questions.

The Hon. SUSAN CARTER: Thank you for being here today. I am sorry for your loss and the loss of the people in the gallery in respect to Mr Simon. Could you talk a little bit more about the difficulties that family members have in being heard or being able to walk with people who are mentally ill as part of their journey, and the recognition, or lack of recognition, by the health system of the role of family members?

COOPER SMEATON: Thank you, that's a very important question. Something that is extremely saddening and that has been expressed by Mr Simon's family is that exact key issue—the fact that they haven't been heard since his passing and the fact that he was able to leave his secure care unit due to the fact that it was under renovations and that it was chosen by that department to move him. It's extremely troubling that they're not able to be heard. They have been contacted for an investigation into this, but the fact is that it shouldn't happen in the first place. I believe that there should be a departmental investigation unit that has family consultants within it, and I definitely believe that the family liaison officer, and not just one—I understand, when it comes to government systems, everything does come down to funding. That's a crucial, key thing because nothing happens without financial backing. I look at it in the way that funding needs to be reallocated in the aspects of evidence from coronial findings, statistical evidence and everything like that, and then also having roundtable opportunities.

I understand with a committee into this aspect, I did a submission and I was then contacted and able to give evidence today. But it does, in a way, unintentionally discriminate people's access because you can't expect everyone to have the ability to do a submission and then have the knowledge. It needs to be Ministers; it needs to be politicians on the ground, who are representing their communities, who need to be talking about this. There is a massive taboo subject when it comes to suicide and mental health, and it's something that needs to be thrown out the window. The taboo needs to end because it's something that families need to know about. It's something that employment at the highest level and community activity still discriminate against. It's something where families and people all alike need to know that they can have a contact, without discrimination, without being attacked or dismissed. They need to know that there is an open-access line for them to be heard.

The Hon. SUSAN CARTER: If I could ask you a question in a different direction, in your submission you raise the idea of mental health intervention teams. Do you have any experience of them in practice or any comments about how mental health intervention teams might make a difference in certain situations?

COOPER SMEATON: I personally haven't had any interactions with them, but I have read of people's interactions with them and I think that they are gold class. I think that they are one of the key fixes to this issue within our community—to have people on the ground when 000 is called, if it requires police or ambulance attention. To have a PACER, per se, officer who is able to attend and assess that situation and then be able to provide the advice to someone, that, in turn, stops ramping at trauma centres. It stops ramping at ED centres. It stops the backlog of police having to guard or look after a patient while they're in ED situations. For me it's a no-brainer—the fact that they are, in their name, something that is going to save lives.

The Hon. EMILY SUVAAL: Thank you, Mr Smeaton, for appearing today. I acknowledge the members in the gallery behind you for also coming. I thank you for being here. Mr Smeaton, do you have any thoughts around recommendations that we as a committee could make regarding more culturally safe and appropriate care, if and when that was to be the case?

COOPER SMEATON: Yes, definitely. I do believe Indigenous medical services, to start with, are doing great work. I see it on a daily basis. I actually used to live in Redfern, and I would see even little posters on telegraph poles and things like that—just simple messages, but knowing that they're out there. I understand that there is still work to be done, but it's more going in a positive direction than it's going backwards, which I think is a credit to the NSW Health system and Aboriginal Health alike. Culturally, with other cultures, with respect, I'm not of any other culture. But I do understand from having knowledge of other cultures within just general life experience that there are other cultures who do have suicide and mental health as a taboo subject, and I understand that it could be harder to break that cycle.

I definitely believe that if we do more campaign work and we do more accessible work, maybe in schooling—I came from a schooling background where we had one school support officer for roughly over a thousand children, so that woman was worked to the bone. She was a godsend, but she was at her wits' end. I definitely think that education is key when it starts with saving lives. If people know that there is health access and there is safety out there—it's one thing to have children's helplines and things like that where kids will call, but it doesn't provide genuine access in the way of ongoing care. It's crisis management, and I think ongoing care is the safety realm that's going to fix these issues.

The Hon. EMILY SUVAAL: I want to ask you a couple of questions about community mental health care, specifically. What are your key criticisms of the current way people experiencing a mental health crisis in the community receive care?

COOPER SMEATON: If I can turn to some of the issues that were found in relation to the passing of Kahi, he didn't receive the committed communication that he was offered from the community mental health team. I believe it's an area that is probably a little bit overworked, maybe, and that they're scrambling to find their feet still, quite a bit, with the overwhelming pressure that they're having with the epidemic of mental health. COVID probably didn't help with that, I understand, but I definitely believe that it would come down to adding more resources into that sector—so making sure that there is accountability, marks hit, maybe an after-action review team that sets benchmarks for them that they have to meet, but then also having the acknowledgement that funding is required and that it starts with what the Government is going to provide.

I was told by Mr Simon's stepfather that, over a four-year period, $60 million of funding was provided to suicide prevention. That's roughly about $15 million a year. For some people, that's a lot of money. In the government sector, that's not a lot of money. I know through experience—employment experience and things like that—when it comes to a media campaign, that's going to take a lot of your budget when it comes to $15 million. It just will; that's how much it costs. Suicide prevention and mental health access in the community are going to have to be something that money is thrown at until we see an improvement. The key criticism I could have is I think it's going to start with actual personal responsibility. If someone is allocated a patient, they need to be held accountable for that patient's care. If they can't be then they need to explain why, and then I think we need to look at another term of—not as in criminal charges or anything to that effect, but I think responsibility slips quite easily.

The Hon. EMILY SUVAAL: We've heard other evidence in this inquiry from the NSW Nurses and Midwives' Association regarding the allocation of case loads, particularly in the community mental health sector, and that ideally someone might have a case load of 30, which to me sounds like a lot but that was the benchmark, but that in actual reality people were having case loads of up to 80. I absolutely take your point in terms of that responsibility and accountability, but if we've got a system that is currently set up whereby the staff that are supposed to be looking after and having that follow-up are being expected to manage 80 people at any one time and there are only so many hours in the day and days in the week, what would your suggestions be around that? Obviously you are quite an articulate and intelligent person. You would understand that it's just not going to be possible for one person to do that much work.

COOPER SMEATON: No, it's not.

The Hon. EMILY SUVAAL: Having an increase in resources in that community mental health sector, where would those resources go? What would that look like? How would that work?

COOPER SMEATON: I can't speak for the association but I think they may agree with me in the fact that patient-staff ratios would need to be higher in the way that the staff ratio needs to be higher than the patient ratio. I definitely believe they would need better support. I think KPIs are something that are great in a corporate sector but not great in a health sector, and I know that there is where corporate meets community and health and things like that but I definitely think we need to move away from corporatising, for lack of a better word, the health sector and bring it back to the fact that these are people managing people who have complex needs.

My mother was a disability mental health caseworker and she was answering the phone at 2.00 a.m. in the morning when she wasn't getting paid to, because she has a heart. There were many times where her boss

would have to say to her, "You're not allowed to bring them to your house for Christmas because it's, first of all, not appropriate and, second of all, you need to be able to respect your own boundaries and look after yourself."

I understand the fact that they need the resourcing and more staff but also more assistance. I think the way of looking at it is maybe going to those people and asking them what they need but then also putting in place operating procedures where they can reach out and say, "Well maybe this person needs more of a complex support system or we need to refer on to somewhere else that can support them more with a more ongoing care." People are going to need 24-hour care sometimes and it's not opportunistic that it can happen with a community care point of view, even if they want to be out-of-hospital care.

I understand the point that it's going to be a hard road, but I definitely think that if people attend to this in a way that opens it up to a more broader aspect of care with more resourcing in funding, more resourcing in staffing and even just better access to facilities—I think maybe even looking at opportunities for use of the private sector if it could be looked at where government funds situations within the private sector aspect of care, we could do better on that. Psychiatrists' appointments and things like that—they're extremely expensive, but I know they do make such a change and I know that through personal experience. I definitely think that if we could have more of a look at more psychiatric resource management in the community, I definitely think there could definitely be good change.

The CHAIR: Thank you. We've come to 10.30 already. Thank you so much again for the time you've taken to give evidence today, and the secretariat will be in touch with you if there are any questions on notice.

COOPER SMEATON: Thank you so much for all of your time. I appreciate it.

(The witness withdrew.)

(Short adjournment)

Dr FIONA KUMFOR, Associate Professor, School of Psychology, University of Sydney, Clinical Neuropsychologist and Co-Founder of the Dementia Law Network, affirmed and examined

The CHAIR: Good morning. Would you like to start by making a short opening statement?

FIONA KUMFOR: I'd also like to acknowledge the traditional custodians of the land on which we meet today, the Gadigal people of the Eora nation and I pay my respects to Elders past and present. I'd like to thank the Committee for the opportunity to present evidence on behalf of the Dementia Law Network. It's estimated that dementia currently affects around 400,000 Australians and, of these, around 25,000 people have younger onset dementia, where symptoms occur before 65 years. Often people think dementia only affects older people and is associated with memory problems, but dementia is an umbrella term of which there are different subtypes. In the younger age group, frontotemporal dementia is as common as Alzheimer's disease and it is characterised by changes in behaviour and language.

In people who develop behavioural changes, these can be misperceived as potential criminal behaviour and as—the term we use—criminal risk behaviours. That indicates behaviours which put people at increased risk of interactions with police or the legal system. We established the Dementia Law Network around a year ago in recognition of the lack of knowledge around issues that the intersection of dementia and the law and, in particular, understanding around these criminal risk behaviours. We found that there was a dearth of research in understanding why these criminal risk behaviours emerged and, importantly, how we can better manage them in the community.

The aim of the network is to bring together researchers, clinician, legal practitioners, people with dementia, their families and broader community to advance knowledge at the intersection of dementia and the law. We're currently working closely with stakeholders, including the Ageing and Disability Commission, Legal Aid, Dementia Support Australia and Carers NSW to understand these issues further. I am grateful for the opportunity to present some of the wok from our stakeholder workshop that we held in June, as well as work we've been doing at the university to understand these issues

The CHAIR: Thank you very much. Firstly, I just wanted to acknowledge the level of consultation and work that went into the submission that you're presenting. I understand you're representing a number of people today and that's really appreciated. It's very valuable evidence.

FIONA KUMFOR: Thank you.

The CHAIR: Having a look at the workshop report, you've got several pages of recommendations that go across a number of sectors. So I appreciate the written submission because I'm sure we won't have time to go into all of them today. But I was hoping this Committee will go forward to make recommendations to Government. If you had to pick what the most urgent priorities are, in terms of your recommendations, to implement, could you speak to those?

FIONA KUMFOR: There's really two areas of really urgent need in this space around dementia. The first is really around early recognition and diagnosis. We find that in the general community, as I mentioned, there is a lack of understanding that behaviour changes can present as dementia and also that dementia affects people in this under-65 years age group. That can really lead to this inappropriate criminalisation. We see this across a number of sectors—so the general community but also health professionals. We know that there's at least a three-year delay in diagnosis from when people first start presenting with symptoms to when they are ultimately diagnosed with dementia. This is particularly the case when it is younger onset or these behavioural changes—around 50 per cent of people get an inappropriate diagnosis of a psychiatric condition prior to being correctly diagnosed.

We think there's a real need in terms of upskilling clinicians and in terms of being able to recognise these issues further, for better education in terms of how to diagnose dementia, and ensuring that people have access to skilled clinicians when these behaviour changes present. Obviously this also involves educating the community so that people are aware if they notice changes in their loved ones or people around them that should really be the trigger for medical investigations or follow-up in terms of health.

The other aspect obviously is in terms of how we manage these changes. There's a number of recommendations that we've made. We know that there is a role for police response in terms of when people do have severe behaviour changes but that police need to be better educated in terms of how to better manage people living with dementia and de-escalate these situations. Our consultations already with police have identified that they have very minimal training in terms of these issues—in terms of being able to recognise dementia and understanding how to move forward.

The other issue is that we see that clinicians find it difficult to understand who to refer to or what services are available in terms of managing these behaviour changes. Something that came out of our stakeholder workshop was that even though these were very skilled clinicians who are working directly in this area, even they felt confusion in terms of who they could refer. Part of this is because of this arbitrary 65-year age cut-off so if someone is below the age of 65 years, they may be more suited to the NDIS but if they're above the age of 65, they're more suited to My Aged Care. This arbitrary cut-off makes it very difficult in terms of knowing who to refer to. Clinicians really expressed to us a need to have a clearer referral system in terms of, when they notice these behaviour changes, who can they contact to help to manage them.

The CHAIR: Thank you. That's really helpful. I will go to other members of the Committee for questions.

The Hon. SUSAN CARTER: Thank you for being here today and thank you for the submission and the addendum—the workshop report. The observation that behaviour that is dementia driven presents as criminal and therefore gets a criminal response, and the recommendation that this could be addressed by more training of first responders, I wonder if you could provide some comments around who could provide that training, how long that training might take, how often it might need to be refreshed and, perhaps, would the training be sufficient? If somebody is engaging in violent criminal behaviours, they have no will to do that but the act is there—whether there also needs to be a typical police response for the safety of that person and other members of the community?

FIONA KUMFOR: Yes, absolutely. This is a very complex and complicated issue so we need to manage both the best interests of the person living with dementia as well as the safety of the community more broadly. In terms of having an appropriate police response, one of the things that's been identified today and also in terms of the terms of reference is PACER. That was something that came out in our workshop report as something that was extremely valuable. Where there is serious violent behaviour or other serious concerns, having a mental health professional as part of the police response is really essential to ensure that the person is appropriately managed and receives a health response, rather than a legal or criminal response.

Our understanding is that this has been really successfully piloted in certain areas but that the rollout has been patchy in terms of the resourcing around this. We think that absolutely there's a need for a police response and PACER is something that really should be expanded and ensured that it's available New South Wales wide. In terms of the training, that is really something that our network is focusing on in terms of what would be necessary and sufficient. There are aged-crime prevention officers as part of New South Wales police who work specifically in aged populations but, as I mentioned, in this younger onset there's this difficult delineation between under 65 and over 65. I should mention that in Aboriginal and Torres Strait Islanders, we should really be thinking about over the age of 50 in terms of onset of dementia. So, again, this arbitrary cut-off can lead to some difficulties in this space.

Certainly having specialised people within the police who are having more comprehensive training, and then potentially more widespread training for all police officers—I think many of the things in terms of de-escalation in these sort of situations are probably not unique to dementia but would also be appropriate for people with other types of cognitive impairment or mental health. So really being able to skill police so that they feel confident in these situations and to defuse situations is really important. That's also something that has come out of interviews we've done with carers and family members. Often they've found when police are called it can make the situation more complex and more emotionally charged. Finding ways to minimise that and defuse the situation is really important.

The Hon. SUSAN CARTER: I'm wondering, given the evidence you've given about the relatively high rate of misdiagnosis, or at least early misdiagnosis, and the difficulties of people in the community being confronted with what they see as a violent situation, how easy would it be at the point of the 000 call or the dispatch of the police to be able to know whether a team was going out to deal with a person with dementia or other cognitive impairment or somebody running through a shopping centre with a knife?

FIONA KUMFOR: That's a really important question. I think there are two groups of populations that are affected here. There are certainly people who don't yet have a diagnosis, and that's obviously even more complex, because we don't know the aetiology. One of the red flags that has emerged in our research is where this is new-onset apparent criminal offending. If someone has otherwise not behaved in this way and this is out of character, that would be more of an indication for dementia. One of the other things that has come out is that, even with people with a diagnosis of dementia, people don't necessarily believe it, because the person doesn't have memory problems.

There's a real stereotype of what dementia is in terms of "it only affects older people" and "it only affects memory". So then, if police or security guards are called and the carer, wife, spouse or family member says, "They have dementia. Please don't arrest them. Please don't charge them," the police might say, "Well, actually, they can

remember exactly what happened, and they're far too young, so they can't possibly have dementia." There is that issue that even for people with a diagnosis of dementia there are various ways that it can still impact on them and their families.

The Hon. SUSAN CARTER: If somebody with dementia, diagnosed or undiagnosed, is in a public place with a knife, police are called, let's say that person is arrested, presumably there are no criminal charges or at least conviction because there is no mens rea. What support and what follow-up is there for that person who has had that contact with the criminal justice system?

FIONA KUMFOR: This is where some of our case studies that we're doing at the moment are really important, because we're looking at specific situations of what happens to people. There is still a group of people who will be charged and ultimately will go to court and will usually be dismissed under section 14.

The Hon. SUSAN CARTER: Sorry, can I stop you there? Why would there be a charge if there's no mens rea?

FIONA KUMFOR: I can't comment specifically on any individual cases. All I can say is that we have examples from Legal Aid and from our links with specific solicitors where it has led to charges being laid. I think it is probably more likely in the situation where the diagnosis isn't definite and so that comes to light through the proceedings. Hopefully that answers your question.

The Hon. SUSAN CARTER: Yes. I find that confusing. I'd be interested to know more about that because, unless it is strict liability, you need the mental competence to be able to complete the crime.

FIONA KUMFOR: That's exactly why we're keen to look at these case studies, so that we can understand better the trajectory of individuals and also identify potential off-ramps where things could have been done differently. The other thing I'd like to mention in terms of your particular comment is that the types of behaviours that we see are very diverse in terms of their seriousness. People with dementia showing these violent behaviours are very rare. What we see more commonly is that it's people showing disinhibited behaviour. They may, for example, approach children that they don't know, or they may be in a shop and have taken something in their pocket and forgotten to pay, for example. So there are issues around trespassing, shoplifting or swearing and those types of things. Often what happens at the moment is the burden is on the family members to manage those behaviours. What we hear from family members is that they just keep the person with dementia at home to minimise these risks. I just wanted to mention that these very violent behaviours or, for example, someone walking with a knife in a shopping centre is very rare and unusual. It's more these disinhibited or inappropriate behaviours that can occur.

The Hon. SUSAN CARTER: That's an even better example, because what I was exploring was the extent to which this contact with the criminal system operates as the red flag that this person needs treatment and support and whether that then acts as a gateway to receiving that treatment and support.

FIONA KUMFOR: I don't think that we have any good data at the moment on that, because the data that we've collected to date is on people who already have a diagnosis of dementia. There are services that are available in terms of managing behaviours. Some that emerged from our stakeholder workshop were Dementia Support Australia's Dementia Behaviour Management Advisory Service, where they can come in and give advice or suggestions on how to manage, through interventions, these behaviours to minimise them occurring, and also the Older Persons' Mental Health Service. There was some discussion in the workshop in terms of who's eligible for that, is dementia falling under a mental health service and do you need to be over the age of 65? That seems to vary across different local health districts. But certainly those services have been found to be very useful for people in terms of managing the behaviours in an ongoing setting.

The Hon. GREG DONNELLY: Thank you very much for coming today and for a very helpful submission. Just go to page 4 with the recommendations. I'd like to have a discussion with you, if I could, and ask some questions around paragraph 27 and paragraph 28. The position at the moment is that, when there's an incident or a potential incident, we have the police as the first responders often going and responding, arising from a 000 phone call. As you would be aware, in some other jurisdictions in Australia and overseas, that's not the case. There is, travelling along with them or intervening with them, a group, and within that group they would have a level of expertise to assist in dealing with the matter before them. They may very well have very limited information but are drawn in to dealing with a particular incident.

If we look, at the moment, where there's just the police, because we haven't moved to the next step—and that may arise or may not arise from this inquiry. We'll wait and see. But with the police, would it not be the case that, even with some improvement in the training, if we could try to get to that first, and them being cognisant that, in intervening, the person may potentially have a mental health condition, it's an even further step to be able to expect them to contemplate that the person may have dementia? Do you know what I mean? In other words,

we are probably at the point of not having them at the level of base understanding. In a sense, the dementia is almost a specialisation within that. Do you think that it is potentially problematic in trying to go straight to that, as opposed to getting this elevation of understanding around mental health and having dementia fall within that as a broad, overarching explanation of the person's potential condition?

FIONA KUMFOR: Yes, I think that's a very important question. It's certainly something that came up at our stakeholder workshop, in terms of whether the expectation for police to diagnose dementia on the spot is too high. Obviously that is not what we're expecting people to do.

The Hon. GREG DONNELLY: No, I understand.

FIONA KUMFOR: I think part of it speaks to a broader community awareness, which includes first responders such as police, paramedics, security guards and so forth, in terms of how dementia presents and the diversity of it. The other thing that I mentioned is I think certainly some of the ways that people can approach people with mental health, cognitive impairment and dementia would hold across the various different groups. You don't really need someone to be diagnosed with dementia versus autism, for example, or some sort of intellectual disability to decide the best way to respond. In many cases, the best way to respond would be similar across these different conditions.

I think we're not talking about specifically diagnosing dementia on the spot, but really thinking about when you're approaching people who may be behaving in a way that is out of character for them, how can you approach that in a way that doesn't escalate the situation further? Are there strategies that we can give police in terms of de-escalating and defusing the situation? That may, for example, be if there's family members there, speaking to the family members and getting them involved and so on and so forth. Certainly our network, that's why we really want to work—I'm an academic. I work in research. We don't have some of the answers to these questions yet. We think it's really important to work together with police and other first responders in terms of understanding what their existing protocols and training are, and then ask how can we as clinicians inform that training for them to be best equipped in these situations?

The Hon. GREG DONNELLY: I wasn't intending to suggest that the police diagnose but rather—I guess you answered my question, that within the, I will use the word, "spectrum" of potential mental health manifestations that that's where we need to really lift up the capacity of that understanding. The matter of de-escalation has been raised by other witnesses and in other submissions. I'm just a little bit curious in that, as far as I understood a key element or a not-insignificant element of the training of people going through the NSW Police Academy is this teaching and mentoring around de-escalation of a matter, whether or not the person has a mental or potential mental condition or not. The sort of, I use the vernacular, "Rambo" style of dealing with issues, as I understand, is in the past, which to the extent that it happened is obviously a very good thing.

I thought there was a fair bit of teaching and training of police to, in the first instance, see if they could de-escalate a situation. Was that not something that was raised in the workshop you had about their existing training? I need to understand—because that de-escalation may not be trained in the context of dealing with mental health manifestations or matters to deal with, but I thought more broadly speaking they were trained in that?

FIONA KUMFOR: I obviously can't speak to what is the current training police have. Certainly in terms of our workshop, we had a number of representatives from the NSW Police Force there and they were all very open and welcoming to additional training and additional resources. Again, one of the things that came out from those discussions is that they didn't really know what to do if the person presented with behaviour changes and the family was there saying, "This person has dementia." Typically, people are taken to the emergency department and then left for the health system to manage in those situations rather than being taken to the police station, for example. They really expressed that they felt that was inadequate in terms of how they should respond. They were really asking us, "What should we do in these situations? How should we best respond and what are the next steps?" Yes, I think that—

The Hon. GREG DONNELLY: Can I interrupt? Did you have any preliminary responses or answers to those questions from them?

FIONA KUMFOR: One of the things that did come up was that, for other issues, there are hotlines that you can call—for example, 1800 RESPECT—which then give you the appropriate services and sort of a flow chart or pathway that you may be able to follow. That's available for people in the community but also for people working in the sector. That really came out as something that not just police but also clinicians and other professionals who were there thought would be very useful, so that when you're in this situation there's just a single number that you can call, and then they will help you navigate through the health system in terms of what health services people would be eligible for in the community or through the health service and so forth. Certainly

a centralised place that people can call in terms of what to do next in this specific situation was really highlighted as the potential thing that police thought would be useful.

The Hon. GREG DONNELLY: That's very helpful. Thank you.

The Hon. EMILY SUVAAL: Thank you, Dr Kumfor, for appearing today. I also wanted to acknowledge the work of your colleague. Obviously she's helped with preparing the submission. Is it Professor Ries?

FIONA KUMFOR: Yes, Nola Ries.

The Hon. EMILY SUVAAL: In terms of the research that you have undertaken, the submission underlines that the cohort that is reflected may be somewhat of a limitation to how that data is interpreted. I just wondered if you could speak to whether or not there is any further research to be undertaken or what caution needs to be applied when interpreting the data?

FIONA KUMFOR: Yes, thank you for that opportunity. To our knowledge, there hadn't been any prospective studies, not even in Australia but also internationally, in terms of how common these criminal risk behaviours are and what some of the predictive factors might be so that we can recognise people who are more at risk. The first piece of work that we've done to date is with 150 people who were all participants in our research at the University of Sydney. We do tend to see people who are willing to participate in research, who have the capacity and who are from specific socio-economic backgrounds. They tend to be more metro and so on. We are very keen to roll this out more broadly. We've got ethics approval to recruit nationwide through, for example, Dementia Australia and through social media to try to get a better sense of what's happening regionally and remotely.

In terms of our analysis, we didn't find any specific demographics that predicted these types of criminal risk behaviours. We looked at things like age, sex, education and so forth, and they weren't predictors. The only predictors that we found were having a diagnosis of frontotemporal dementia and also having a longer disease duration, which may be that people who progress more slowly are living in the community for longer and have more opportunity to interact in public settings. But absolutely we don't have very good data on, for example, people from Aboriginal and Torres Strait Islander backgrounds, culturally and linguistically diverse, regional and remote Australians, or lower socio-economic groups. We know that there are some aspects that are predictive of people being in the criminal system more broadly that may also apply in this particular space. That is something that we're working on and investigating in more detail. But yes, at the moment we don't have more data on that more diverse population yet.

The Hon. EMILY SUVAAL: Just a very quick, final follow-up question with the time we have left: Paragraph (19) of your submission mentions the consequences for people with dementia after contact with police or authority figures, including being scheduled in psychiatric wards, which I found quite interesting. In terms of the 150, were there any that were more highly represented? Was this something that everyone had—were there any patterns, I suppose, in that data?

FIONA KUMFOR: Of the people who showed these criminal risk behaviours, around 20 per cent led to interactions with police or other authority figures, such as security guards or paramedics and so forth. In the vast majority of cases, it was managed outside the legal system or outside the health system—for example, they were banned from their local shopping centre.

The Hon. EMILY SUVAAL: Which would still have consequences on some of them.

FIONA KUMFOR: It absolutely still has consequences, not just on the person with dementia but also their family. For example, the spouse said, "I can't do my groceries anymore"—because they can't be left at home—"and I can't go to the shops", so there are very simple, practical implications. In terms of being scheduled in psychiatric wards, from memory that only happened in one case out of our 150, so it's relatively rare.

Again, something that came out of our workshop was that for people with severe behaviour changes, there is a degree of recognition that it is inappropriate for them to be in custody but it can be difficult for them to be living in the community. There aren't residential facilities that will take people with these severe behaviour changes because of potential risk. There are a couple of very specialised residential facilities Australia wide—I think six, maybe, off top of my head—but otherwise people won't take someone with dementia with these severe behaviour changes. Unfortunately, often they will end up in hospital for extended periods of time, as that's really the only place where they can be managed.

The Hon. EMILY SUVAAL: Thank you. That's very helpful.

The CHAIR: Thanks so much for the time you've taken, not just to give evidence today but in preparation of the submission and holding the workshop. We really appreciate it. The secretariat will be in contact with you if there are any questions on notice.

FIONA KUMFOR: Thank you for the opportunity.

(The witness withdrew.)

Mr KEVIN MORTON, President, Police Association of New South Wales, sworn and examined

Mr TONY BEAR, Manager, Strategy and Relationships, Police Association of New South Wales, sworn and examined

KEVIN MORTON: I am also a serving sergeant of police, with 35 years' experience.

The CHAIR: Would you like to start by making a short opening statement?

KEVIN MORTON: I would like to thank you for the opportunity to address the parliamentary inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales. I've stated many times that the police are the 24/7 problem solvers for the communities of New South Wales. When someone calls, we don't have the luxury of hanging up, but there comes a time when the reliance on police to fix the downfalls of other government agencies becomes untenable. Responding to mental health incidents is one of those areas. Police are not mental health clinicians. More often than not, the mere sight of a police officer's uniform will only exacerbate a person dealing with a mental health issue. The use of police officers to prop up a failing mental health system not only affects those involved in the incidents but affects the broader community, as we see more and more police officers consistently taken away from their core duties of protecting their communities.

The CHAIR: Thanks very much for being here today. The voice of police officers and their representatives is really important for the kinds of questions that we've been asking. I've got a few of my own questions. The first one is that I'm aware that some New South Wales police officers have been sent across to the UK to have a look perhaps an alternate model of responding to mental health incidents. Is it something that you're aware of or would be able to speak to?

KEVIN MORTON: Yes, absolutely. I'm not aware of whether those police officers have returned in relation to it, but they've been sent over there to review what the UK has in place, and what has also been in place in Scotland for some period of time, called the Right Care, Right Person model. It was a decision made by the Premier about a month and a half ago to see how police involved themselves in mental health issues in the UK. In essence, it says that it is not our job to be attending these mental health incidents, and that's the model that the UK police are looking at implementing.

The CHAIR: My second question has come up in evidence from a number of other bodies and individuals: the question of what training police actually have with regard to mental health. What is the current training that is provided?

KEVIN MORTON: That is more an operational question. You would have to ask the commissioner in regards to that. We did have a mental health training program that police did. It also involved the PACER program as well, but I'm led to believe that that has now ceased.

The Hon. WES FANG: It's a nice segue from your previous comments—I want to ask you about the PACER program. We've heard much about how PACER was initially rolled out by the previous Government. I was interested in your thoughts about how you felt that supported your frontline members and how you feel about the program not receiving an increase in funding in the recent budget.

TONY BEAR: The PACER program is a good initiative. It adds to policing and it helps our members on the front line. Our point is that even given that funding, which was good and changed the way the police were able to go to a situation and defuse and otherwise avert those types of incidents, we have now come to the point where with community sentiment and the way the amount of work police officers have day to day, our call is now that it is time for Health and others to take the ball up and run with mental health, and police should, at the very least, be the last of the last of the last resorts to mental health incidents.

KEVIN MORTON: Fundamentally, PACER still requires a police involvement in that initial care. The program, as Tony said, did have some positives to it, but we're a 24/7 organisation and you may only have that person with you for eight hours a day.

The Hon. WES FANG: I guess it's a question, though, of whether that eight hours of the day made a difference if you were across situations where you were asked to attend for any number of reasons—and, you're right, police are the 24/7 problem solvers in our community, along with many of the other frontline workers who we have—and whether it played a beneficial role. Do you have any firsthand accounts from people within your organisation that might be able to either support or give us an idea of how it made a difference? And what do you think the difference would be if we didn't have that program but looked more towards removing police from that mental health first response? I think that the community very much values the fact that the police attend all those difficult situations because of the value that you provide to the community and surrounding the incident.

TONY BEAR: As we stated, PACER made some good inroads into helping frontline police understand. I think there were four trial points to PACER and, during those times, it was beneficial. But, again, the work that needs to be done on a long-term basis and which we currently see happening within the metropolitan policing in the UK where, although health didn't want to take over to begin with, they are showing strong gains in the way that incidents are being dealt with—although beneficial, and if police were to continue to have to do it it would be a tool that we'd talk to government about, moving forward, our call, at this point in time, is to move forward with a model that has little to no police involvement in it.

The Hon. WES FANG: I am just trying to rationalise, in my thoughts, the proposal that you are putting forward, which is, effectively, not including police in that response. But I think the community themselves often feel as though there is value in having police there. It's reconciling the two. Given that there was no increase in PACER funding in this recent budget from Labor, what do you see as the alternative when the community itself is seeking to have law enforcement available, if for nothing else than to protect the other frontline workers who are there and the community, who are rightfully concerned, but also to protect the person themselves who is at risk?

KEVIN MORTON: If I may add, I disagree with you in regard to your comments in regard to the community. We will always respond to those incidents if the mental health crisis team believes that we need to attend or if ambulance officers require us to attend. That is our role—to protect them whilst they deal with this matter.

The Hon. WES FANG: You might have misinterpreted that then, sorry.

TONY BEAR: When there's a violent incident, police will be called. I think that sometimes in this place we see police used as a bit of a punching bag for incidents that will never stop being police incidents, and I think that's where you're going with it. They will never stop. If people call 000 and there is a person who is in a public area being violent, then police will need to be the primary agency. What we are saying is that on occasion—and on a lot of occasions—the primary agency should be Health and that sometimes when police are called the mere fact that police are present can escalate the situation.

The Hon. WES FANG: Yes.

TONY BEAR: On that point, it's the two Houses here and government that set the legislation for what police do. Never should the frontline worker, whether they be Health, whether they be corrections or whether they be police officers, be held responsible for merely enforcing the laws of the day.

The CHAIR: Can I just ask a brief follow-up and then I will go to the Government. I was interested in your perspective on the South Australian Mental Health Co-Responder program, which, if you're not aware, is a collaboration between Central Adelaide Local Health Network and the SA Ambulance Service where mental health emergency calls go primarily to a mental health clinician who responds in person with a paramedic. Of course, those clinicians have the opportunity to ask for police to co-attend if they think it's necessary because of an individual risk assessment of that person, with the knowledge of their mental health medical records. Do you think that sort of model would be more agreeable for New South Wales police to work in, compared to what we've got at the moment?

TONY BEAR: Given the opportunity, especially with escorting those with mental health issues, schedules and so forth, they shouldn't be put in police vans. They shouldn't be put in police cars. They should be transported to their hospitals and so forth in a respected way. Police vans aren't for those with mental health. But, unfortunately, in New South Wales other agencies for a long time have cost shifted and have moved towards the 24-hour, seven-days-a-week worker, which is who has the resources and—I am not here to put any—

KEVIN MORTON: Cast aspersions.

TONY BEAR: —on other frontline agencies, such as the old Department of Community Services or Health or whatever. But across this State, which is so wide—you are talking about places like South Australia and others that are so much smaller than this State. And even England—I mean, how many times does it fit into New South Wales? But in country areas—this isn't just a problem with mental health in the city. It's everywhere. Unlike a lot of other crime that we deal with—this is not crime. It's socio-economic in basis, a lot of crime, whereas, for domestic violence and mental health, there are no boundaries. There is no way of saying that because you live in this area or that area—it's going to not be effective. Mental health transportation, in particular, is exactly the right way of going, where you would have Health and those that are on mental health—

KEVIN MORTON: Crisis teams.

TONY BEAR: —crisis teams and Ambulance. But, unfortunately, we've had those MOUs in New South Wales and, simply because Ambulance aren't resourced or Health aren't resourced or whatever—and this isn't the

last 12 years. It's not current. This is 40, 50 years of underfunding across all sides of government, where they need to be effectively resourced. Health needs to be effectively resourced. Ambulance needs to be effectively resourced. We are not pushing back on these things to try to cost shift back to anybody else. But, if you're going to make recommendations out of a committee, they've got to be recommendations that are able to be put into place with the right funding. Otherwise we're going to sit back here in five, 10 or 15 years' time talking about the same problems. Because we all know what the answer is. The answer is for the right people with the right training and the right time, with the amount of resources that are needed to do the job.

The Hon. SUSAN CARTER: How much information do police have when they go out on a call? How often do they know ahead of time that there's a mental health issue that they're dealing with as opposed to somebody exhibiting troubling behaviour?

KEVIN MORTON: I was going to say the South Australian model is good. Tony has explained reasons why it would be difficult to have that in New South Wales. But the initial information from treating practitioners would be essential. What we have, basically, is any interaction that we've previously had with that individual that may or may not have been recorded by the police that dealt with that person, or the information that comes in from that person that has called the police on behalf. That is it, in a nutshell.

TONY BEAR: We are not privy to health records or anything like that. To be honest, neither should we, I'd imagine, for privacy concerns. I know that we wouldn't want our members to have their privacy going across government. So apart from the initial information and what family share with the 000 operator, that's it.

The Hon. SUSAN CARTER: So if you get a call about a 60-year-old man, naked, walking past a school playground, no name—you just don't know anything.

TONY BEAR: Look, police officers are fairly cluey. We've been around for a long time. We know when we are going to a mental health issue. The trouble is that you can know you're going to a mental health issue but we don't see mental health when a person is carrying a weapon, who is next to five other people or needs to be kept within an area. That then becomes another ball game altogether. That's the problem that, when it gets to that point, when police must act on the training that they're provided, and so be it. And I think the public expect that to be preserved: life and property. That's our oath of office.

The Hon. EMILY SUVAAL: I will just continue along with that line of questioning in terms of that oath that you've taken. With the PACER model, which we have heard about, I am just keen to understand how that attendance varies if and when it is the case that someone has a weapon.

TONY BEAR: The PACER—they're not involved in those.

The Hon. EMILY SUVAAL: So if someone's in a mental health crisis but they've got a weapon—say a knife or something—and that's how the emergency is called in, automatically the health clinician is struck out. Is that correct? They won't respond?

TONY BEAR: They don't have the training to be in that front part of the line. They may well be at the incident but until it's de-escalated to a point where they can safely be involved, then, yes, they could be involved. But, as you would realise, once it gets to that height part, the de-escalation part of that is rare.

The Hon. EMILY SUVAAL: Is there training around de-escalation? Does that cover processes to de-escalate someone when they're in distress?

TONY BEAR: On several accounts.

KEVIN MORTON: Yes.

TONY BEAR: We have mental health training, and we had other programs called the MHIT program that was discontinued. But we have other core training. Most importantly, we do have what we call the circle of—

KEVIN MORTON: Use of force.

TONY BEAR: Use of force. So the number one use of force is your mouth, and then you have a circle—and what we have, it's a circle because you go forwards and backwards on it. It's not one size fits all. You may take a taser out, put it back in, continue to talk, assess. One may need to have a firearm out. One may need to have a baton out. But it's never once you've pulled something out that you've got to use it. It's always using your communication to get the best results for everybody in that circle.

KEVIN MORTON: Without a doubt the use of communication skills for any police officer is their most important weapon that they have. Unfortunately, when we get to mental health incidents, the mere fact that we are there in uniform with a person that is seriously and critically having a mental health episode, again, like

I said before, it just exacerbates the situation and no amount of communication skills, even for the best of officers, may not be able to de-escalate that—may not.

The Hon. EMILY SUVAAL: Just on that, you talked earlier about this UK model. I'm keen to understand from your perspective what are the alternatives to PACER? What would be, in an ideal world where there's infinite funding and no demarcation issues about who does what—

KEVIN MORTON: It starts at the very beginning, obviously, with the patient being able to get sufficient care, being able to call up and get that opportunity to speak to their treating practitioner. We have incidences, and I will give you a very simple example, where we've decided as a collective to put these people back into society because quite often that is where they need to be to get that care. Unfortunately sometimes they have to have medication and they will be put under a community treatment order. That requires them to attend the local pharmacy and pick up their medication for the week. Should that person not attend, the chemist makes a call to the doctor and says, "Kevin Morton hasn't turned up to pick up his meds." The doctor calls the police. That is not a police matter, but we are getting involved in that low a level of interaction with mental health patients. That's what we're saying: That is not our job.

The Hon. EMILY SUVAAL: So police will be called if someone has breached a CTO?

KEVIN MORTON: Police will be called, saying, "Kevin Morton hasn't attended to pick up his medication. Can you go around and do a welfare check on him and make sure he's okay?"

The Hon. EMILY SUVAAL: Who should be called in that instance, from your perspective?

KEVIN MORTON: In a perfect world, as you suggested, it should be the doctor's decision as to whether they should activate either themselves, a mental health crisis team or some other resource other than a police officer.

TONY BEAR: It's a health matter if someone is not taking their pills. It's a health matter. At this stage, there is no evidence on the call that they're violent or threatening violence to themselves or anybody else. These are the kind of things that can quickly escalate. When someone knocks on the front door, someone hasn't taken their medication, they see police and suddenly they see something else. It's not a police officer; it's someone else going to take them away, and that escalates the problem.

The Hon. EMILY SUVAAL: You mentioned that police have had MOUs previously in New South Wales regarding mental health response. I'm keen to understand how they worked and, if they didn't, what has happened there.

TONY BEAR: Especially in the bush, where not enough hospitals were designated to be mental health drop-off spots or designated hospitals, it could take up to two hours, three hours for them to be transported—one part-time ambulance in that country town—so it reverts to police. The biggest problem is, in schedules that they have, a doctor will automatically just tick the police to go and do it because it's easier and quicker. But they have to say that the person is likely—or he has a fear that the person is going to be violent. These are ticked because Chatswood police might have seven cars working that day and the ambulance are sitting out the front of North Shore hospital and they want them either brought to a privately-funded or other institution. It's just easier to tick the schedule, tick police, fax it through to the police station and the police are off. It would not be fax these days.

KEVIN MORTON: They don't fax anymore.

TONY BEAR: Sorry, it has been 12 years since I was a police officer. But these are the kinds of things that you're talking about. I was talking earlier on about the way that it can be manipulated so that the police are used as the primary agency, where it should be a lot harder and there should be a lot greater threshold because, quite frankly, our members are burning out. Our members are upset and traumatised by putting people into police cars or having to be physical with people. We don't want it, and nor do we want the fallout when things ultimately go pear-shaped.

The Hon. EMILY SUVAAL: Kevin, did you have anything to add to that one?

KEVIN MORTON: No.

The Hon. EMILY SUVAAL: I am keen to understand as well about this issue because I had a question about the scheduling and what occurs there. So is it the case at the moment that when someone's scheduled, it may just be police that attend and pick them up and take them?

TONY BEAR: I think 90 per cent of the time.

KEVIN MORTON: Yes, I would suggest that it's 90 per cent of the time.

The Hon. EMILY SUVAAL: And are there statistics around that?

KEVIN MORTON: Under the schedule, the threshold is a lot lower than what the ambulance have in regards to taking that person for a mental health assessment.

TONY BEAR: The crisis team should be attending those in the first instance every time.

The Hon. EMILY SUVAAL: The crisis team—if one exists.

TONY BEAR: Yes.

The Hon. EMILY SUVAAL: Are there crisis teams that your police work with or have a relationship with?

KEVIN MORTON: I couldn't accurately answer that question now because, again, there is such a reliance on police to do this. I think there are a lot of small organisations out there—independently funded—that do a fantastic job. I have a cousin who works in one up at Port Macquarie. Again, it comes down to funding of what her and her team try to do in this mental health space. But, ultimately, it becomes a reliance on the police.

TONY BEAR: Especially for schedule. I think mental health and the people working in mental health do an outstanding job with what resources they have, to be honest. It's hard. I go back—and I'm sure the Committee has gone back in time—and when I was working at Balmain in the early nineties, we had Rozelle hospital with six or seven lock-up wards and we had the hospital at Ryde. There were plenty of hospitals for mental health. Then the Richmond report was done and halfway houses and in-community care—I'm not saying it was right, wrong or indifferent, but funding over that period of time has gone from here and it's down here, and there are more people; there is more population. That's one part.

I will say this straight out: Mental health is an epidemic problem. Now, whether it's been brought on by any number of different things—stress, whatever it is, drugs, or whatever it is—it's a problem and it's got to be dealt with. But you're asking the wrong people to deal with it because it's simply easy to do. It's simply easy to pass it down to police, who are 24/7, who are there to pick up kids who need to be picked out of places for the department of community services, for the transporting of prisoners when there are no Corrective Services, and for scheduling or to go to mental health incidents. Quite frankly, our members are stretched, our members are stressed and they need other agencies to be funded to do what is not their job.

The Hon. WES FANG: I just wanted to find out what representations you've made to the Minister—and not just the police Minister, but obviously there'd be representations to Ryan Park, the health Minister, and to Rose Jackson, the mental health Minister—about your concerns in relation to your members and what the Government has said to you about how they're viewing the concerns that you're raising.

KEVIN MORTON: This, for our membership, has come to a head, and we made quite an issue of it several weeks ago. It was the first time—and I applaud the Premier for this—that I ever saw anyone act so swiftly in finding out what happens overseas, in sending two senior police officers overseas to see if we can do it better. Again, like I said, I applaud him for those actions because I have never, in my 35 years, seen a government act that swiftly. Now, I'm very keen to see what those police officers bring back. But I'm sure, as we move into the future—I believe that this Government is definitely listening to ours and my members' concerns.

TONY BEAR: Listening is one thing. What we will do is see what the outcomes are and, as I said, my previous evidence is are we going to be here in three years, five years, 10 years' time asking the same things?

The Hon. EMILY SUVAAL: Hopefully not.

The Hon. WES FANG: I'm just curious. Obviously it's one thing for the Premier to be listening, but the Ministers involved—and in this area you've got three Ministers: You've got Minister Catley, you've got Minister Park and you've got Minister Jackson. All three of them need to be on the same page for your concerns to be actioned. Have you had the opportunity to meet with those Ministers? Have you had the opportunity to get commitments from them around how they are viewing your concerns—other than just another review, which is what this Government seems to be very good at doing?

TONY BEAR: I understand where you're going down the path of, and I think this kind of question would probably be best if this was another 12 months down the track.

The Hon. WES FANG: I am sure we will have the opportunity to do so. In fact, I probably might ask them tomorrow.

TONY BEAR: I am sure if we're sitting here in 12 months' time, my answer will probably be slightly different, but let's give them the time to see how those actions take place.

The Hon. GREG DONNELLY: It was very interesting to hear that example about the CTO and how the police are injected into the whole process, so to speak, at such a base level, which got me thinking. Forgive me for what is probably going to obviously be my ignorance, but through the 000 contact to the police, that would be a basis upon which police would find themselves often—sorry, that would be a not-unusual means through which police find themselves turning up to a situation where there is a mental health dimension to it. Is that a fair statement?

TONY BEAR: Yes.

The Hon. GREG DONNELLY: Through the 000?

TONY BEAR: Yes.

The Hon. GREG DONNELLY: If I could just set that aside for the moment and look at the example that you gave, very helpfully, of the CTO—and I think there were another one or two examples that you have given—which is not necessarily through the 000 but where there's a default of involving the NSW Police Force for CTO scheduling and what have you. Has the Police Association—perhaps this is a question on notice that I'll put—been able to line up all of these activities, if I could describe it that way, which form, as a total, work in the area where there might be mental health dimensions to it to help scope out all of these areas? It would be true to say that if you aggregate the 000 involvement of the police and all these others, that really becomes the universe of the issue, is it not, for the NSW Police Force? Is that right?

TONY BEAR: Yes, the Productivity Commission themselves reported that 10 per cent of police time is spent responding to mental health.

The Hon. GREG DONNELLY: That is 10 per cent, right?

TONY BEAR: Yes, 10 per cent. But that, I believe, would be under. I believe that that's recorded incidents. I wouldn't be surprised if it was double that.

The Hon. GREG DONNELLY: That is a good reference. I will have a look at that. That is helpful. The other thing I was going to ask goes back to the 000 call. Once again, I am showing my ignorance. The phone call comes through to 000, to the police. The person answering the 000 call for the police, do they have any expertise? Perhaps the better way of putting it is: What is their level of expertise of engaging with the person who is putting the call through to establish whether this is a mental health issue or not, potentially? Is there protocol to, if in doubt, default that it potentially might be and involve the police?

KEVIN MORTON: Quite often the response that is recorded by the VKG operator to be transported to the police officer is reliant on who calls. Now, if it's a member of the public, if it's a neighbour, then obviously the information that you are going to get is going to be limited in regards as to whether it's a mental health incident. If a person is in the house yelling and screaming, that is all that person has. If it's a friend or relative who has intimate knowledge of this person—I can see where you're going, kind of, in that a VKG operator may, in the future, have the option to say, "Have you contacted the doctor? Have you contacted the mental health crisis team?" But police are caring people. At the moment, we go to everything. It would come across as a concern for welfare. Irregardless of what the content of the information is, we would attend.

TONY BEAR: Can I say outwardly, and it might be controversial, but police officers and police organisations are so risk averse about now being criticised by the Coroner or by a range of different people—the LECC, and others—that failure to respond directly to an incident would see criticism in some shape, manner or form. Until guidelines in black and white are put in place, people have lost the urge to try and say, "Hang on, this isn't right. I will just do what the policies and the procedures do."

These organisations that are there to look over—and they've got their job to do; we are not here criticising the LECC or the Coroner or others. But you've got to understand that a by-product of so many recommendations about so many things—people, human beings, will then revert back to, "That's what the steps say, and that's what I have to do," because if I go one divergence from it, if I use initiative and say, "Hang on, this isn't a police matter. Why don't I ring the local health team," or whatever, if that is not on there, then they won't do it. I understand where you're coming from, but 000, and especially in the bush, there's no-one else to ring anyway. We try, and we're trying our best, but at least we try. So many others, especially after 5.00 p.m. and before 7.00 or 8.00, there's no-one else trying. There is no-one else trying.

The Hon. GREG DONNELLY: My line of questioning was actually to get to that. That is why the UK model review will be interesting, because there will need to be some certainty around the parameters of it going one way or the other, which is in a sense a triaging exercise, isn't it—a decision point to be made about whether a mental health team, so to speak, is sent in to deal with a matter versus the police, or both. To make that work and work effectively, particularly in a State as large as New South Wales, with its resources, and in some instances

very limited resources on the ground in isolated and remote areas—it is going to be a challenge. I understand that UK model will be obviously quite instructive. My only other question was—and we are going to hear about that, obviously, because there have been some senior representatives from the police force sent over—are there any other jurisdictions in the world beyond the UK that you've become aware of that might be worth having a look at? I am not suggesting that we've got the power to—

KEVIN MORTON: The UK model actually started some two years prior in Scotland. But in regard to any other models of a suitable—let me make this quite clear: The UK model is quite controversial. I will read to you. It says, "To the end it is to govern the inappropriate and unavoidable involvement of police in responding to incidents involving mental health needs." That is their mantra. They have a tiered process to determine what response police will have.

The Hon. GREG DONNELLY: That's what I was getting at.

TONY BEAR: Can I say, we live in a great country. No matter what resources we have, and no matter who does it, this country is so far ahead, because in so many others they believe that if you have got a weapon—it doesn't matter whether you are 10 years of age or 90, suffer from a mental illness or otherwise—you are breaking the law and the consequences are the consequences. They don't care. I feel proud to be in front of this Committee here today and talking about how, in this country, we can better serve your constituents and our members and the people of New South Wales, because in Australia that is what we do. We look for ways forward.

The Hon. GREG DONNELLY: Thank you very much.

The CHAIR: We are out of time for this session. Thank you both so much for the time you have taken to provide evidence today. The secretariat will be in contact with you if there are questions on notice.

TONY BEAR: Thank you.

KEVIN MORTON: Thank you very much for the opportunity.

The Hon. GREG DONNELLY: Pass on our thanks to the members, who do wonderful work.

(The witnesses withdrew.)

Magistrate CAROLYN HUNTSMAN, President, Mental Health Review Tribunal, affirmed and examined

The CHAIR: I welcome our next witness. Thank you for making the time to give evidence today.

CAROLYN HUNTSMAN: Good afternoon. I am Magistrate Carolyn Huntsman, but I am here as the President of the Mental Health Review Tribunal. I am on leave from the Local Court, so I am not speaking for the Local Court; I am speaking for the tribunal.

The CHAIR: Would you like to make a short opening statement?

CAROLYN HUNTSMAN: I will make it quite short. You have got my written submission, so I am just going to highlight a few points from that. The first thing is to underscore that the tribunal is not a service provider, so I cannot speak for that perspective. I respect that you will hear from people much more qualified to answer questions about service provision and resourcing, so I don't presume to be able to answer questions in that space. Why we did a submission, I think, was because community treatment orders are a huge part of the tribunal's case load. Given that legal role, we thought it might be helpful to provide a bit of background about how CTOs work. That is why there's quite a lot of legal material in my submission, because that is where we come from; we are a legal decision-making tribunal.

We are an independent specialist tribunal under the Mental Health Act, and we have a civil division and a forensic division. The forensic division deals with people who have an intersection with the criminal justice system and the criminal courts, either because there's a verdict of "act proven not criminally responsible" or because they are found unfit to plead, and there is a whole complicated court process which sees them become forensic patients. We do make community treatment orders for forensic patients in the forensic division. They have two purposes. One is to provide treatment within the custodial facility under that order and under that treatment plan, and the other is that they are often applied for when someone is about to transition to community—either on parole, they are finishing their sentence, or maybe bail is possible. There is a very important transition role and it can be very helpful to have a forensic community treatment order in place when people leave custodial facilities.

They're the two divisions, and the civil division—that is all the people who are not involved with criminal court orders. That will see a lot of involuntary patients who are detained in mental health facilities for assessment and/or treatment under involuntary patient orders. They will be discharged by the hospital, sometimes by the tribunal at a hearing, and sometimes they're discharged on a community treatment order from an inpatient admission. Community treatment orders are also made from the community by community mental health teams. Sometimes they're for people on existing orders; a further order is applied for. Sometimes it's a new application for someone that perhaps is looking at a need for more intensive interaction and the backing of a legal order.

It's important that the tribunal acknowledge, in making this submission, that we engage with consumers who are presented for treatment orders. That's only one percentage of what your Committee will be looking at, because there are, of course, a number of people engaged in treatment in the community who don't have the backdrop of a legal order. We see a subset, and perhaps people with more acute or more chronic mental health conditions are often the people that come before the tribunal.

What we do know and what we have seen over time is that there seems to be a real move to collaboration with consumers by community teams—to trying to have a recovery-oriented approach. We have seen a cultural shift over time, which is a really positive thing. We've seen some amazing work by community teams in engaging with people who are quite unwell and trying to support them holistically for their treatment. One thing that cannot be underestimated is the importance of community engagement, community support and stable housing. Social isolation is counterproductive, so what we see is that people who are well engaged with either work, study, family or hobbies and interests—pets too—who have those sorts of engagements and responsibilities are better able to manage their mental health and to engage with the supports available.

There is the nexus with substance use. It's marked, in my experience. Not all mentally ill people, of course, have a substance use problem, but when both are present it makes treatment more difficult. I've been asking—I came to this role about almost exactly 12 months ago, so I'm at the end of my first year. In my first year I did go and visit a lot of facilities and, particularly, I was interested to go out to regional New South Wales. When I was out in Orange for some of the forensic hearings at Bloomfield Hospital, I made a point of going out to Dubbo and meeting people there and seeing what the facilities there were like. This was mostly the inpatient facilities, but they gave me a bit of an overview of some of their challenges in terms of the very wide geographical region that they cover. I've just gone on much longer than I meant to—my apologies. I'm here for you to question. What I would say, just in closing, is that social supports, housing supports, drug and alcohol rehabilitation, and

individualised recovery planning between community care providers and those with a mental health condition are all major, important matters.

The CHAIR: Thank you very much for your statement, as well as the written submission you've provided. It is really valuable evidence. I have a question about your recommendation for further research. To be honest, it's quite distressing that there really isn't the broad evidence base from large studies to support or inform the use of community treatment orders, and I'm interested to know if the Mental Health Review Tribunal is actually involved in any such research. Have there ever been requests for de-identified data, for example, or are you aware of any work happening?

CAROLYN HUNTSMAN: There has been work done in the forensic space, and the researchers came in and went through our physical files. We had to have a lot of protocols around that because there's a lot of confidential information and restrictions in the legislation against publication and identification of names and such matters, so there was quite a lot of work put into that. Some very good research came out of that. That was in the forensic space.

The difficulty is that the tribunal has a very ancient database. One of my priorities since being appointed is to try to obtain funding to upgrade the database. It's facing critical failure. It's antiquated and cumbersome and cannot really be used helpfully. If we get our new database, one of the ways we will want to design it is so that there can be statistics obtained for researchers to better inform everybody. We have a huge repository of potential statistical evidence, but we can't even access it, and the researchers who came had to go to the physical files. We're not digitalised, and there's a significant modernisation need that I've identified with my registrar; she's identified it too. She's very able in this space, and both of us are well ahead in looking at what will work, what interstate tribunals have used and what is available. Once we have that, we would be very keen to have researchers visit us and to be able to assist them in that regard.

I do know the Mental Health Commission is doing something on community treatment orders at the moment, and one of the tribunal senior team members of the civil team is participating in a group associated with that. I'll be very interested to see what they come up with. But, to answer your question, there's not a lot of qualitative or quantitative research in the area. What we do know is only from our experience as a tribunal. Community treatment orders can be very effective in keeping people well. At the same time, one would hope that there would be a transition to voluntary engagement rather than legal orders. Clinicians will tell you why they think some people need legal orders as a backdrop. The problems are the treatment plans are mandated in the orders. If they're individualised and worked with cooperatively with the consumer, that makes the whole thing more easy and acceptable. But where the consumers feel a lack of choice, I think it can be a very difficult experience to be on a legal order.

The CHAIR: From your 2022 annual report, there was an 18 per cent increase in the number of individuals being considered for community treatment orders and, I understand, a smaller increase but an increase nonetheless in orders being granted. Given your answer about the dearth of research—I understand that I'm probably asking for your opinion—do you have any understanding of what's happening or why we're seeing that increase?

CAROLYN HUNTSMAN: One reason could be—and I don't know—shorter hospital stays. When someone is going to be discharged perhaps a bit early, you might place a community treatment order as the least restrictive care option on discharging someone. A lot of people get discharged from early in the admission at a mental health inquiry, and the tribunal might make a community treatment order that the hospital asks us to make on discharge. I don't know the correlation between length of hospital stay and community treatment orders. I don't know the correlation between difficult substance abuse and relapsing mental health conditions, and whether that is seeing an increase in community treatment orders. I really don't know. The people that are presented by the community teams seem to be not any changed to previous years, so I really can't comment, I'm sorry.

The Hon. EMILY SUVAAL: Thank you, Magistrate Huntsman, for appearing today. It has been very useful so far. You mentioned the need to digitise the database for the tribunal and you're aware this is what other States are doing. I wondered if you could talk us through what some other States are doing and how we in New South Wales could perhaps do things better?

CAROLYN HUNTSMAN: Probably the most instructive experience I had was with Queensland because they've basically modernised their tribunal in five years. I've seen it five years after they started. They have very efficient AVL and in-person hearings. They have good AVL technology and good hearing rooms at their head office. They have modular member training, which is part of the website and data on their website and in their tribunal. Members can access a great range of information and there's very active professional development via these monthly modular webinars. They have digital orders. Except for the typed orders that we do in the forensic division, in the civil division our orders are handwritten on a typed form. It's much more efficient

and saves a lot of time to be able to have all of these processes—we haven't even digitalised the paper files. We need a project to do that.

The current registrar arrived and COVID started. She is keen to get all of this done, and the first thing she had to do was put in place a lot of extra equipment so that we could do remote hearings during COVID. It was lucky she has such a good technology background that she was able to nimbly move. I'm very guided by her in terms of the digital questions, and what she has told me is she needs to digitalise the records and she needs to be able to create efficient orders and systems by having really good websites. There are court data case management systems that are provided by different IT providers and there are tribunal ones. NCAT has a certain system here in New South Wales. South Australia has a very good system for its tribunals, which is a different case management system. And Queensland has another one again.

But it just needs to be fit for purpose, and you can just so increase your efficiency. But also for the healthcare agencies and the hospitals to be able to upload their documents really simply onto our website, like a really efficient document portal, as well as access our orders really easily, that would save them so much time.

The Hon. EMILY SUVAAL: It would save healthcare workers in the hospital time?

CAROLYN HUNTSMAN: Yes.

The Hon. EMILY SUVAAL: You've gone to the next question about benefits.

CAROLYN HUNTSMAN: There's a tribunal clerk in most major hospital facilities who sends through the list of patients. Every hearing list changes because the patients change. We go to facilities in person because that I think is better whenever we can, but we also do some AVL hearings because in some country regions there is not enough work in the day. They might have a couple of patients in some of the smaller units in the regions. We do a mix of both AVL and in-person, but the tribunal clerk has to send through all the medical reports and evidence to us usually by email. It used to be by fax. In Queensland and other places, it's all much easier for the health facilities. You'd save time and money in the health facilities, you'd save time and money in the tribunal, and you would arguably have a higher quality.

The Hon. EMILY SUVAAL: Yes, and the benefits would be to consumers.

CAROLYN HUNTSMAN: Yes.

The Hon. EMILY SUVAAL: A very different question now if I may. In the submission it talks about the CTT program, which I know we've referred to already. I just wanted to understand, four weeks post-release doesn't seem like a lot to me but that's my rudimentary mind. I note your submission also talks about the model of care and how that could be afforded to perhaps civil patients to achieve similar outcomes. What would that look like? Does the role of HASI and CLS, which I note you've already have referred to—does HASI have a role to play in that regard for these civil patients would you say?

CAROLYN HUNTSMAN: HASI has a role to play for people that need wraparound supports of housing, case management and some home-care visit type assistance. They often work in with NDIS and there will be a service which might assist with shopping and cooking. So it's a very particular high-level support model and there are different levels of it, depending on the NDIS package and depending on the needs of the consumer and the kind of housing. There are many consumers that live with family. There are many that work and are independent, and they don't need that level of support. To get back to the CTT question, I'm happy to take some of that on notice and get back to you, but what I know about that transition is that it is intended that the community team take over from the transition team, so they will be on a forensic CTO.

That transition team will help line up where they're going to be in the community, who is going to be the community healthcare agency. When they leave custody, a variation application will come to the tribunal and we will have the new treatment plan for the community team and we will vary the order so that it's no longer Justice Health implementing the CTO but the community team is. I think it's envisaged that the role stops and the community team steps in. In terms of your question about leaving hospital care for civil patients, again, it would be a gradient. Someone who has had a very long and complex admission—and there are some lengthy admissions—might have lost a lot of their community engagement. That population would probably go to HASI or seek community living.

That group could do with a transition team perhaps, but I think that's what inpatient facilities think they already have as well and I'd be respectful of that. They're multidisciplinary, inpatient facilities. There is a social worker. There's a discharge planning team. But some are less resourced than others, of course, and I know that in some facilities sometimes they're down a social worker or two and they're trying to recruit. In those circumstances, it would be hard to have the depth of discharge planning. I guess my answer is saying it's, again, specific on need

and individual planning, but I could see a role for it because it's working so well in the custodial space and it's relatively new.

The Hon. WES FANG: Thank you very much for appearing today. Just noting your earlier answers and comments, I'm just curious to know whether there might have been any money in the recently announced budget to improve the IT and back-end services of the tribunal and if there have been any representations made to the Attorney General or the Minister for Mental Health, who I imagine would probably have oversight for those budgetary outlays and how responsive they've been in order to provide you the increased budget that you clearly need in order to modernise the system.

CAROLYN HUNTSMAN: I've met with the Minister for Mental Health. I've met with the Attorney General. They listened and were very supportive of the need to address this. I have met with the mental health branch who we sit under. Even though we're an independent tribunal, we do sit within the mental health branch of the Department of Health.

The Hon. WES FANG: And that would be Minister Park. Is that correct?

CAROLYN HUNTSMAN: Yes, and also the Minister for Mental Health as well.

The Hon. WES FANG: Yes.

CAROLYN HUNTSMAN: The mental health branch were supportive. They have funded a project officer so that we can get ready for procurement.

The Hon. WES FANG: So is that effectively essentially another review? A review of the systems—

CAROLYN HUNTSMAN: No, I think it's to help us get to procurement.

The Hon. WES FANG: Okay, and the money's in the budget for the procurement of the system? Or is it—

CAROLYN HUNTSMAN: Not at this point.

The Hon. SUSAN CARTER: I just have one last question. I'm interested in your comments at paragraph 11 in your submission where you're talking about that population—and you've touched on this before—with drug and alcohol problems and mental health problems. In terms of treatment and support for people with dual diagnoses, are there separate pathways that are needed? Is there a complementary pathway that's available? What are some of the challenges dealing with people with mental health and AOD issues?

CAROLYN HUNTSMAN: My understanding—because I'm not a clinician—is that substance use can lessen the impact of prescribed medication so it can play a role in return of symptoms and relapse. That's one issue. It depends on whether they need residential rehab and long-term treatment. I know for methamphetamine it can be very difficult. If you've got an entrenched, long-standing substance use issue, it can be quite difficult to become abstinent so there probably is a need for residential rehabilitation which addresses both mental health and substance use in the one facility—so it does both treatments and is not separate. I don't think there's a great deal in that space.

I know that it's very difficult to get into residential rehabilitation anyway and when you're perhaps more difficult to manage—because you're on prescribed medication and you have a mental health condition—maybe you'll find it harder to get a place, I don't know. I would not be surprised, just because there's a lack of places. Then there are people who can be assisted by not needing residential rehab but by drug and alcohol counselling. I can see them being co-located in the community and working together, and I think that already happens. The MERIT program in the Local Court is an example of an intensive program that does actually achieve abstinence without residential rehabilitation. Again, it depends on the person, the severity of the substance use issue and their treatment needs. What I think needs to happen is there to be a variety of available programs. One size doesn't fit all.

The Hon. SUSAN CARTER: I gather from your submission you're concerned that there aren't enough AOD and mental health programs currently available.

CAROLYN HUNTSMAN: Yes. I can't speak completely for the sector but over the years in various positions that I have had, I'm well aware it can be very difficult to get a spot.

The CHAIR: Thank you very much for the time you've taken both to present today and prepare the submission. It's really valuable evidence. We really appreciate it. The secretariat will be in contact if we have questions on notice.

CAROLYN HUNTSMAN: Can I just say it's wonderful that you're doing this inquiry. If you resource the community, that is where the success really is in treatment, so it's very good that you're doing this inquiry. I endorse the efforts that you are putting into it. Thank you for your time.

(The witness withdrew.)

The Committee adjourned at 12:30.