**REPORT ON PROCEEDINGS BEFORE**

# PORTFOLIO COMMITTEE NO. 2 - HEALTH

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

**CORRECTED**

**At Macquarie Room, Parliament House, Sydney, on Friday 17 November 2023**

**The Committee met at 11:00.**

### PRESENT

Dr Amanda Cohn (Chair)

The Hon. Susan Carter (Deputy Chair)
The Hon. Scott Farlow
The Hon. Greg Donnelly
The Hon. Emily Suvaal

### PRESENT VIA VIDEOCONFERENCE

Ms Cate Faehrmann
The Hon. Mark Buttigieg
The Hon. Bronnie Taylor

* Please note:
[inaudible] is used when audio words cannot be deciphered.
[audio malfunction] is used when words are lost due to a technical malfunction.
[disorder] is used when members or witnesses speak over one another.

**The CHAIR:** Welcome to the fourth hearing of the inquiry of Portfolio Committee No. 2 - Health 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 of the hearing. I urge witnesses to be careful about making comments to the media or to others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage Committee members and witnesses to be mindful of these procedures. Welcome and thank you so much for making the time to give evidence today, especially from interstate.

**Mr PAUL LEMMER, ASM**, Executive Director of Operations, South Australia Ambulance Service, before the Committee via videoconference, sworn and examined

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

**PAUL LEMMER:** Certainly. I want to clarify that the evidence I'm here to give today relates to the mental health co-response team that exists within SA Ambulance. I think before I start I just want to confirm that is exactly what it is you're seeking from me.

**The CHAIR:** Yes, absolutely. I'm very interested in the MH CORE program.

**PAUL LEMMER:** Certainly. The MH CORE program in SA Ambulance—or SAAS—is a paramedic working alongside a community mental health clinician, primarily to respond to low- to medium-acuity mental health cases. The model was implemented as a way of trying to provide some alternate care pathways and improving some patient outcomes for a cohort of patients that we knew needed access to health care but not necessarily access to an emergency department. As part of this, we've developed a series of referral pathways for the Mental Health CORE team, which includes, obviously general practitioners, community mental health teams, a mental health triage program, private psychologists and counsellors, support services as well as an urgent mental healthcare centre, which operates in our central business district and is designed as a walk-in or community referral centre.

We have teams based at three local health networks. Adelaide is divided into three metropolitan health networks. We have a team that works within each of those LHNs, responding primarily to patients that exist within their catchment. They generally work an afternoon shift of around 11 or 12 o'clock start for a 12-hour duration, and the teams are [audio malfunction], which is then supported by our radio network, mobile data terminal and obviously the emergency ambulance kits. The key piece is to have a really broad inclusion criteria, which is designed really to meet anyone over the age of 18 who is likely to benefit from community-based care. But when we first started the program we had some exclusions, which included the first presentation of behavioural emergency or mental illness, and obvious or suspected intoxication or drug use.

As the program has evolved and we've become more comfortable with what it is we're delivering, those exclusion criteria have actually sort of been withdrawn and now really the only two exclusion criteria for the team are people who have a suspected medical cause for their deterioration, in which case obviously we want them to go through a different pathway, and those who have an altered GCS as a result of intoxication or drug use. So alcohol or drug use is no longer an exclusion, but obviously if you have an altered GCS and are not able to engage in a community health team, then we won't send this team. I think that's a brief outline of what the team is.

**The CHAIR:** Thank you very much. I'm sure we all have lots of questions for you, trying to understand how this model works and what lessons there are for us here in New South Wales. My first question is about the triage process. I am hoping you could elaborate in more detail exactly what happens when someone rings 000 with a mental health emergency. Who's doing that triage and how does it work?

**PAUL LEMMER:** We sort of expanded and altered the way this is from when we very first put this in. Initially what would happen is it would go through our normal call-taking process. We have an emergency operations centre that handles all the 000 call volume. They would bring these patients in, assess them and then make a decision on a priority. If they determine that they needed a lights and sirens response, it would go through to a normal dispatch model and an ambulance would be sent. If they were triaged as a priority three or lower—which is not a lights and sirens response in South Australia—then we would have a look at that case and make a secondary assessment as to whether or not it was able to be assessed by MH CORE, or a crew may refer to them directly when they're on scene. We found a lot of our early interactions with this team came from crew requests. So they would be with someone in the community, a mental health consumer, a decision that ED was probably not appropriate and seeking access to community mental health teams, and therefore they would tap into this program.

What we have seen as the program's evolved, though, is in 2022—much like many other ambulance services around Australia—as we came through COVID we started to experience back to extreme demand and pressures on our service. As a result of that, we created what we called a demand management cell to try and assist with that demand of patient support. One of the things we identified during that, though, was what we didn't do well was a clinical review of the mental health events that were pending within the community. By nature, because they were being assigned a lower priority—they tended to not be a lights and sirens, so no immediate life-threatening need—what was happening is these patients were waiting an extended period of time for an ambulance and we were identifying that was starting to pose a significant clinical risk for them. What we have done since then—whilst we had a CTA, so a clinical telephone assessment team, which most services around

Australia have in a secondary triage model, which is some way to review those calls, what we didn't have was anyone who had the particular telehealth assessment of mental health.

What we've decided to do to support our MH CORE and deal with a broader cohort of these patients, is we've actually now introduced what we call a PTC, which is a mental health clinician working within our emergency operations centre. What they're doing—and it's a paramedic. What we have done that is different is—historically we've spoken about bringing a mental health clinician from outside of SAAS in, and working in that environment. Whilst that has been quite useful, what we've found is they don't necessarily understand the environment in which we're operating and some of the complexities that come across in a case when you are seeing it from a telephone perspective versus face to face. We were finding we were missing a cohort.

What we've done is recruited paramedics who have experience or training in mental health and brought them into the role and are using them now to undertake this first-line assessment. What we're seeing is particularly the suicide, the threatening suicide type cases, they're engaging quite early, having that conversation and making a decision very early whether they're going to manage via the phone or whether we're going to send our MH CORE team in, and then the MH CORE team are responding to the case and deciding how to manage that. What we have seen is a significant reduction—a reduction of over an hour—in our average response time to that patient cohort now since we've introduced the two.

**The CHAIR:** Mr Lemmer, you may or may not be aware that at the moment across the majority of New South Wales there are police leading the response to mental health emergencies, and it's a common concern in the community that if there is a health-led response to those emergencies it might put workers at risk. I'm interested in understanding what the safety of staff has been like in the MH CORE program and have you got any data around that?

**PAUL LEMMER:** I think one of the things in South Australia is that a very clear decision was made that mental health is a health problem; it's not a police problem. We've been really, really clear as a State in trying to say response to mental health consumers should not be SAPOL led; it should be ambulance led or health led, and police come in and support, if there is a safety risk, but it's not a primary response.

That being said, in the Northern Adelaide Local Health Network in South Australia we do have a team of a mental health clinician and a police officer, very similar to the Victorian PACER model. They only operate in the one local health network and they are primarily dealing with jobs that police are first on scene to—domestic situations and stuff like that where there is subsequently discovered to be a mental health involvement—and are using that clinician in that case.

But from a SAAS perspective, one of the things we do is we do a quarterly review of all of our data. Every quarter we publish a report that has a look at the total cases that we attend. The second quarter's report is out; the third quarter hasn't yet been published, so July to September is not quite out yet. But if I talk April to June, as an example, the MH CORE teams did about 700 events through that quarter. About three-quarters of those cases, they were able to manage within the community, which means we didn't need to transport to a hospital. We didn't need to bring SAPOL in to help us manage those cases; we could manage them quite locally and most of those were managed with community-based care. There was some referral that went to things like our Urgent Mental Health Care Centre, which is not a hospital—it's a consumer-led service with mental health clinicians within it; it's a different sort of model—with a low re-presentation rate.

The bit that is important to us is what we've seen is a very low rate of SAPOL attendance now when we have MH CORE involved. We used to have a very high rate in people with PICT comments within the case. Challenging behaviours that were identified in the call-taking algorithm would lead to a SAPOL response with SAAS, and we still have a number of cases that do that. But what we have found is by having a mental health clinician within the team, they have access to CBIS, which is our mental health records system, and it allows them to make a much more informed risk assessment of the response when we go. What we now have is a much better linked-up, informed response and comfort in dealing with this particular patient cohort. It's resulted in a much lower rate of SAPOL involvement.

I think what's probably the bit that helps for us is—obviously under the Mental Health Act in South Australia we have a section 56, where we're able to take a patient into care and control to take them to get medical treatment. What we've actually seen with this trial is that MH CORE have a really, really low need to utilise that. Often when we utilise that we need to involve SAPOL, because it's about directing a patient to go to receive treatment. It's not a detention order but it is treated in a similar manner, in the sense that obviously the patient has no choice but has to be transported to a place of care. Often it involves SAPOL to take them. What we're seeing is a very low use of that power from this team, and it is able to transport patients in a voluntary manner. It really is about that de-escalation technique that they're able to use when they're on scene, which means we don't have to bring that third-party agency in to help. I can send you the quarterly reports, if you'd like them.

**The CHAIR:** Thank you. I'd really love it if you'd be willing for us to table those reports as evidence for our inquiry.

**PAUL LEMMER:** Yes.

**The CHAIR:** I think that would be of great interest to the Committee. My last question, before I go to other members of the Committee: I wonder if there's been any work done to look at expanding that model into rural and regional areas, or if you have any suggestions about how we might look at a model like this that would work in the regions.

**PAUL LEMMER:** [Audio malfunction]. South Australia, in a practical context, is quite different. We have quite a narrow band of what we call a metropolitan area that's about 90 kilometres but quite narrow and bordered by ocean and hill space. Our population is obviously nowhere near the size of New South Wales. It also means our regional centres are quite small and so our work volume within those regional centres is very low. What we do have in some of the towns—Ceduna, as an example. Forgive me if you don't know the geography of South Australia, but it's 700 kays from Adelaide. It's over towards the Western Australian border, very remote. We have what we call a community paramedic that works within that town. We have a normal paramedic response and then we have a community paramedic.

It's a town that has a very high First Nations population and is often where a lot of First Nations people come from the lands—it's often their first stop from the lands before they make their way into either metropolitan Adelaide or into Port Augusta. We have a regional paramedic that works out there that is not really an MH CORE because they have a much broader—they do a lot of primary health care and engagement with that cohort of the community. [Audio malfunction] mental health teams so they can try and help manage these patients prior to them needing to access the health system. They are very proactive—get out in the community and go and meet with them rather than making the patient come to them. They go to a lot of the local community meeting places and do that. So we haven't really looked at the MH CORE. We don't quite have the work volume to support it in regional SA, but we are trying to look at how we can diversify our response by sort of hybridising components of this role.

**The CHAIR:** I think it's really important—even in a place as remote in Ceduna, it sounds like in the majority of cases you actually are getting a paramedic or a health-trained person to those mental health emergencies.

**PAUL LEMMER:** Yes.

**The Hon. EMILY SUVAAL:** Just to continue on and tie off that line of questioning, in the case of the community paramedic—I'm particularly interested in that model—is it the case that that is one person? If it is one person, what are their rates of overtime like? We have a particular issue in New South Wales where, in our regional areas, we have vast amounts of overtime that are sometimes done by regional paramedics.

**PAUL LEMMER:** The South Australian context is we have a—if I talk just regional South Australia, noting that I would consider myself a metropolitan expert, not a regional expert, regional South Australia is really serviced by both career paramedics and volunteer ambulance officers.

**The Hon. EMILY SUVAAL:** So you have volunteer ambulance officers?

**PAUL LEMMER:** Yes. We have volunteer ambulance officers, recognising, as I said, the way our population is spread. We will have lots of towns that are serviced by volunteer AOs and then in regional centres—the Whyallas, Port Augustas, Mount Gambiers—they will have career-based teams, and Port Lincoln. But in between Whyalla and Port Lincoln, which is a couple of hundred kilometres, there will be Cowell volunteers, Lock volunteers, Elliston volunteers that provide a service and are supported by career teams, if needed, or by aviation assets from Adelaide, but otherwise managed at local—the question around overtime is quite difficult because obviously in a volunteer context, that doesn't apply.

What we do have, though, in a town like Ceduna is a career-based team that provides the primary ambulance service to the team in Ceduna. They deal with the 000 volume, whereas the community paramedic tends to—like I said, it is a much more proactive piece and it's really about that early engagement. It's a non-traditional ambulance role. We don't wait for the 000 call to arrive. There's a place in Ceduna where a lot of First Nations people go for breakfast and go for a conversation. That community paramedic will often go there in the morning, just take free blood pressures, blood glucose monitoring and just start this conversation, start talking to people about how they're feeling and then try and direct them to a community support team, if needed, prior to that emergency eventuating. They are really playing in a proactive primary health rather than a traditional emergency response.

**The Hon. EMILY SUVAAL:** I'm interested to know whether in South Australia you have a single EMR across the State that helps with this CORE model?

**PAUL LEMMER:** I'd love to say yes. We are the only ambulance service that still uses paper. We have a paper-based record. The emergency record for health in South Australia is still being rolled out. Not all sites are on Sunrise; multiple are. A complexity in mental health is they run in a separate system called CBIS. Even though their Sunrise record will exist, which is their electronic medical record, they will have another electronic system called CBIS that, historically, only mental health clinicians have had access to. That has a far more detailed level of detail regarding the patient's previous presentations. What we have done through this program is we've been able to get access to CBIS for our teams who are working in MH CORE and those who are working in PTC and EOC. Only in the last week we have broadened access to CBIS to try and give it to some of our operational team leaders, who are going out and helping manage some of these very complex cases within the community.

**The Hon. EMILY SUVAAL:** So you have access to those mental health patient records?

**PAUL LEMMER:** Yes.

**The Hon. EMILY SUVAAL:** Great. You've covered off the process of triaging, which I was quite interested in, and how there is an allocation to your service. Was there anything else that you wanted to add to that in terms of, when a call comes in, how that's triaged and then how it's referred onto CORE that we should know?

**PAUL LEMMER:** Again, like every ambulance service, we've seen an increase in requests for service or demand on service and managing in an environment where resources are tight and we have the eternal hospital flow issue, which results in transfer of care or ramping times that impact. That means that lower acuity case, which unfortunately is where mental health sits, often sits in a pending case. We've had this focus on looking for alternative pathways. We have some really well-developed alternative pathways for traditional medical presentations. What we haven't had is the mental health alternative referral pathway, which is why they've sat and waited.

What the team has given us is that ability, noting that we currently only have them for a 12-hour shift a day, and we only have one MH CORE team running in each LHN. It can mean that some of these cases may be three or four hours in duration while they deal with it, because often what we find is that it's not necessarily a medical need they're dealing with. It can be a social need, so they also have access to things like food vouchers and emergency support. They build these linkages with a lot of the other social services that exist so they can try to help these people stay within the community and then refer them for community-based care rather than needing to come into the health system. We know an ED is not the ideal environment, 90 per cent of the time, for these people.

**The Hon. EMILY SUVAAL:** In terms of your workforce in South Australia, have they had concerns around this model? What has been the response?

**PAUL LEMMER:** It's been very well accepted; noting, though, that because it's low numbers we don't have issues attracting people into the role. But it's not like we're trying to attract 200 people to undertake the role. There was apprehension early from people around the concept of what they view as working solo. So whilst they were working with a mental health clinician, there is a lot of confidence in our profession or our sector with working with each other. People are really comfortable that their partner will understand and read a room. Suddenly having to work with a clinician who comes from a different specialty and hasn't cut their teeth, if you like, working in that true community emergency setting, that led to some apprehension around safety and where that would sit.

We put a number of processes in place. We have duress alarms. We have regular contact from EOC. We put AVL on all our vehicles. We have a number of processes to make sure we can track. We do risk assessment over the telephone. We have very clear disengagement for them if they turn up and decide that the scene is unsafe. As those issues have started to go away and people have started to get comfort in the response model that we're providing, what we're now seeing is some increased requests from staff to get access to work on this team. What we have found interesting is that there's a strong push for people to spend a component of time working on this and then a component of time back on a normal ambulance. What they're finding is that the paramedic skill set is enabling them to really support that mental health clinician. It's making sure they remain contemporary in their traditional paramedic practice that enables them to work really well with this mental health clinician.

**The Hon. EMILY SUVAAL:** That's an interesting concept. Have there been any incidents where harm has been caused to the workforce in this model?

**PAUL LEMMER:** No. One of the things we're really proud of—we do a lot of reporting. We've had some cases you would define as a near miss, where a crew have turned up in a highly aggressive, volatile situation. The one thing I say our workforce does very, very well is that ability to walk in a room, pick that very quickly and make a decision about whether they need to disengage or not. We've had some scenarios like that where we

have disengaged, but there hasn't been any physical harm towards the staff involved. We run a safety learning system, an SLS reporting system, where all events are reported, and we run an incident reporting system for acts of violence that are also captured and reported. We make sure any of those physical threats are looked at.

We have a high-risk address register. If we were to go to a case and experience physical violence or threats of physical violence, that would come into one of our regional officers, who would undertake a review, link in with SAPOL, link back in with mental health and develop a response plan. It may mean that we have a particular response plan assigned to an address that says we won't send the MH CORE team because of the arrangement, or it might be that we will send them but we will involve SAPOL. We develop a co-response plan with local police and have an agreed response plan to that particular consumer at that particular address.

**The Hon. EMILY SUVAAL:** Obviously this is made a lot easier by having this one record you're able to have access to. Does that record then speak to New South Wales police as well?

**PAUL LEMMER:** I'm sure it's very similar. We have local liaison groups for mental health that are established within each LHN, and we have an information-sharing guideline that applies across government that allows the agencies to share particular information if it's in the interest of the safety of the responders or the safety of the consumer or person. We use those ISG guidelines to share information between the parties and agree on a response model. There may be a consumer that lives within northern Adelaide that needs a depot med that mental health will provide. It doesn't need an ambulance involvement, but police will go because of a previous history of violence. The police will go and support just the mental health clinician. Or it may be a patient who has a history of physical violence but can be de-escalated, so we may have what we call a HRA2 plan on it that says we'll attend. Police will still come, but we may keep police outside. We go in and try and resolve the situation and, if it escalates, police are there to support.

It sounds great. There are imperfections in all of that, and there are resource challenges for every agency. Lining everyone up at the same time is not without its challenges and can sometimes lead to a delayed response, which is really where the PTCs become important for us in the EOC. They are able to reach in by the phone, have access to all of that record and actually start some of that assessment to make a decision, particularly around the lethality of suicide. We're concerned that what we don't want is a history of violence but a person threatening to commit suicide and us not entering the house, only to subsequently enter later and find that they've completed that suicide.

That's the real tricky piece as we try to line up different agencies to respond together, which is why, in the north, the concept of having a mental health clinician with SAPOL plus a mental health clinician with SAAS—we're finding it's sort of ticking both off. We've now got this really well-linked-up system where we have two mental health clinicians who work with the same LHN—one working in an ambulance, one working in a police car—that are able to talk to each other and say, "We think you need to bring police into this," or are able to sit at one they're at with police and say, "We actually think this is a health issue not a police issue. We want to try and disengage. Can you can come in and pick this up?"

**The CHAIR:** Have you had any feedback from the community, from the patients that you're serving? How have they found it?

**PAUL LEMMER:** Yes. I'm happy to share some staff surveys and some consumer surveys that we've undertaken to try and understand what that experience is like. As a general rule, what we find is that it's very well received because a lot of it is focused on keeping them out of hospital. It's about trying to address those needs within the community and finding out where that goes. Obviously there is a cohort of patients we end up using a section on and needing to transport, and their experience tends to not be as positive. It is, for us, about trying to do that trauma-informed care and trying to remove that. What we're seeing with MH CORE versus our normal ambulance response is that lower use of those powers means you have much better engagement from the patient, the consumer, in their health care and what is happening, compared to the one that feels that they're losing that control because a normal paramedic crew have responded and said, "We're going to use a section 56. Essentially, you don't have an option in this treatment path anymore. We're going to take that away and transport you." We find that paramedic crews tend to use that more frequently on the same cohort of cases than MH CORE does.

**The Hon. EMILY SUVAAL:** I will jump in with the last question. In terms of the MH CORE, you mentioned earlier some of the safety mechanisms that have been put in place. I wonder if you're able to provide—perhaps even on notice—what those are and how those were undertaken, and if there is any additional funding or any sort of arrangements in your awards to provide for allowances for these workers in recognition of the skills that they have and the work that they do.

**PAUL LEMMER:** Certainly. I'm happy to send some stuff over across just to outline the steps. In regards to the remuneration, our enterprise agreement has a particular classification for a single responder. Whilst

acknowledging that they're not a single responder, because they are working with a mental health [audio malfunction] and that classification, which gives them a slightly higher rate of pay than a traditional paramedic [audio malfunction] within a normal ambulance, which is really just designed to reflect the fact that some of that operational safety awareness piece is relying on them as an individual, rather than both. Probably the biggest challenge we've had in this has actually not been our workforce, because our workforce is quite used to responding to these. It's actually been working with the mental health clinicians, recognising that some of our mental health clinicians are nurses, some of them come from social work and from other specialties, and so getting them comfortable with responding to some of these environments—they're still in an ambulance.

A really good example is recently we had a case where we attended a hanging, and the mental health clinician was really confronted by that and didn't want to enter because we'd got confirmation from the scene that they had completed the hanging, and therefore we were going in to respond to cut them down and run a cardiac arrest, and they didn't want to come in. That is not an environment that they are comfortable within, whereas for our workforce it's sort of the bread and butter piece of what they've come into, so they say okay. That's probably been our biggest challenge in this—in the relationship between, and an expectation of risk and safety between, our workforce and the mental health clinician. In certain operational areas, our risk tolerance is much higher. In other areas, the mental health clinician's risk tolerance is much higher. We're trying to find that happy medium.

**The CHAIR:** We're out of time for today. Thank you so much again for providing that evidence from interstate. It's been really valuable. For those questions on notice, or any further questions on notice, the secretariat will be in contact with you.

**(The witness withdrew.)**

**Ms KATIE McKENZIE,** Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, affirmed and examined

**The CHAIR:** I welcome our next witness. Would you like to start by making a short opening statement?

**KATIE McKENZIE:** No, I'm quite happy to move to questions.

**The CHAIR:** That's alright. I will start with a very broad opening question. One of the terms of reference of this inquiry is looking at alternatives to police for responses to mental health emergencies. I understand that the ACT has a program called PACER, which, confusingly, is the same name as the New South Wales program, but which is run quite differently from the New South Wales PACER program. Could you give us an overview of what that PACER program looks like in the ACT? How does it work?

**KATIE McKENZIE:** Sure. Thanks for asking. Our PACER program—obviously, PACER is quite a commonly used acronym now: Police, Ambulance and Clinician Early Response. Within the ACT, it is a tri-agency response between Canberra Health Services, ACT Ambulance and ACT Policing. It is a combination of a mental health clinician, a police officer and a paramedic to situations that have been triaged as a mental health crisis. Our PACER response commenced at the end of 2019, and we did a formal evaluation of it this year to have a look at our first three years of operations, and how we can build and strengthen on what it is that we do. We have shared that report with the secretariat prior to me coming.

**The CHAIR:** Wonderful. We were very interested in some of the really positive results that have come out of that evaluation. I was hoping you could just expand a bit further, because I think this is the critical difference between our jurisdictions, on the role of the police officer within the team in your tri-response model. Could you clarify that?

**KATIE McKENZIE:** Sure. I can give you some broad comments, acknowledging that I am here from Health, and anything specific about the policing role will need to be directed to ACT Policing. I'm sure they're happy to answer any questions outside of this forum today. The role of the police officer, as outlined in the initiation documents for the PACER project, is one of safety. It is of safety for the PACER team, safety for the person and of course, in line with policing, safety for the community. As I said, that is their role, and any further information would need to be directed to Policing. What I think I can say from our perspective on the Health side of it is it's a really critical relationship that we have with police. I think it is under-recognised how important it is to have a collegial and combined response to crisis situations in the community. For my team—that's the mental health clinicians in the PACER space—they find a lot of value, a lot of support and a lot of reassurance in attending with the police.

**The CHAIR:** What does that response look like from a patient or a consumer perspective if they've rung 000 and that's been deemed a PACER response? What arrives at their residence in the community?

**KATIE McKENZIE:** It will be three people in a vehicle designated for those three people. I think what it might look like is more people coming with a therapeutic intent, rather than somebody coming along to take them somewhere where they don't want to be taken. But I will acknowledge, if you have read our report, there are some varying points of feedback from our consumers. Of course I am relaying what is a positive point of feedback, which is that that therapeutic input is critically important to them in de-escalating the situation, and also in allowing the person to be able to remain home and get the immediate support that they need to be able to move from a point of crisis.

**The Hon. SCOTT FARLOW:** Just briefly, if I can jump in on that—in terms of that vehicle you were talking about, is that an unmarked vehicle, not a police vehicle or a branded vehicle?

**KATIE McKENZIE:** Unmarked.

**The Hon. SCOTT FARLOW:** Great, thank you.

**The CHAIR:** You've brought it up. It would be worth exploring some of that consumer feedback further. I know it is in the report that you have tabled.

**KATIE McKENZIE:** It is, and I did bring it up because it's very obviously in the report. I think—and I've talked about the positive feedback—some of the feedback that is not so positive has really focused on expectations. When you say it is a mental health response, there is an expectation that, potentially, there might be more coming than what does come. It is, at its core, a crisis and assessment response done by a skilled mental health clinician. For people that need more than that, it requires them to be linked or to follow up at a later time. So there are some differences in expectation.

I think with all emergency diversion programs, there is an inherent tension in what we as the system mark as a success measure, and that is to stay out of the emergency department, versus sometimes the person might have wanted to come into the emergency department. I think there's tension in how we measure success, and I think that has particularly come across for carers, because if you're a carer in that environment, actually staying out of the emergency department, which is a success for us, is not necessarily what is right for them in that moment. That is clear in our report, and we've also received that feedback from carers as well—that there might need to be more surrounding a PACER interaction for those times when an emergency department visit is not warranted or needed or in the person's best interests, but equally there might need to be some time of further de-escalation in the home environment.

**The CHAIR:** Could you talk us through in a bit more detail how that triage process works? When a person or their carer calls 000, what happens? How does that call end up with PACER?

**KATIE McKENZIE:** I'm so sorry. I'm not actually triaging. Again, that's an ACT Policing function. There is a process at which they determine it's a mental health emergency and the PACER team will be dispatched, but outside of that, the detail of that would have to be directed to ACT Policing. Apologies for that.

**The CHAIR:** I understand the PACER program in the ACT has recently been expanded beyond what it was currently funded for. What was that based on? What were those evaluation criteria?

**KATIE McKENZIE:** When PACER was first set up, it was started as an 8.00 a.m. to 6.00 p.m. shift. No, I think it was even less than that. It was a 40-hour a week, weekday response. It very quickly moved into a 10-hour per day, seven-days-a-week response. Our second budget uplift allowed the PACER team to be able to bring on an evening team, so the PACER hours of operation now are from 8.00 a.m. to midnight, seven days a week, and we are currently exploring whether there is demand for an additional PACER team, on top of the two that we have in operation.

**The CHAIR:** Has there been any cost-benefit analysis of the program?

**KATIE McKENZIE:** The KPMG report does do that. It does outline in saved police time and saved emergency time, and that has to be put alongside the cost of the program. Also, there are a lot of positive benefits that are unable to have a monetary figure put to them. I know that's always a difficult space for Treasury, but for people who do not need to go to the emergency department and were not seeking that as an outcome, the actual cost of not being retraumatised and not having to be in a busy environment is immeasurable. Whilst the cold, hard dollars are outlined in our evaluation report, I think there is a lot more benefit for the PACER program for the people that have found it very useful for them than what can actually have a dollar figure put to it.

**The CHAIR:** My last question is about the level of information that the members of that team have about a person when that response is initiated. In terms of police records or medical records, and from the health perspective, what data is accessible to that team?

**KATIE McKENZIE:** We have a memorandum of understanding about clinical information sharing between our three agencies, which outlines that the information that's shared is one that's going to the immediate situation and the circumstances of an imminent risk. The sharing of that information is the responsibility of the PACER mental health clinician. The recording of that is done by all three agencies and the database is maintained by ACT Policing. I think it's good to have those guidelines and, I think, in any information-sharing context. It is an evolving conversation and we continue to have it as we learn where other people start to have this evolving conversation. Information sharing is an important part of what we do, but we do need to recognise that there are some boundaries to it, and those boundaries are the situation and imminent risk.

**The CHAIR:** Are there questions from other members of the Committee?

**The Hon. EMILY SUVAAL:** What would you say are the differences between your model in the ACT and what we have here in New South Wales, particularly any differences that you might see between the two health services—whether you have a single EMR and all of those sorts of things?

**KATIE McKENZIE:** I can actually only primarily talk about ACT. My understanding is that we have a tri-agency response and New South Wales might have a dual-agency response. Being a singular-city jurisdiction—listening to my colleague talk before me—we don't have the challenges of having different ways of record keeping through different cities that other States might have. So we have, in the last 12 months, moved to a digital health record. It is not accessible by our colleagues in our other partner agencies. One of the key roles of the PACER mental health clinician, among many key roles that they have, is to access the relevant information from the digital health record and share that as it pertains to that interaction that they're going to.

**The Hon. EMILY SUVAAL:** Would I be right in saying you have one digital health record, but you also have one local health network or LHD, as we call it?

**KATIE McKENZIE:** Yes.

**The Hon. EMILY SUVAAL:** That sounds like a utopia, from where I'm sitting.

**KATIE McKENZIE:** It sounds like a utopia. Sometimes it might not feel like that, but it does, absolutely, sound like it.

**The Hon. EMILY SUVAAL:** In terms of the challenges that we would obviously face here in New South Wales with rolling out a similar model, particularly for regional areas, where we have challenges with staffing which are quite unique, is it something that is likely transferable? Or, given the differences between the two that we've just outlined, being that you're one LHD with a wonderful digital health record that everyone in Health can access, is it something that would be transferable or is there a long way to go there?

**KATIE McKENZIE:** I think there are principles that could be transferred, and I don't want to downplay the complexity that distance brings to any health service delivery. I think the principle that would be transferable is that it is the role of the mental health clinician to share that information. Again, listening to my colleague before me, our PACER mental health clinician is a senior role. The reason we have seniority in that role is that they're able to make judgment about what information is or isn't relevant to the situation at hand, and I always think that is supported by very clear and concise memorandums of understanding about information sharing across the agencies. Those things do transcend geography, but I won't back away from the challenges you have in bigger States.

**The Hon. EMILY SUVAAL:** What are the safety considerations for that workforce? We heard some of that earlier, for South Australia. Are there specific measures that have had to be put in place in the ACT?

**KATIE McKENZIE:** It was interesting listening to a far colleague from one of the other partner agencies—ambulance—speak. He did describe one of the challenges that we have as a mental health service area—that our PACER mental health clinicians are being exposed to situations that they wouldn't ordinarily be exposed to: as he described, real-time incidents that haven't been part of their experience and training to date before they move into the PACER space. The other situation that he described which resonated very strongly as I listened to him is that we have a multidisciplinary workforce, so our PACER mental health clinician might be a nurse, they might be a social worker, they might be an occupational therapist or they might be a psychologist. So on top of not having that exposure to various different things that other emergency services do, they come from very varied professional backgrounds with different training to reflect each of their professional backgrounds.

Some of the ways we've overcome that—they're all mental health officers, and that does mean that they have an allowance that goes with being part of the PACER team. They're all senior. As you can see from the evaluation report, we've really had to strengthen our approaches to clinical supervision. We've also had to strengthen our approach to debriefing, and that is a function that's actually taken by ACT Policing to reflect their skill in debriefing of those situations that Health wouldn't normally respond to. But I will also say there haven't been, in reference to one of your earlier questions, issues of safety. There haven't actually been issues of safety. These are longer-term psychosocial effects of working in such a raw, fast-paced environment.

**The Hon. EMILY SUVAAL:** For frontline workers, yes, indeed.

**KATIE McKENZIE:** Yes.

**The Hon. EMILY SUVAAL:** You mentioned that they're a mental health officer, which I presume is a classification within one of your industrial agreements.

**KATIE McKENZIE:** A mental health officer is a classification of the Act, and the allowance that we give to a mental health officer is determined by their industrial agreement, depending on what profession they come from.

**The Hon. EMILY SUVAAL:** So it's an additional allowance. I'm just trying to think how that would transfer to a setting where we have different awards and agreements for—

**KATIE McKENZIE:** Yes, it's an additional allowance. If we take it as a tiered approach—seniority—they're a senior role and they get the allowance on top of that, as outlined by their industrial agreement.

**The Hon. EMILY SUVAAL:** I would invite you to talk more about, particularly, the clinical supervision and debriefing. Obviously, you can't speak for ACT Policing, which we have previously canvassed, but I'm particularly interested in their approach to debriefing, which you may or may not be able to provide commentary on.

**KATIE McKENZIE:** As I said, I can briefly say that we have recognised that it's a very important thing that ACT Policing offer our team. I'm happy to talk about it from that perspective. What it actually involves would

have to be directed to ACT Policing. They have systems and mechanisms for that emergency service debriefing. For our clinical supervision, we have moved to a space where we have invited a person in on a weekly basis to do a group supervision on top of individual supervision that might be given to individual clinicians if they require it. But that emergency debriefing that happens after a particular incident is very, very important for psychosocial safety for the team. It's with thanks to ACT Policing that I say that they offer that for our team.

**The Hon. EMILY SUVAAL:** Is that something that's specific to ACT police? Is it not done anywhere else in Health but in the PACER program?

**KATIE McKENZIE:** No, that debriefing is done for PACER. Clinical supervision we have in all parts of my service, but that one is particular to PACER program.

**The Hon. EMILY SUVAAL:** In terms of that clinical supervision where you're inviting someone in for a group session, is that someone external to Health? How does that work?

**KATIE McKENZIE:** External.

**The Hon. EMILY SUVAAL:** Is clinical supervision offered to those that might seek it on a one-on-one basis as well?

**KATIE McKENZIE:** That's determined within our broader service. There is opportunities for individual clinical supervision and that would be determined with their professional lead, so their director of nursing, their director of allied health or our director of clinical services, which is a medical role. So there are opportunities but, as a broad approach, we offer group supervision throughout the whole mental health division.

**The Hon. EMILY SUVAAL:** The onus is then on the individual if they need to actually ask for it, which may or may not occur.

**KATIE McKENZIE:** It is for individual supervision, yes.

**The CHAIR:** In cases where that very skilled team is a primary response, they get there and realise there is a safety risk and then request a secondary response from police, how often has that happened?

**KATIE McKENZIE:** I'm not entirely sure down to this level of detail for the other States, but one of the nuances in the ACT is that the mental health team—the PACER vehicle—may be diverted to other emergencies. The mental health clinician then may attend other emergencies—for example, a motor vehicle accident—which they're attending just because they're part of an emergency response, not because it's a mental health crisis. How often does that happen? I don't actually have an exact amount. In those spaces, it is the role of the police to ensure the safety of our mental health clinician. That role is outlined in our PACER memorandum of understanding. Again, for transferability through to other jurisdictions, I think it's really important that there is clarity over who has the role of work health and safety in the moment. That has to sit, as well as individually—and each agency also has to have a clearly defined remit at point of response, and policing do that for us.

**The CHAIR:** I don't have further questions. I do note that you've already tabled this really extensive KPMG report for the Committee. Do you have closing remarks or are there particular elements of the process that you've gone through that you think would be valuable for us to understand and learn from?

**KATIE McKENZIE:** A couple of things that I think are reflections from our learning is that PACER is an extremely important response in a robust mental health system, but follow-up is equally as important. Just a brief interaction is never going to be enough for people in crisis. As you move to thinking about what might work in New South Wales, I encourage you to think of the whole spectrum, not just that immediate response. The other learning, as we've got here, it's really important to recognise that it is a successful program and move it from a pilot phase into a permanent phase, because that's when you get those good structures around your program that, at their core, support clinicians and the consumer that we're hoping to serve. Otherwise I think that's all outlined pretty clearly in our report. Thank you for your interest in what we do.

**The CHAIR:** Thank you so much for travelling all the way from Canberra. We really appreciate it. If there are further questions on notice, which I'm sure there will be, the secretariat will be in contact with you.

**KATIE McKENZIE:** Our partner agency is happy to be contacted as well.

**The CHAIR:** Fantastic, thank you.

**(The witness withdrew.)**

**Ms NICOLE COCKAYNE**, Director, Policy and Research Operations, Black Dog Institute, affirmed and examined

**Mr LAWRENCE MUSKITTA**, Head of Government Relations, Black Dog Institute, affirmed and examined

**The CHAIR:** Welcome. Would you like to start with an opening statement?

**LAWRENCE MUSKITTA :** Thank you, Chair and members of the Committee. We would also like to acknowledge the land on which we meet today, the Gadigal people of the Eora nation, and their continuing custodianship over this land, and pay respects to Elders past, present and emerging. In Australia we've had more than 50 reviews and inquiries into mental health in the last 10 years. I could talk to you today about all the problems but I suspect, at this point of the inquiry, you probably know all of them. You know that New South Wales spends the least per capita out of all States and Territories in Australia and that it's the only State where per capita spending has decreased in the last decade. You also know that demand for mental health services has never been higher. Psychological distress has almost doubled in the past decade and there have been steep rises in depression, anxiety and suicidality, especially with our young people. You also know that in New South Wales, people need help are struggling to access it. Wait times are longer, co-payments higher and the mental health work force are burnt out and leaving their professions en masse, leaving huge vacancies and shortages.

You also know the solutions. They've been repeated time and time again during this and other inquiries. We need, first and foremost, funding that meets the burden of disease, at a minimum. We have presented you with options on how to find that funding, including a mental health levy like in Victoria and Queensland. We need funding that is directed towards community-based services with a focus on prevention, postvention and early intervention so people not only get treated when they're at a point of crisis, but we get them well and help them stay well before the crisis point. This makes economic sense and it's better for people. We need a system that, no matter how people try to access care, there should be no wrong door. They should be able to be quickly referred to a service that is right for them and based on the best available evidence. We need data and transparency so we know how the system is performing and can improve it over time.

But you know all of that. What I want to speak to you about today is the why—why I'm hopeful that this inquiry will be different, why I believe that we cannot only tinker round the edges but help fix the mental health system and why the time is now. The first reason I'm hopeful is that we now have evidence-based interventions that we know work to prevent and treat common mental illnesses. With the right care, we are achieving long-term recovery rates of up to 80 per cent for depression and anxiety. For the other 20 per cent, which we call treatment resistant, there are a range of new treatments in the pipeline. For treatment-resistant depression, for example, we at the Black Dog Institute are investigating a range of novel treatments, including ketamine, psychedelic-assisted therapy and neurostimulation. They're achieving promising results, which are pushing the overall recovery rate for depression to upwards of 90 per cent.

For anxiety, we are studying new ways of scaling exposure therapies using virtual reality, which are promising results similar to face-to-face treatment, meaning we're able to reach more people at lower cost. For PTSD, a condition which used to have a recovery rate of around 40 per cent to 50 per cent, we at the Black Dog Institute trauma clinic are seeing recovery rates now of 70 per cent to 80 per cent using new treatment modalities. With new MDMA-assisted therapies, we're looking to push those numbers even higher. We're currently living through a renaissance in mental health science with breakthroughs happening almost every other month. In Australia, New South Wales is leading—we are at the cutting edge of this research. We should also be at the forefront of its implementation and practice and that requires investment.

The second reason I'm hopeful is we now have a committed and constructive partner in the Commonwealth Government. Through the leadership and tireless work of Minister Mark Butler and Minister Emma McBride at the Federal level, we'll soon have a road map for systemic mental health reform in Australia. We at the Black Dog Institute have been working hand in glove with the Federal Ministers and other leading mental health organisations to deliver an ambitious and comprehensive reform, which will be announced later this year. The Commonwealth Government is moving to close the missing middle, but it needs States like New South Wales to meet it halfway. The time for passing the buck between State and Federal governments is over. Now is the time to be working together and finally close the gaps in the mental health system.

Lastly, the reason why I am hopeful is we now have in New South Wales a mental health sector that is organised, mobilised and ready to stand to support new and systemic reform. Through the New South Wales mental health alliance, established earlier this year, we have brought together the key stakeholders in the State to speak with a unified voice. We invite you to walk this journey with us, to make mental health a priority and to see New South Wales leading the country in mental health outcomes. Our invitation to you is this: Don't let this be

another inquiry. Let's do this right. Let's make strong recommendations that will turn into meaningful, systemic reform and let this be the last inquiry that we will need into mental health in New South Wales.

**The CHAIR:** Firstly, I commend you on the work you've done through the New South Wales mental health alliance. It's an extraordinary piece of work to bring together some of the most important voices in the sector to have a unified position. I really commend that. I'm interested in your written submission. You talked about the need for an independent gap analysis, particularly looking at workforce in New South Wales. Is that data not already available? Why do we need to do that?

**LAWRENCE MUSKITTA:** That is a very good question. Firstly, I think it's a bit of a scandal that we don't have this data available already. We are talking about some very basic data points. We are talking about what's the demand of services broken down by area, what's the current level of service and workforce by these areas to meet that demand, and what's the current vacancy rate broken down by profession and area. We should already be collecting this data and we should be using it to inform service and workforce planning, but we don't, as you've heard previously. We have asked for a comprehensive gap analysis, which the Minister has agreed to. I also thank members of this Committee for their advocacy on this.

But this shouldn't be a one-off activity. This should be business as usual. We should be collecting this data regularly to be monitoring how the system is working and then improving it over time. This data should be transparent. It should be made public for both policymakers like you and the sector like us to be able to adjust and make recommendations on how the system should change. It's also not a new idea. I'd like to take credit for it, but I absolutely cannot. It was actually raised as a recommendation in the 2020 Productivity Commission that all States should publicly be publishing this data, collecting this data and using the National Mental Health Service Planning Framework to be able to coordinate workforce development nationally.

**The CHAIR:** Coming back to your written submission, you've provided some really helpful information about some of the more vulnerable and marginalised populations of specific interests in our terms of reference. I wanted to particularly discuss people from low socio-economic backgrounds. I was interested in some of the ways that services are funded actually being prohibitive to people that need them the most. I am hoping you could expand on that issue and perhaps what your recommendations are so that we can better target services to people who do have the greatest need.

**NICOLE COCKAYNE:** Thank you for picking up on that. I think that we all know quite well that people from low socio-economic backgrounds and a low socio-economic status experience mental ill health at a much higher rate compared to the rest of the population. This actually requires a whole-of-government response; however, this is not simply a health issue. What we know and what our research has shown us is that there are critical issues such as housing, homelessness, financial security, education and employment that are all gearing toward why these groups suffer so dramatically different.

I think what we've seen from global data is that, for instance, around 20 to 30 per cent of all suicides are actually driven by unemployment. It's not necessarily a solution that is focusing on improving mental health services alone. There are broader measures that governments right across the country need to put in place. What we saw during COVID is a really good example of this, where we were very concerned about what would occur as a result of the pandemic itself and the lengthy lockdowns and the loss of employment. The sector as a whole anticipated that we would see mental health suffer dramatically as a result of that. That didn't actually occur, quite fortunately. We saw that suicide rates actually steadied during this period.

What we know from other data elsewhere from previous similar sorts of crises where you have put financial supports in place for the most vulnerable people in the community, such as social benefits, welfare payments and that sort of thing, it actually is protective. I think, as we go toward what is a deepening cost-of-living crisis, these are the sorts of things that government needs to be looking at—these broader whole-of-government supports across social support services, education and welfare more broadly. That's what we would be encouraging this Committee to look toward as you consider how we can improve outcomes for people from this particular demographic.

**The CHAIR:** I am interested in your submission with regards to the most appropriate or most effective use of digital technology and telehealth. I understand there are researchers in Black Dog who are at the forefront of this work. What recommendations should we be making around using digital tools in a way that will be genuinely helpful?

**LAWRENCE MUSKITTA:** I think the first thing to say about digital is that there is a lot of evidence that shows that digital solutions can be very effective—almost similar levels of effectiveness and safety—within mild and moderate cases of depression and anxiety, which are the most common mental illnesses. Digital has the ability to not only add to the mental health services available but multiply. One thing that we've been looking at

is not just purely digital tools like apps as digitally therapeutic but how do we integrate digital into the therapeutic and clinical practice. One way of doing this is what's called "blended care". There might be a fifty-fifty split. You might see a clinician one week and then the clinician will prescribe you a digital tool or self-paced module to do in the week in between and then see you the week after. That way, the patient gets extra dosages of treatment. So we are almost doubling the amount of dosage of treatment at far smaller costs.

One way that we've been looking at scaling this is looking at how do we reimburse both GPs and other clinicians to both prescribe and monitor these digital tools. That's more of a Commonwealth issue, however. But I think what can be done at State level is really training within the clinical workforce and the mental health workforce about the possibilities and opportunities of using digital tools and thinking about how they can include digital within their own workflows to both increase patient outcomes and also cost efficiency of their service.

**The Hon. EMILY SUVAAL:** Thank you both for appearing today. It's wonderful to see you. Thank you for making such a wonderful submission to our inquiry. It was one that was very interesting to read. To start off, in terms of our funding for mental health here in New South Wales, there were some interesting statistics within your submission that went to the total burden of disease. Mental health is 13 per cent but investment into mental health only represents 7 per cent. Is it the case that that figure of 7 per cent should be 13 per cent, if we are looking at burden of disease and how much funding, and is that the same that happens with other conditions?

**LAWRENCE MUSKITTA:** That's the recommendation that we made in our submission—that funding for mental health should be commensurate or proportionate to burden of disease. As you mention, there is quite a wide gap there of it currently being 17 per cent[1] and the burden of disease being 13 per cent. I want to be clear here that it's not always a one-to-one proportion because the proportion of it is to the total health budget and, as we know, the total health budget could and should be more than it is.

The point that we want to make here is that the current level of funding is not meeting the need within the community. It's not meeting the clinical need as well. That's the lens that we want funding to be looked at. We know that the level of need in the community far surpasses the amount of service that we're giving, such that only half of people that need mental health support actually access it. So the need in the community is far bigger. I think one of the reasons why it's lower than it should be is because funding traditionally has been looking at historic service usage. That makes sense for a lot of other non-communicable diseases, where the prevalence doesn't change dramatically over time—diabetes, for example. The pressures around diabetes are diet and exercise, and the population doesn't really change in that way that quickly. However, if you think about the pressures or stresses that determine mental illness, they're a lot quicker.

For example, COVID was a massive stressor on people. The cost-of-living crisis was a massive stressor on people. Natural disasters have been a massive stressor on people as well. All of these, compounded together, happened very quickly, including other reasons, and that's why we've seen such a huge spike of mental illness in the community, plus also additional awareness. But our system isn't set to be able to work dynamically in that way, if that makes sense. What we do currently is we look at how many people did we treat last year and then let's see if we can add a little bit more to that. Whereas the demand in the community and the need in the community has increased quickly and steeply, and the funding has not met up with that. That's the point that we want to make with burden of disease. It's not an exact measure, but it's a close measure. It's an approximation that we should be aiming for.

**NICOLE COCKAYNE:** If I can add to that as well, I think the issue that we face is that the investment should be much broader than what it currently is. There's a real opportunity to invest in prevention and early intervention, and to divert people away from needing more acute services across the course of their life and their mental health journey. I think also it's worth noting that the global burden of disease—I've worked in mental health for about 20 years now. We always talked about 2025 to 2030, when mental health would surpass every single other disease burden, whether that be cardiovascular disease, cancer, what have you. We're actually there now; it's already upon us. Probably the worst thing that we can possibly hand over to the next generation is the fact that we're not doing anything about it. I would really like for the Committee to consider the opportunity to extend the investment in mental health services, but extend that into early intervention and prevention because that's where you're going to have the biggest bang for buck and improve generations for years to come.

**The Hon. EMILY SUVAAL:** It's interesting looking at the graph you have provided, which is on page 10, in terms of the New South Wales recurrent expenditure per capita on services. There is a couple there

[1] In correspondence to the committee received 19 January 2024, Mr Harry Grant, Government Relations Adviser, Black Dog Institute, provided a correction to the evidence by replacing '17 per cent' with '7 per cent'.

that have plateaued, but there is an interesting data point where specialised psychiatric units or wards in public acute hospitals, indeed, intersects with and then overtakes community mental health services, which then sort of plateaus. That point occurred in 2011-12. What has been the impacts of that for the rest of the sector, and is it the case that the community mental health services, which now receive less money per capita than the psychiatric units or wards in public acute hospitals, that that needs to now overtake?

**LAWRENCE MUSKITTA:** I want to be clear that there's sometimes a false dichotomy between community services and acute. Both of them are within the same environment of a shortage. When the overall spending is less—

**The Hon. EMILY SUVAAL:** It has gone backwards.

**LAWRENCE MUSKITTA:** It has gone backwards. It's the only one that has gone backwards out of all the—

**The Hon. EMILY SUVAAL:** We have the least spend in the whole of the country.

**LAWRENCE MUSKITTA:** Exactly. When you take into account this environment of shortage, you've got a scarcity mindset. You're making decisions with very small resources. So I understand why in the last 10 years we have been putting more money into acute services, because that's where the crisis point is. That's where the most extreme and urgent need is. But Nic is right in that the right investment to make is in early intervention and prevention, which happens at the community level. But we have to be doing both. That's why we have to be increasing the overall funding and moving the funding, hopefully, a little bit more to prevention and early intervention. I don't want it to be an either/or situation.

**The Hon. EMILY SUVAAL:** No, certainly not.

**LAWRENCE MUSKITTA:** We have to be looking at the entire system. We know that acute services are still in dire need right now. Everything is in very dire need. There aren't enough beds for people to go into inpatient units. There aren't enough of the right beds. For example, having juvenile or youth acute beds—a lot of young people are inappropriately being housed in adult wards. We've spoken to multiple people, carers and consumers during this process where their children are in a ward with adults, and that is absolutely inappropriate and not the right care for young people. So the point that I want to make is, it's the overall budget that we should be looking at. Once we have that overall budget, we can start moving more of the investment into community prevention and early intervention.

**The Hon. EMILY SUVAAL:** In terms of the budget that you talk about, I noted with interest your suggestion around how to fund the reform in terms of a mental health payroll tax surcharge. I just wondered, particularly in the light of recent events, the High Court decision regarding the EV tax in Victoria in particular, whether that is actually an option and what implications that would have.

**LAWRENCE MUSKITTA:** We put this recommendation together as a way of showing that there is money out there, and there are ways of raising revenue. This is one of many different revenue-raising options, many different ways that the Government can find the money for this. The reason why we put this particular one up is because there's a precedent for it. Both Victoria and Queensland have this particular payroll tax, which has raised substantial funds. In Victoria, in the last financial year, I think this tax, this levy, raised $900 million for them in one financial year. To put that in context, overall spending for mental health in New South Wales is $1.9 billion[2]. So that could be a massive increase. We're not the government of the day, obviously.

**The Hon. EMILY SUVAAL:** So long as it's constitutional.

**LAWRENCE MUSKITTA:** Yes. We're making a recommendation of how you can find funding. I also want to be clear that there is always money for things that we prioritise. This excuse that there's no money in the budget this time around is not really an excuse. There have been cases where there have been health emergencies, like COVID, for example. We found, what was it, $7.5 billion as a response to COVID, which was the right thing to do. We can talk about the dollars and cents of it all, but it was the right thing to do at the time. But here, in mental health, we're seeing a similar sort of emergency. Suicide is the biggest killer of people under the age of 45. It kills more people than road accidents and skin cancer combined. If this is not a health emergency, I'm not sure what is. So the excuse of saying, "We don't have enough money," is not really an excuse. If we prioritise it, we

[2] In correspondence to the committee received 19 January 2024, Mr Harry Grant, Government Relations Adviser, Black Dog Institute, provided a correction to the evidence by replacing '$1.9 billion' with '$2.9 billion'.

will be able to find money. The recommendation that we made is one option for how we could find that money, but there are others.

**The Hon. EMILY SUVAAL:** In terms of recommendation 10, which also led to savings, has there been any work done in modelling an expansion of the HASI or CLS or PCLI program, and what those savings would then entail?

**NICOLE COCKAYNE:** There has been an independent evaluation of the HASI program which has shown really positive results. What they have seen is that there has been a decrease of around 10 per cent in people that are accessing services who are in that program, and that's magnified for people that remain in the program for over 12 months. They've also seen hospitalisations decrease by 74 per cent by participants in that program, and so that is huge. That actually is driving quite a cost offset with regard to program provision versus cost to the health system, and the economic analysis that they have done has demonstrated that the per-person saving over five years is around $86,000.

**The Hon. EMILY SUVAAL:** Per person.

**NICOLE COCKAYNE:** Per person. There were 5,000 people in the initial pilot program between around 2016 to 2019, so extrapolate that, expand that program and you would see dramatic savings in delivering a really effective and efficient service.

**The Hon. EMILY SUVAAL:** Do you know offhand what the cost is per person of that program per year?

**NICOLE COCKAYNE:** No, I'm not sure what the cost of that is. That evaluation was done by colleagues from UNSW at the Social Policy Research Centre, and there is a detailed report that is available that we can provide to the Committee.

**The Hon. EMILY SUVAAL:** If you could, that would be great.

**The Hon. SCOTT FARLOW:** Thank you for your submission and for being here today. I'm just interested in the different outcomes. We were talking before about the role that different States play when it comes to mental health, but within New South Wales there is a difference as well, and your submission points out, in terms of regional communities in particular, the different outcomes. I think you suggest that there needs to be emergency training in mental health when it comes to emergency departments because that is, I imagine—I don't think your submission necessarily calls this out—the key interface that people may be interacting with the mental health system when it comes to regional and rural communities in particular. I'm just interested in what your understanding is of what's occurring in regional and rural communities, and the disparity between mental health support services in the city compared to our regions in New South Wales.

**NICOLE COCKAYNE:** I think you're quite right. I don't think that the emergency department is necessarily one of the key points that people can go to in rural, remote and regional areas of New South Wales; it's quite often the only one that's available to them, and unfortunately the emergency departments are just really ill-equipped to be able to deal with people in crises. If anyone has presented to one recently, there are constant demands all the time, there are really short triage times that are occurring there and, as you've pointed out, there are staff within there that haven't got mental health training or indeed suicide prevention training. That is a real opportunity for us to be looking at a very, relatively, simple and low-cost measure to implement in the rural and regional parts of New South Wales.

Black Dog Institute ran one of the largest suicide prevention trials in the Southern Hemisphere over the last six years; it was called the LifeSpan trial. That involved implementing a number of different interventions across a number of different settings in four communities in New South Wales. One of the interventions in the settings in particular was in the emergency department itself. In that instance, we developed a set of guidelines which looked at a whole range of things but including training for health professionals, and we trained over 900 health professionals from across the State during that period and that was all in best practice in suicide prevention care. This sort of training already exists. We've demonstrated that it's effective, and that would be a very simple and effective way to address the experiences of people in rural and remote areas so when they do reach out to the only avenue available to them, they're going to be met by people who are able to adequately care for them.

**The Hon. SCOTT FARLOW:** In terms of the disparity—and I take it from this discussion as well—it largely falls on the fact that it is in many cases the only interaction that people are having with mental health providers, in emergency. I think part of your story there effectively is the distress people feel in terms of that triage system. If you're just sitting there in an emergency department, people would walk away because it's not a broken leg or the like in being seen. But the disparity in particular between the regional experience and the metropolitan

experience is because that is the only, or one of the only, interactions you can have. Whereas I imagine when it comes to metropolitan emergency departments, there are other services around. The problem isn't necessarily as significant as it is in regional communities but it still would have a benefit in metropolitan areas as well.

**NICOLE COCKAYNE:** Yes, that's right, and I think that there are a number of initiatives that have already been implemented to a degree across New South Wales that we could look at expanding into regional parts of New South Wales to address that issue of having only an emergency department, and they are the Safe Havens. I understand that you've heard quite a bit about them during this inquiry already. Black Dog Institute is actually involved in evaluating six of those sites across New South Wales and the ACT. The study is still underway but we've got really positive early data that is demonstrating that it's a very effective way to have people present to a very warm and caring and appropriate environment, so we're able to meet people where they are rather than in the chaos of an emergency department and we're actually seeing economic efficiencies through the data as well as a result of that.

That information will be available over the course of the next six to 12 months, but it's very promising in early days. That would be a very reasonable and sensible approach for New South Wales to take in looking at expanding the existing services such as Safe Havens in rural areas of New South Wales but looking at your data and understanding where these are actually needed and expanding the program itself to be in more community regions because they are effective and they do work.

**The CHAIR:** I have one last question. In your written submission, you cited the very distressing statistic that 23 per cent of people discharged from a mental health hospital do not receive follow-up from a community mental health service, and that was from the Productivity Commission. You've cited that as part of your recommendation for a statewide community mental health navigation support service, which has been touched on in other evidence as well. I'm interested in understanding how that model might look and who might be running that service.

**NICOLE COCKAYNE:** I think that the problem that we face in New South Wales, which is right across the country really, is the difficulty in how fragmented the various services are and how complex they are. They're not integrated and they're terribly misunderstood in terms of what's available to you. The irony is that somebody in distress is not functioning in their usual state so they're not able to comprehend information that's available to them, they're not able to make decisions as readily, and so what we have available at the moment typically is a service directory, if you like, that people can log into or call a phone line to find out about, but it's not tailored to their needs, it's not meeting them where they are and it's simply not meeting a need.

What we think could occur as an alternative to that is having a support service where you have that warm and friendly concierge type of approach where somebody is there to support you, to understand where you're at, and to understand and guide you toward the services that are appropriate to your own local area, whether that be a bricks-and-mortar kind of service or a digital service that you can access—whatever it might be. Typically I think that we've seen through work of the New South Wales Mental Health Commission, through their peer support project, that these could actually be served by peer support workers. We don't necessarily need mental health clinicians to do this. They bring a level of empathy and understanding from their own experience of service utilisation. We'd actually suggest that the peer navigation project from the New South Wales Mental Health Commission should be the grounding for which we could look at how this could operate.

We know that the WayAhead service also has a very similar type of program where they're directing consumers toward the right treatments and the right services at the right time. I think critically in order to address the accessibility issue, the peer support worker is paramount but also providing a digital gateway for this is really important as well. Where we've seen digital gateways established in mental health and in other areas before which haven't been successful, it's usually because they're not designed in a way that promotes an ease of use. So we really need a human-centred approach to how these would be developed and then implemented, but there are certainly foundational programs and pilot projects in the State that we could look at and adapt in providing such a navigation service.

**The CHAIR:** Just in that final bit of your answer there you mentioned existing pilots in this State. Is that something you'd be able to provide more information about on notice? Do you have access to that?

**NICOLE COCKAYNE:** Some of those reports are publicly available, yes, so we can provide those to you.

**The CHAIR:** Fantastic, thank you. If there are no further questions from the Committee, do you have any closing remarks or anything else you wanted to point out to us?

**LAWRENCE MUSKITTA:** No, I think we've covered everything. Thank you so much for having us.

**The CHAIR:** Thank you so much again for the time you've taken to present today and also for preparing a really excellent written submission. It's much appreciated.

**(The witnesses withdrew.)**

**(Luncheon adjournment)**

**Mr SIMON DODD**, Head of Workforce Planning and Development, headspace, affirmed and examined

**Ms ANNIE HONG**, Youth National Reference Group Member, headspace, affirmed and examined

**The CHAIR:** For your information, I know the room feels a little bit empty today, but we have a couple of our Committee members tuning in via Webex on the screen in front of you. Would you like to start by making an opening statement?

**SIMON DODD:** Yes, thank you. First, I'd like to acknowledge that we're on Aboriginal land today and acknowledge the Gadigal people of the Eora nation as the traditional custodians of the land on which the Parliament of New South Wales stands, and I pay respects to Elders past, present and emerging. I also would like to acknowledge people with lived experience of mental illness and their valued contribution in building and reforming mental health services and systems. We thank the Committee for holding such an important inquiry and providing the opportunity to give evidence today. We're here representing headspace National Mental Health Youth Foundation and the young people, centre staff and lead agencies who comprise our network of centres and services across New South Wales. In our submission we highlighted that young people need accessible and holistic services to meet their mental health needs, that building the youth mental health workforce is critical and that there is a growing need and focus on providing integrated services and supports for young people. I'd like to invite Annie to offer a brief perspective of these issues as our opening remarks.

**ANNIE HONG:** Good afternoon Chair and Committee members. Thank you for inviting me here today. My name is Annie. I'm a member of the headspace Youth National Reference Group. This is a group that works with headspace to ensure that young people's voices and opinions are at the front and centre of all the initiatives and the resource allocation that headspace does. But outside of this position I'm also a 23-year-old university student studying psychology and law at the University of Sydney. I'm here today to share my lived experiences about my experience through the mental health system.

Late last year was a particularly difficult time for me, leading me to seek help and go to headspace Camperdown to get a mental health plan for the first time and also to seek help from a psychologist. Despite my studies, navigating the system was eye-opening, to say the least, revealing the challenges of the cost as well as the wait times. I saw how these factors, in addition to the quality of care, really shape and influence how a young person perceives the system as a whole, as well as their general wellbeing and the way they seek help in the future. Today I speak only of my experience, but we know that more young people struggle with rates of mental ill health than any other age group. Three-quarters of mental health issues emerge before age of 25 and more young people die from suicide than from anything else, and the statistic is 40 per cent.

But getting help isn't easy. If a young person works to overcome the stigma associated with seeking help, they're faced with additional barriers like I've mentioned, such as wait time and cost. When we have the courage to seek help, we need services that we can trust and are easy to access. We need to know that we are unlikely to be turned away and that we will feel welcome. Youth mental health services should be youth-focused, designed with young people, for young people. We are the experts in our own lives and we want to be actively engaged in the whole process. It shows that we are trusted and respected, and helps ensure services are credible, approachable, and relevant.

**The CHAIR:** Thank you very much. We now go to questions from Committee members.

**The Hon. SUSAN CARTER:** Thank you both for being here today, for your opening statement and for your submission. I notice that you've been working in the space since 2006. I wonder if you could give the Committee a sense of what might have changed since 2006?

**SIMON DODD:** I might take that one, Annie. I don't know whether you're old enough to have worked for us at that time. In 2006 we started with 10 centres. We now have 154 centres across Australia. Obviously the landscape in terms of the delivery of service with those resources is massively changed. There's 45 centres, services, in New South Wales. There is another six that have been planned in the next few years. Young people's needs have increased in that time. I think very clearly there's quite a lot of evidence that you've already received about the increased demand from young people, which is an interesting thing. Also, probably our capacity to deliver services to those young people, even though we've increased the number of services offered, we have a reduced amount of capacity in many ways to support young people and their families at the same time.

**The Hon. SUSAN CARTER:** Sorry, can you just explain that? Why if services have increased has capacity to deliver services decreased?

**SIMON DODD:** The whole services being able to be delivered have obviously increased; however, if we look at the MBS percentage of services offered by headspace, which is a bulk-billing entity, the MBS services

five years ago in New South Wales, about 48 per cent of our occasions of service were delivered through the MBS. Now that's around about 18 per cent, so that's what I mean by the decrease. Although there has been an increase in our capacity to, in total, offer services through the funding that's resulted in headspace, we've seen an increase in demand such that it's been difficult to keep up with it. I think that's what we mean.

**The Hon. SUSAN CARTER:** The demand is because we've got a higher rate of mental illness and mental distress, or it's because we've got a more educated population who understand when they need to seek help and are seeking help at earlier and more appropriate times? Any sense of which one of those it is?

**SIMON DODD:** I think it's all of those. In the 2022 national youth survey that we did—which has a fairly significant cohort in the tens of thousands—we found that young people had a higher rate of high to very high levels of distress, compared to the previous time we had done that, which was about three years before. Distress is a good indicator and proxy of either existing mental ill health or emerging mental ill health. I think that there are significantly increased levels of natural disasters, and the impact of the response to COVID has significantly impacted young people. But also climate change, concerns about climate change and also the trauma and future concerns, and cost-of-living issues are all issues that young people talk about. Annie, do you want to add to that?

**ANNIE HONG:** Yes, sure. In addition to what Simon talked about, a lot of my peers are more open about their mental health. That's not to say that's the same for everyone. I think there's more encouragement from people to speak out, so that's why there might be an increase in demand. There's also the increase in pressure of social media that has really taken a hit on young people, such as TikTok and Instagram, and all those are factors. There's sort of a dual message behind those. On those platforms there's a lot of calls that you can seek mental health, but at the same time it's also perpetuating a lot of standards that might lead to a lot of mental health problems.

**The Hon. SUSAN CARTER:** That's really interesting. If we were looking at shaping recommendations, should we be looking at recommendations that might shape or limit the way social media can be used if it's a harmful influence?

**SIMON DODD:** I'm sure Annie's got some thoughts on that. I think social media is a complicated beast, that it absolutely provides benefits to young people and forms of connection and supports. Of course, it's an avenue for distress and there's well-documented multiple concerns around bullying and access to people after hours. One of the main differences between now and 15 years ago is that if there were problems at school, those problems often follow a young person home. So that makes it very difficult to get any relief from that.

**ANNIE HONG:** I completely echo what you mentioned about the benefits of social media. From my perspective, people need to understand boundaries related to social media use and know how to manage and when to shut off from that platform. I think a lot of people subconsciously turn on social media as the first thing. Often you don't really feel the impacts of it until you've hit sort of a breaking, in a way, where you think, "Perhaps I should limit my use." But perhaps if there was more education around that platform as well as ways to manage it, that would be quite helpful.

**The Hon. SUSAN CARTER:** So an education campaign rather than a set of regulations, perhaps?

**ANNIE HONG:** I think it's difficult to regulate the space, and it's perhaps easier to make informed choices for young people about when they can best manage the use of social media for themselves.

**The Hon. SUSAN CARTER:** I notice in your submission that there's quite a lot of reference to drug and alcohol. I just wondered the extent to which drug and alcohol feeds into mental health issues for young people, or the extent to which it's self-medication of undiagnosed mental health issues. Do you have any commentary around the interaction between drug use and mental health issues?

**SIMON DODD:** Substance use and alcohol and other drug use is a complex area. Certainly some young people use it to manage the level of distress. It rarely exists in isolation, and it regularly coexists with either an emerging or an existing mental health difficulty. Does it lead to mental health difficulties? That's one of the questions that we're asked, but certainly it usually exists co-occurring.

**The Hon. SUSAN CARTER:** You would perhaps recommend, or it would be appropriate for us to think about, if a young person is in contact with the police because of drug possession it might be appropriate for an automatic mental health referral for investigation?

**SIMON DODD:** That sounds like a great idea, but the detail would really need to be explored to see whether it would work. Certainly there's lots of evidence of the benefits of diversion programs. As I said, substance use is complex. People use substances for different reasons.

**The Hon. SUSAN CARTER:** But wouldn't a mental health examination be part of a typical drug diversion?

**SIMON DODD:** It absolutely could be, yes.

**The Hon. SUSAN CARTER:** You don't have any experience with drug diversion programs or mental health and AOD interaction?

**SIMON DODD:** Headspace is a holistic program and has four core streams: mental health, alcohol and other drugs, work and study, and physical and sexual health. Our services absolutely have an ability to support young people with AOD services. The reason why they're bundled together, those four core streams, is because young people present how they present and we have an obligation to provide the services that they require. Most people who come to headspace centres come for mental health difficulties. Alcohol and other drug use is a much smaller percentage. I strongly think that a young person should have access to whichever services they require and that AOD services are well placed with mental health services and not in isolation. Isolated services and siloing of services is a problem for access.

**The Hon. SUSAN CARTER:** I guess that's what I was trying to explore, the relationship between the two and whether they're related or not.

**SIMON DODD:** Yes, I think that they can be related, but not necessarily. I think that each young person is different and their exposure to services should be related to what they need. But AOD services should be a part of that solution, as should be physical and sexual health, and work and study services.

**The Hon. SUSAN CARTER:** That's your model, isn't it?

**SIMON DODD:** Yes, that's exactly right. That's why the model exists as it does, and we stand by it.

**The Hon. EMILY SUVAAL:** Thank you both for appearing today. My first question is probably best directed to Mr Dodd in your capacity. Given you're national framework in governance, your licensing is done at the national level and then you've got funding through the local PHNs, how do you manage those competing interests—some would say even a conflict—at the local level in terms of what you're able to implement?

**SIMON DODD:** Could you—

**The Hon. EMILY SUVAAL:** You've got a national framework and governance structure but you're funded through local PHNs, and local PHNs may have their own recommendations about how you deliver care. How do you manage that conflict?

**SIMON DODD:** The PHNs are funded by Federal Government for the commissioning of headspace centres and the funding of them. Our role is in terms of the fidelity of the headspace model. We do that in a variety of ways. We have a model fidelity framework that we undertake each three years for every centre, which is a very involved program to ensure that the centres are aligned to our structure. We also have an escalation process from centres to the national office around critical incidents. However, the clinical governance and the day-to-day governance sits with the lead agencies. They report to the primary health networks in terms of their activities.

How do we implement things? We implement things usually through funding opportunities. For example, the New South Wales recovery program that was implemented following the COVID funding was an expression of interest offered to centres that were eligible. The eligibility was related to their maturity as a centre. Following this expression of interest, there was an allocation of funds for them to allow them to do the activity and then that was contracted and we ensured that they were compliant with the activity deliverables through the contracting process. That's an example of one of the processes where we hold the governance, whereas if the primary health networks have funding through the Federal Government for other activities, then that sits with the primary health network in terms of their governance.

**The Hon. EMILY SUVAAL:** My understanding is the primary health networks fund centres, which is an intentional decision to meet that sort of local need, and then that funding is obviously disbursed to the lead agencies. What some people may not know is that obviously you've got different lead agencies delivering different headspaces. How do you ensure the delivery of care is of a standard if you've got different lead agencies? You've got several levels within that.

**SIMON DODD:** That's what the fidelity model is aimed at doing. It is very challenging because there's a responsibility—it's multiple layers. The commissioning process includes headspace national, so there's an opportunity to ensure that the lead agency is an appropriate lead agency to perform the tasks. There's heavy involvement from national office staff in assisting the lead agency to set up the program. There's a number of lead agencies with multiple centres, and obviously they're well placed to deliver services with the experience they've

had in delivering elsewhere. Then we have ongoing contact with them to ensure that they meet the minimum requirements for service delivery and service—

**The Hon. EMILY SUVAAL:** Understood. Given you've got the national framework, which is very clear is consistent across all headspace centres, and then you've got the PHNs at the next level and then you've got the lead agencies, how is it that we're making sure that what the PHNs are recommending to the lead agencies is in fact best practice, and what the community needs at that bottom level, when they've got to fit in with that framework at the top? Is there a conflict there, and how is that resolved?

**SIMON DODD:** I certainly think there's a challenge for the lead agencies, as the centre representatives, in having two masters. That's resolved through discussions with the primary health network and headspace national, but it is aligned with the Federal Government's guidance around the activities that are undertaken by the centres. But it is a challenge. It's absolutely a challenge, yes.

**The Hon. EMILY SUVAAL:** With the model fidelity framework that you mentioned and that sort of auditing measure that's in place, it's my understanding that there are several headspaces that struggle to pass that auditing system. Is that the case?

**SIMON DODD:** Centres are placed in a process whereby they may not yet meet the requirements, so there's a coaching and support process by which we endeavour to get the centre over the line in order to be able to meet the minimum requirements.

**The Hon. EMILY SUVAAL:** I might ask if you could provide on notice for the Committee, certainly for New South Wales, what those results are across New South Wales. I think that would be very interesting in terms of making sure we ensure the regional aspect in particular is met. I've got one or two last questions before I finish up. I'm mindful of time. I just wanted to confirm that all your centres are free of charge.

**SIMON DODD:** Effectively, yes. The centres we have are low or no cost. I'm not aware of any centre that doesn't bulk-bill when there's MBS funding.

**The Hon. EMILY SUVAAL:** Low or no cost?

**SIMON DODD:** That's right.

**The Hon. EMILY SUVAAL:** So there may be some that charge a fee?

**SIMON DODD:** That is part of our charter but, to my knowledge, there's no centre that charges a fee.

**The Hon. EMILY SUVAAL:** Are you happy to take it on notice? My understanding is that that's not the case. We'd be very interested to find out if there were centres that were now charging fees.

**SIMON DODD:** Yes. My understanding is that there are no centres, but I will take that on notice and find out.

**The Hon. EMILY SUVAAL:** Thank you. In terms of the existing rural headspaces that are open, are these an appropriate model and are these effective? It's my understanding, again, that some of these rural headspaces are only open a couple of days and are not sufficiently staffed.

**SIMON DODD:** A centre and a satellite and an outpost are different models. Satellites, which sit under the governance of a centre that's regionally connected, have the same lead agency nearly always. That has a minimum of three days a week open and must offer three of the four core streams, including mental health. That's a satellite, and they would be open three days a week. But all centres must be open five days a week. If they're not open, then that's a notification for a "please explain" process. I think there are 22 or 23 centres or services in non-metro areas out of the 45 in New South Wales. Across a large number of services, they vary in their capacity to deliver services, depending on—one of the main things all services in the sector are having to deal with is the mental health workforce. We really, really struggle to get staff—clinical staff and all staff—and that's the single biggest rate limiter on our ability to deliver service.

**The Hon. EMILY SUVAAL:** I have further questions but I'm mindful of time.

**The CHAIR:** I'll come back to you. I firstly want to acknowledge the extraordinary reputation of headspace to provide cultural safety for young people. That's no doubt informed by the fact you have a youth reference group; it's really wonderful to see you here today, Ms Hong. My question is about continuity of care. I understand that the core business of headspace, from a mental health perspective, is lower-acuity mental health presentations. We've heard from young people some of the challenges where they might have a known counsellor or support worker through a headspace who then is forced to refer them to another service when their condition becomes more serious, and they feel bounced around between services. I'm interested in what work either is being

done or needs to be done to better enable that continuity of care for a young person when a headspace might not have the full scope of services that they need within a centre.

**SIMON DODD:** I'm conscious that I'm answering a lot of the questions, Annie, so jump in any time. I think this talks to the so-called "missing middle", in some ways, where we have a higher level of complexity or severity than the original charter of headspace, which was mild to moderate early intervention. It's much more common to see moderate to somewhat severe than it was, and that's a significant difference. Also, in terms of how things worked 15 years ago when we started to now—the best practice is continuity of care, absolutely, in a multidisciplinary team, including a shared care process.

Where that includes tertiary services, where the therapy is delivered by headspace, where it's delivered through salaried staff—there are very few salaried staff in centres, as you'd know—then there's potentially greater capacity to hold that shared care. When it's held through MBS funding and through a mental healthcare plan, there's challenges in that system in terms of shared care. In some ways, there are complexities on how you can do that. But we absolutely acknowledge that shared care and continuity of care is best practice, and we endeavour to ensure that best practice occurs every occasion. I'm sorry. I don't know whether I answered your question, Chair.

**The CHAIR:** I think you spoke very well to some of the challenges. From the point of view of Parliament and making recommendations in this space, I'm interested in what needs to be done to potentially enable better continuity in those scenarios.

**SIMON DODD:** One of the things that the New South Wales recovery funding allowed us to do was to trial some work in centres that we've been wanting to for a long time around GP practice. GPs in headspace centres typically are seeing people who have a higher level of complexity and severity than the centre would normally be able to manage, in alignment with the therapy that they're receiving by the counsellors. Particularly when they have access to psychiatry through secondary consultation or consultation, they're able to hold a much higher level of severity.

About 10,000 occasions of service occurred through this 18-month period by GP and GP-supported services. That includes practice nurses and nurse practitioners in centres through the same funding. Although those occasions of service don't sound like many, it is equivalent to about three centres worth of services in a year. The level and the quality of those contacts are different. They're higher levels of complexity. In the same program, about 1,000 occasions of service were held by psychiatrists. Obviously the services that they're offering have a much higher level of complexity and severity than we would normally be able to manage in headspace centres.

I speak to this because that allows for continuity of care in being able to hold someone in a headspace centre rather than referring to tertiary services. I think some of the bilateral funding, where LHDs are offering resources into headspace centres that's co-funded by the Federal and State Governments, is looking to try to emulate that. I think we could say we've had good success with those models, but the GP component isn't part of that bilateral funding, likely. It's certainly something that we would love to explore. We think GPs are essential to headspace services. But unfortunately it's very difficult, because they're primarily funded through MBS, to get them into centres beyond more than a day or so, or a week, in most centres. I think only nine of the 22 of our regional centres have GPs in them, for example.

**The CHAIR:** Just to clarify, I'm really interested in this work. I think it does sound like a useful model to embed GPs and psychiatrists into the service to enable that continuity. You said "recovery funding". Are you referring to the COVID-19 recovery funding?

**SIMON DODD:** Yes.

**The CHAIR:** So you were only able to properly embed GPs in headspace because of COVID funding?

**SIMON DODD:** What it allowed us to do was to fund the GPs in a salaried model. I think Dr Virgona spoke to this earlier in the proceedings. It's something we've been interested in doing, but it's very difficult to find that funding. This allowed us to trial that—and trial it successfully, I think.

**The CHAIR:** When did that funding run out or when does it run out?

**SIMON DODD:** At the moment, we're in discussions with the Government. At the moment, it finishes in June next year.

**The Hon. EMILY SUVAAL:** My question sort of leads into that, around the staffing component. You mentioned earlier having some challenges with attracting and retaining staff. Is it the case that that is more so felt in headspace? If so, why, and what suggestions do you have, particularly around your funding model? How are your staffing positions funded? Would it make sense or would it be more effective if you could attract people to permanent positions when you're competing with the private market and all those other things?

**SIMON DODD:** Yes, it would make a lot of sense to have ongoing salaried positions with multiple-year contracts, absolutely. There are challenges with getting private providers in headspace centres, as I said. That's not New South Wales; that's nationally. Our biggest competition is actually not private providers. It's actually the State Government services.

**The Hon. EMILY SUVAAL:** What is the difference between the salary and the arrangements between the two? At the moment, you can't provide a salary to your staff. It's just based on occasions of service.

**SIMON DODD:** We have some salaried staff in the centres. The model was originally structured to have some salaried staff, but the predominant therapy would be through private providers through MBS. As we have reduced a number of MBS providers in the network, then those delivery of therapy services has sat with the salaried staff.

**The CHAIR:** We have run out of time. Thank you so much again to both of you for making the time to give evidence today, and also for your detailed submission. The secretariat will be in touch with you with any questions on notice.

**(The witnesses withdrew.)**

**Ms NICOLA RABBITTE**, Wellbeing Nurse, Wellbeing and Health In-reach Nurse Coordinator Program, before the Committee via videoconference, affirmed and examined

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

**NICOLA RABBITTE:** Yes, please. First of all, I would also like to acknowledge the traditional owners of the lands on which we meet today and pay my respects to Elders past, present and emerging. Good afternoon Chair, Deputy Chair and Committee members. Thank you for the opportunity to speak to this mental health inquiry. I'm here today only in my capacity as a wellbeing nurse in Cooma. Working for Southern NSW Local Health District, I am part of a wider New South Wales wellbeing nurse in schools program. I can only speak to my experience working in southern LHD, and I will shorten my reference to this program to the "WHIN" program.

I began working in this program in 2018 as a nurse in schools pilot in Cooma. It was funded by Snowy Hydro initially, and then evaluated and funded by NSW Health from 2020. It expanded to six and now to 100 nurses across vulnerable communities in New South Wales. We work in an innovative partnership between the NSW Ministry of Health and the NSW Department of Education. The WHIN nurse does not sit alone but operates as part of a wellbeing team in school and works closely with school counsellors, school executive, wellbeing teachers, student support officers and school chaplains. As WHIN nurses, we're utilising a universally trusted relationship with children and young people. We have an advantage of developing relationships early and being present and available across longer periods. This is especially useful during periods of transition, including at the Kindy Start program, the transition from primary to secondary schools, and leaving secondary schools to work and study.

Nurses are making referrals and staying with their students to make sure the service met their expectations, and, if not, supporting alternative referrals. Advocacy and connecting our students is the biggest part of our role. Our engagement with community also assists vulnerable groups of students to access culturally safe care, including our First Nations, CALD, LGBTQIA+ and students with disability, often connecting them to lifelong support networks and groups. For the quarter of young Australians now experiencing psychological distress, support for mental as well as physical health in school is paramount. As a WHIN, I was initially surprised that mental health issues make up more than 70 per cent of my work.

Some of the key ways the WHIN nurses in my LHD work to improve student wellbeing are that they serve as a connection point between teachers, students, primary health care and allied healthcare services, improving the flow of referrals, appointments and follow-ups. An example of this is the WHIN in Eden is working with this week's award-winning new pilot model of care at the Eden high school wellbeing hub. The project known as the Djing.gi Gudjaagalali kids clinic has been running on the school grounds for the past 18 months. The project is a collective partnership with the school principal, Ms Viv Chelin, and Dr Corin Miller, and links students and their families with a GP in school on school grounds. The WHIN, allied health services, school counsellors, NGOs and oral health also operate from this building.

The WHIN is able to collect all of the students' assessments and refer to this GP in school, in a town where GP appointments are limited. I'm often coordinating referrals to external mental health providers in the primary health setting, including GP referrals to GP mental healthcare plans, attendance at GP appointments, and supporting GPs with information on who the referral needs to go to, spending time mapping and navigating who is actually available. Our role is much about the relationship, and also assists parents when they are managing a child's mental or physical illness. We support the families with children and young people with behaviour problems to access GPs and specialist diagnostic supports, and connect struggling families with financial brokerage and social support services as needed.

The WHIN nurses are agents for change for students and their families, promoting care and integration and addressing barriers to this care. We're mobilising more targeted, appropriate and coordinated care, building family engagement with both health and education systems, and achieving longer term gains. Our evaluation also identified that school-based nurses have a constant need to be responsive in their local context and the importance of clarity about the nurse's role to enable smooth collaboration and referrals. The expanded WHIN program is funded until June 2024, and the evaluation is due for completion in 2024.

**The Hon. BRONNIE TAYLOR:** Thank you so much for coming and doing that, Nikki. That's terrific. I'm in the park at Nimmitabel. It's great to see you online. I'm really happy for others to ask any questions they have, and I'm happy to follow on, because I'm really familiar with the program. Nikki, just to start with, congratulations on the recent award that you won with the Eden program at the big evening that was held. I think that's really exciting. Do you think that program that you've run with the GP down there has the potential to roll out across New South Wales, or with the assistance of the WHINs?

**NICOLA RABBITTE:** Thank you for the question. I think the pilot model looks transferable to other communities, and I'll be striving to try to build some relationships with the GP to pilot that in my community as well.

**The Hon. BRONNIE TAYLOR:** Fantastic. Nikki, seeing you were one of the first WHINs to start—and I know that you're here to speak about your particular community—could you just give the Committee an insight as to how the WHINs are going in what's a relatively new program across the State? Are they all able to support each other? Is it working, in your opinion, as had been intended? You said that you were surprised that over 70 per cent were mental health referrals. I was expecting that we'd get around that, but that is very high. How are you seeing that being worked out around the State in terms of integration into existing models, say, with counsellors and things in schools?

**NICOLA RABBITTE:** I think that's a great question. It continues to be a surprise for me. When I first started in this position, I thought that much of my role would be quite broad. It was a really big surprise that 70 per cent of my work, or more, is around mental health issues. Across the State, we have some Wellbeing Nurse Network meetings; Southerners attach to Murrumbidgee and Far West LHDs in our network meeting. I feel that many of the nurses have similar experiences to me. I can't comment on their work without seeing their statistics.

**The Hon. BRONNIE TAYLOR:** I'm happy to let others ask questions and then I can come back again.

**The Hon. EMILY SUVAAL:** Thank you so much, Ms Rabbitte, for appearing today. Noting your experience with the scheme—it's wonderful to hear you've been in the role for such time—what has your relationship been like with the Department of Education and your local principals? How have things worked at that level between the two agencies? Is that the case for all WHIN nurses or are there some difficulties there that need to be overcome?

**NICOLA RABBITTE:** I can only comment within my own capacity in my schools. I'm not overseeing the whole project. Certainly it's such an innovative project of health and education working together and two quite different cultures working together. That definitely required some initial working out of how we each work. What was really helpful was that this project has a very supportive clinical governance. We have a meeting once a term between the school executive and Health. Most of the issues that come up can be ironed out at that point. Building relationships with the school executive in the initial stages was really the most important part of the success of this project. Certainly my relationships with the school executive in my schools is fantastic.

**The Hon. EMILY SUVAAL:** Just to clarify, what is your role currently graded as?

**NICOLA RABBITTE:** I'm a clinical nurse specialist 2. So I come as a registered nurse and a registered midwife. I have expertise in sexual health, mental health, and drug and alcohol. I think most of the nurses across the State that are working within the wellbeing nurse role come from quite varied backgrounds but, certainly at a clinical nurse specialist 2 level.

**The Hon. EMILY SUVAAL:** That pre-empted my next question about the nurses that are working in their roles across the State. Are they people that are working within their scope of practice or, indeed, to the scope of their practice, acknowledging you've obviously got some fairly significant skills, given what you've just listed?

**NICOLA RABBITTE:** I think we all work within our scope of practice. The role in schools is quite different to our role in Health. We have operational guidelines to support us working within that scope of practice. It's not a clinical role; it's more a care-navigating role, but without my previous skills it would be quite difficult to triage young people for the correct service.

**The Hon. EMILY SUVAAL:** You mentioned a care navigator role. Is it the sort of role that could be done by a general mental health trained clinician or a social worker? I'm just thinking of other disciplines that have got similar care navigation skills.

**NICOLA RABBITTE:** I think it's really interesting that you say that, and it's a great question. I think my schools quite quickly decided that a nurse filter with a nurse perspective was quite important in this role. We see some health issues in young people that are quite unexpected. Whilst I speak about mental health generally, there are many young people with mental health issues that also have a parallel physical health issue. As a nurse, we've been able to look at those young people, correct the physical health issue by a great referral to a GP and then often improve their mental health.

**The Hon. EMILY SUVAAL:** That's really helpful. In terms of the referrals, given that you mentioned earlier that 70 per cent of people you're dealing with have mental health concerns, how do you go with referral pathways and referring on to services? Are they there? What are the challenges that are there, if any?

**NICOLA RABBITTE:** There are many challenges in a rural area. I'll speak to my rural area, around finding specialty services to support young people. Taking some time to become aware of what's available in your network and your community is really important to the success of this job, and working really closely with primary health care, especially GPs, is one of the most important. My relationships with GPs are very important to the success of this role. As wellbeing nurses, we've learnt how to become very creative. Often when there's not someone available in that role we are creatively looking for virtual referrals for other services, including NGOs that may be offering quite a similar role, but we're also advocating for our students to get the very best care. Certainly these days we're using more virtual referrals to specialists, including psychiatrists and paediatricians online, which is something I had never done before.

**The Hon. SUSAN CARTER:** Thank you very much for being here, Ms Rabbitte. I just wanted to follow on from the questions of my colleagues in relation to some of the challenges of whether there's adequate support, outside of the school, for accessing resources in rural communities. I'm also wondering—and perhaps the program is too new—are there issues for handovers? When a student is leaving school at year 10 or year 12, or at some other point, is there a pathway to make sure that they're handed over to somebody who can help them to navigate their way through their particular mental health needs and to access appropriate services?

**NICOLA RABBITTE:** That's a great question. In New South Wales, working in Cooma, you have great difficulties finding some psychiatrists to refer to, but we are filling that gap with virtual care. Periods of transition are the most important part of a young person's life and much of the work of the school wellbeing team, including the school counsellor, is finding young people a service to work with them into the future, especially leaving school.

**The Hon. SUSAN CARTER:** We have discussed a lot in this inquiry people who have mental health issues the importance of having somebody who can help them navigate through the system and help them perhaps understand their own issues and connect them with the right people. I realise you're much more involved in primary care than simply navigating, but it seems that you also provide a really important role helping students navigate their way through the whole of the mental health and health system. Would you comment on that?

**NICOLA RABBITTE:** Yes. Linking young people with a GP for life—if our first appointment with a GP is not great, then I'll keep advocating until we find someone who that young person has a relationship with. I'm also looking at care navigation services, especially in mental health. It could be an NGO providing a Happy Healthy Minds program. It could be other long-term mental health programs, but helping young people become aware of what's actually in our community, and advocating and helping them attend. It could be headspace. It could be a step-up step-down arrangement between an acute mental health service, such as child adolescent mental health, and then step down to headspace. Much of my work is around just making sure that those relationships work. A young person may go to see a psychologist at headspace or a private psychologist and not make a great connection. So my relationship is about checking in; not opening the client and closing the client but staying with that client for a longer period of time just to make sure that the referral was successful.

**The CHAIR:** I will come back to Mrs Taylor.

**The Hon. BRONNIE TAYLOR:** Did you have any questions?

**The CHAIR:** I came in with loads of questions about referral pathways that have all been answered beautifully in both the opening statement and all of the other questions. I'm delighted to hear how involved the relationship with the GP is. I'm happy to pass back to you, Mrs Taylor.

**The Hon. BRONNIE TAYLOR:** No bias, but the GPs and the nurses. The Hon. Emily Suvaal and I have to keep Dr Cohn in line, Nicola, don't you worry. I'm familiar with it, but I'd like you to explain—going on a bit from the Hon. Emily Suvaal's question—the importance of having a nurse in those roles and how you've shaped those roles in terms of what you're doing. You said you do a lot of navigating and, when we put care navigators into hospital, that just wouldn't work in this situation. Can you explain to us why it's so important to have an RN in these positions?

**NICOLA RABBITTE:** I have many scenarios of the success of working with young people where having a nurse lens was quite useful. In our wellbeing team meeting, we discuss students on a weekly basis and work out who's best placed to work with a young person when they're referred to our learning support team. Sometimes the very first point of referral is the school counsellor but I will hear some things about the student that makes me think they may have a physical health problem so we will work really tightly together. The school counsellors and I work very well together—all my secondary and primary schools—to work out what's going on with a young person. My school counsellors will often provide examples of times where they had been seeing a young person for anxiety or some other mental health issue and hadn't really worked out what the core of that issue is. So sometimes a referral to me brings about a GP appointment, some blood tests, some anaemia diagnosis

or some other diagnosis. It may have been that I looked at that young person and saw some physical health issues and then together we concentrate on that issue and improve that young person's mental health.

**The Hon. BRONNIE TAYLOR:** Thank you, that really explains it well. The other thing I want to ask you to reiterate for the Committee, because it's something that I hadn't thought about when all the pilots started because we hadn't envisaged it carrying through primary and secondary—can you elaborate to the Committee the importance of maybe when you see someone at, say, Cooma North primary, when you're able to follow them up in that first year of high school and how important having you working across those different sites has been?

**NICOLA RABBITTE:** I can think of a young person I'm currently working with that fits into that scenario. I have a young person who I met at primary school in year 5. She had some issues around school refusal. It was quite obvious there were some relationship issues and some bullying issues. The school proactively was working to sort that out. In year 7 she decided to go to a private school that was also locally accessed by her and her family. In year 8 she arrived at my public secondary school with her mum for an enrolment interview. I noticed her in the corridor and remembered our relationship and remembered her anxiety. I chatted to her mum about anxiety when she was at primary school, and her mum felt that she'd probably grow out of anxiety. After the meeting the principal realised that I had recognised the student and we had a little bit of a chat about how we could best support that student at high school.

I then called her mum and introduced myself. She remembered me from primary school. We worked on some plans to help the student be successful at high school. Quite soon that student started some school refusal so I checked in with her mum. We sent her to a GP, got a GP mental healthcare plan and she started seeing an external psychologist once a week, which was quite useful. We also connected her with a school counsellor, gave her some other check-in adjustments at school and she's eventually started some medication for her very treatable anxiety. I think her attendance this term was 91 per cent and previously it had been 13 per cent or not at all. I really have enjoyed a relationship over a longer period of time with that family. Recently, as part of her evaluation, I asked that mum to fill out a survey just around her experience of working with a wellbeing nurse. I have no idea whether it was positive or negative, but I presume positive.

**The Hon. BRONNIE TAYLOR:** If you see someone in primary school, like you have explained with this person, how often does that happen where they'll actually re-connect with you a year later or two years later because they feel safe within that space of working with the WHINs? Are we seeing that happening across the board?

**NICOLA RABBITTE:** This happens a lot. I feel like the luckiest person in a school because I'm the only person in school that goes to a primary school once a week and then is in a high school three times a week. I have this very lucky position of knowing these children through primary school and into high school. I definitely manage to leverage that relationship but then handhold some referrals to other services including the school counsellor and the student support officer, and we all work together around that relationship.

**The Hon. EMILY SUVAAL:** The program's got quite a broad focus—the WHIN—but it is evident there's quite a heavy focus on mental health throughout the program, as is evidenced by what we're discussing. CNS2s, it's fair to say, are very experienced senior nurses. Are there enough appropriately mental health credentialed nurses across the State?

**NICOLA RABBITTE:** That's a hard question. I think there's definitely not enough credentialed mental health nurses across the State. That seems to be the reality of health. I think that we're filling some gaps in the health service at an earlier intervention point. Certainly having a broad experience—not everyone in our WHIN team has experience in mental health—but also building a relationship seems to be the most important part of our work.

**The Hon. EMILY SUVAAL:** You mentioned not everyone in the WHIN team has experience with mental health. Are all the WHIN positions filled, do you know?

**NICOLA RABBITTE:** I spoke to the ministry yesterday and I think we have 96 out of the 100 WHINs filled at this time. There's some WHINs on maternity leave. Not everybody is mental health trained or with a mental health background. We have quite broad backgrounds across the State because we're not providing the clinical care—all nurses are trained to provide some kind of triage when it comes to mental health symptoms. We're providing a service that refers children and young people to a mental health service. We're not holding that young person or providing those therapies. We're referring to the school counsellor, private psychologists and GPs—a lot of referrals to GPs. Luckily I have some GPs that have great skills in mental health.

**The Hon. EMILY SUVAAL:** That would be a benefit, which pre-empts my next question about the referrals and how effective you're finding that. Is it the case that you can refer someone locally and then they have

a relatively good result? Or are you seeing these people multiple times because the services aren't sufficient or aren't appropriate?

**NICOLA RABBITTE:** Certainly there's a mix of both. I often see young people more times than I think I am going to see them. Certainly I'm not going to start seeing a young person and then stop seeing them once I made a referral because I don't know that that referral is going to be successful. There's many young people that the first person I've referred them to is not that successful. Luckily I'm able to check back in with that young person and work that out and then make another referral. There are wait lists, but holding that young person within my WHIN program is really important to that young person's success of feeling like someone's working with them.

**The Hon. EMILY SUVAAL:** Is there any data, do you know, about how long people are being held in those WHIN programs? I'm just thinking of the access issues, if there are any.

**NICOLA RABBITTE:** I can take that question on notice, but we have the Wellbeing and Health In-reach Nurse Coordinator Program pilot evaluation, with the next evaluation coming in June next year.

**The CHAIR:** Thank you so much for making the time to provide evidence today. If there are questions on notice, the secretariat will be in touch with you.

**(The witness withdrew.)**

**Ms CATHERINE LOUREY**, Commissioner, Mental Health Commission of New South Wales, sworn and examined

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

**CATHERINE LOUREY:** Yes, thank you. Thank you very much for inviting me to be here today. The topic of your inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales is so very important, especially when we are looking at how our communities are experiencing the impacts from COVID, bushfires, floods and the many things that have really impacted upon psychological wellbeing and mental health over this last period.

I also would like to pay respects to the Gadigal people of the Eora nation, upon whose land we are all meeting and discussing today. I especially want to acknowledge people with lived experience of mental health issues and caring, and especially of those who have lived experience of trauma and suicidality. Of course, I think that is so key to the discussions that the Committee has been holding about how to understand ways that we can better improve service delivery to improve the outcomes and of course the lives of people who live with mental health issues.

The Mental Health Commission's role is to monitor, review and advocate for mental health reform. In New South Wales we are coming to the end of the 10-year Living Well strategy. As we reflect upon that, we really have seen that, whilst there have been great efforts in improving mental health services in the community, what we are seeing is that there are still gaps that exist and that there are inequities across regions and across vulnerable communities and communities of special need. For us this means that there are always ongoing efforts to be made. As we move forward we really will need to consider how we can really embed a whole-of-government response that strengthens community recovery, embeds lived experience and invests in evidence-based community supports.

Whilst we look backwards for a moment, I think one of the key issues for mental health and community mental health is around comparative levels of funding. Whilst we have had continuous investment in community-based supports, that has not been as invested to the level of inpatient and clinical hospital-based services. In New South Wales, according to the Australian Institute of Health and Welfare, in 2021 New South Wales had the second lowest per capita expenditure on community mental health in Australia. Community mental health spend per capita in New South Wales increased by only $2.23 in the past decade to $88.83. This is below the per capita increases for the Northern Territory, which was just over $28; in Victoria, almost $17; and in Queensland that was $5.

New South Wales per capita funding on community mental health for 2021, overall, was the second lowest nationally at $89, which was just ahead of Tasmania at $79 and well below the Northern Territory at $156. Meanwhile, the national average was $113. New South Wales per capita spend has been consistently below the national average for the last decade. The commission would like to see an increase in the proportion of expenditure, at a minimum, in line with the national average. This has also been advocated for in our recent submission to the Special Commission of Inquiry into Healthcare Funding.

In terms of equity and accessibility, this inequitable distribution of resources—whether that be staffing, services or funding—perpetuates a model that leads to inequitable outcomes and, moreover, the inequitable opportunity to live well with a mental health condition. I understand the Committee has already heard on a number of important topics in proceeding hearings, and so I really would like to contribute and further any questions that may have also arisen from those for you. But of course one of the issues that has arisen has been the intersectionality that exists in mental health across all areas of life and for many diverse population groups. This has also been increasing attention to emergency services responses.

The commission has been appalled by the recent tragedies in New South Wales and acknowledges the efforts to provide more compassionate and humane care to prevent these occurrences. Collaborative efforts to develop a person-centred, safe and trauma-informed response are needed. Discussions that focus on supporting people at their most vulnerable, while acknowledging those who may be vulnerable to risk around them, is essential. But, of course, we want a system that has early response and support capacity for our community mental health teams to have assertive outreach teams and to be resourced together, with services that can wrap around the person, whether that be psychological support, housing support or crisis care.

We have also continuously heard people calling for a system that lifts the burden of obstacles in reaching the right care at the right time. It's not only a matter of having the level of services improved but accessibility to those. Obstacles of wayfinding or navigation are continually raised by the community in consultation with the

commission. Equally, those consultations emphasise the importance of expanding the lived experience workforce across all levels of leadership, service design and delivery because of the known benefits that this has to offer. Peer workers connect and support with people and they can also help people navigate through the complex mental health system when they are most unwell or in need of support. The commission has looked at this ourselves, and we have piloted a navigation peer model that has had resounding impacts across those particular communities where we have trialled them. We hope that there will be good evidence for others to take up this approach.

The commission recommends better integration of care and that this not only occur between publicly funded mental and physical health services but also in partnership with the non-government private and community managed sector and, importantly, with local communities. To address these issues, we suggest a rigorous focus on collaborative commissioning, regional commissioning and establishing place-based partnerships as part of a cross-agency response and in less stigmatising community settings. This is necessary to bridge the gap of the missing middle, where people are told they are unwell enough for the support offered by primary care services and do not meet the arbitrary threshold to be able to access tertiary mental health services. This approach still focuses on what is provided, not what is needed by the person.

Across these and other areas, the commission is committed to working to elevate the voices of people with lived experience with mental health issues, their families and their carers and kin to improve equitable outcomes across our many different communities, across towns and cities and age groups, while acknowledging that cultural diversity and a range of experiences of mental ill health and suicidality can severely impact the lives of so many. I look forward to our discussion this afternoon. Thank you.

**The CHAIR:** Thank you very much and for your very detailed written submission on behalf of the commission. I've got a few of my own questions, starting with community treatment orders. I understand from your submission that the commission has recently undertaken a project to understand experiences of people affected by CTOs and that that's been substantially negative for a large number of people. You've made reference to the work being done in other jurisdictions to review the way that CTOs are used. I was hoping you could expand on that and what is some of the work that we should be considering that's happened elsewhere.

**CATHERINE LOUREY:** The way that community treatment orders are set up—and this may have been said by other people before me—is it's very hard to establish a therapeutic relationship when it is compulsory care, where it is coercive care. So because mental health does have a recovery focus in the way that it works, CTOs do bump up against that very much. Whilst we can have people who are said to be noncompliant, it actually can also be seen as expressing a choice about how they are treated, about how valuable that treatment is and also about understanding how people may feel about their human rights, because coercive care, whether it be seclusion at an inpatient unit or a compulsory treatment order, is also about an individual's human rights. In other jurisdictions—and I can provide more information to the Committee outside of this, if you wish—that is what they are looking to; how can we support an individual on their recovery journey by looking at what is most effective in that and utilising coercive practice less and engagement more?

We have looked at international literature where it also states that the difficulties around community treatment orders are not only about that coercive aspect but also an assumption that that is going to be the most effective intervention, when we know that people on community treatment orders have a range of issues that would impact not only their engagement with mental health services but also even attending and engaging with mental health services. So there we're talking about housing, employment or psychosocial services, their natural support networks that they may have in the community. When we start to look at the whole person, it's not just not engaging with the service and therefore they need compulsory treatment; it's about understanding how can we support the whole person before we get to that point.

**The CHAIR:** We've already received a large volume of evidence about the need to increase resourcing to community mental health services to provide additional support to people, whether they're on a CTO or not. I am interested in your view on whether you think we need to review the Mental Health Act.

**CATHERINE LOUREY:** That's a great question. My off-the-cuff answer, so to speak, would be yes. The yes is because we need to consider CTOs in the broader aspect of a person. If we were to do any review of the legislation, it would have to have the voice of lived experience in there. That's one of the projects that the commission is currently doing on CTOs. A lot of the research is very much about compliance, medication, and risk and safety. We want to investigate more and to engage with people who have been on community treatment orders to understand the broader impacts it has upon them. If we are about having trauma-informed services and trauma-informed approaches, then being on a compulsory order isn't necessarily very trauma informed. In our piece of work that we are going to be finalising next year, they are the perspectives that we want to bring.

In looking at any review of the legislation, it is imperative that the voices of people who are subject to that legislation, who are impacted by that legislation—and that includes families and carers—need to be part of

that. Contemporary legislation needs to understand how we evolve with models of care. We have seen so much innovation in many other areas in supporting people with mental health issues, whether it be having alternatives to emergency departments, that really go to where do we provide mental healthcare. It's not always in hospitals. It's not always through our legislation. What we want to understand better is how can we have a service framework that isn't reliant upon involuntary admissions or other coercive practices.

**The CHAIR:** Elsewhere in the submission you've mentioned the Mental Health Investment Decision Tool. Could you explain to us how that works?

**CATHERINE LOUREY:** Yes. Absolutely. In the Living Well in Focus mental health strategy that we released four years ago, this was one of the recommendations. I'll go back to a little bit of history to give you a bit of context. In mental health we can be very good at planning hospitals and planning community mental health services. We have a model called the National Mental Health Service Planning Framework that does that. It sets the standards that you would need for a hospital or the standards you would need for how many beds for young people, older people and supported accommodation. We know people don't live in a hospital; they live in the community. So we were really after how can we plan and allocate our resources most effectively that is about early intervention and prevention, and about supporting people whenever they become unwell to get the supports they need to keep them well or to have early enough intervention so that their illness doesn't progress to the point where they need inpatient care. Of course for some that's the most appropriate type of service and specialist care that they need.

Our model is a modelling tool, which means that you can put in the variables and have those calculated. It's all about community-based care, which is different from community mental health. So it's not a clinical model. It looks at what are we doing in education, in housing, online services and peer-led services. Because we don't plan those. We know that there might be evidence and emerging evidence but we don't look at them as a suite of services that support people to be well. If we can plan and coordinate our resources and investment in those areas—and this is what our model has shown us—you have less presentations to emergency departments and less need, therefore, for inpatient beds. It also means that that frees up beds for the people who are most in need of specialist inpatient care.

You also find that people's psychological health improves. So whilst they may be in the severe category of mental health illness, that will go down to medium and medium to low. It really is about supporting people early and giving them those supports in the community. It's also about helping our young people and we have, as I said, the interventions in schools and education. As you probably know, the majority of mental health issues arise before someone's 16, then the remainder of the impact is normally then up to around age 24 or 25. It is really important to understand how we set up our young people to lead mentally healthy lives, but that when they become unwell we are able to get in early to support them in their environment and support their families.

That tool has been shared with NSW Treasury. It's been shared with Health, Education and other departments. We've shown it to the Commonwealth Government as well. We have to be smarter with our money. We have to get the better outcomes not only for the bottom line of the budget for New South Wales but also for people. It's always about people for the commission. We always know the results that we are after are the results that people are after, which is, "When I become well, I get a service that I can access," or, "When my son is in high school and he has his first episode of psychosis, I know where to go. My school understands him." These are the things that are important. In our model we are really looking at how can we have a cohesive strategy about community-based care that can sit alongside our clinical services so that we have a person-centred approach, because people don't live in hospitals; they live in communities. It is their communities of support around them that will sustain their mental health recovery journey.

**The Hon. EMILY SUVAAL:** Thanks so much for appearing today. It's wonderful to have you here. In terms of the role of the commission, I wondered if you could talk through your view around the function of the commission and what this also has tangibly led to in terms of improvements in the sector.

**CATHERINE LOUREY:** Sorry, what was the last point?

**The Hon. EMILY SUVAAL:** What has it tangibly led to in terms of sector improvements, the role of the commission?

**CATHERINE LOUREY:** The role of the commission is to improve the mental health and wellbeing of the community of New South Wales. We do that through three things: advocacy, undertaking reviews, and monitoring and reporting. The commission holds no budget. We don't fund services. We don't mandate policy. That is up to each individual agency. In our role what we do is provide frameworks, as we did with the suicide prevention framework Shifting the Landscape, which is there not only to provide a statewide strategic approach but also to guide how each agency can then interpret and develop their own suicide prevention strategy.

For example, when the first framework was released six years ago, it was accompanied by about $80 million worth of investment that led to Towards Zero Suicides. Using that as an example, through that work of the commission we have now got a regular suicide monitoring system, which New South Wales did not have before. We had a coordinated program which was called Towards Zero Suicides that did focus on education, training, standing up new services such as safe places, alternatives to EDs, and supporting peer-led initiatives as well as establishing community collaboratives. Using that as the example, that would be one of the tangible results.

**The Hon. EMILY SUVAAL:** I suppose given it's a framework and there's no requirement to implement it, I suppose that's one potential obstacle, but then I suppose the other things that we've heard in other submissions and in hearings that we've held is about the level of distress that exists and is increasing within the community. If, in fact, it is the role of the commission to ensure that mental health advocacy as you say, what is it that is not working as well as it could be in ensuring that those levels of distress are lower?

**CATHERINE LOUREY:** I'll just go back to the suicide prevention example. Our reports also go through Cabinet, and so I think that does give a level of endorsement to implementation of the frameworks, and there also is a Mental Health Taskforce which is chaired by the Health secretary that has all of the agencies, human services and other associated agencies that sit on that. For example, the suicide prevention framework goes through that. Our reports on progress of implementing Living Well in Focus go through that committee. We do engage very much at that whole-of-government, cross-government level to not only discuss how engaged other agencies are but also what they are undertaking.

For example, we have just completed the midyear progress report on implementation of Living Well in Focus, which will be published shortly, and there we really identify not only what each of the agencies are doing but our role is also to hold up a mirror to them to where they need to do further effort so that it is very clear about where, in regard to Living Well in Focus, work needs to be done but also to be very clear about the expectation that, for example, there's only two years left in that strategy so this is the time that we need to focus. We're doing the same with our suicide prevention framework, Shifting the Landscape for Suicide Prevention, where we are having reports in years one, three and five that do the same, that we ask agencies where they are going because if we—

**The Hon. EMILY SUVAAL:** I'm just trying to understand whether holding a mirror up is sufficient to ensure that those goals are met.

**CATHERINE LOUREY:** Yes.

**The Hon. EMILY SUVAAL:** We've heard other evidence about the Living Well strategy and framework, and indeed this is now—is it the second iteration of the plan?

**CATHERINE LOUREY:** Yes.

**The Hon. EMILY SUVAAL:** But there are still things in that initial strategy which would work well in merit but that have not been implemented.

**CATHERINE LOUREY:** I guess there are two things there. One of the recommendations out of Living Well in 2014 was that both Morisset and Macquarie, those freestanding hospitals, were to have their services transferred to the community because it was really focused on standalone psychiatric hospitals. One of those hospitals is progressing towards that, and that's Morisset, but the other standalone hospitals—and I think mostly now Macquarie Hospital—have not been progressed in that way. I agree, that's one where we haven't but that is also one where we continue to prosecute that case with the ministry and the ministry very much understand that it's about having contemporary models of care where people can have the best type of care.

For example, if I use Macquarie Hospital where there is an acute inpatient unit, that is a freestanding acute inpatient unit. We know the high levels of comorbidity between physical health and mental health, and you're on a site where there are no physical health services and supports for people, there's no imaging, there's no pathology. A lot of it is about quality of care and contemporary practices. But, yes, not every point—Living Well had 141 recommendations. Living Well in Focus had 24, so our current monitoring and reporting is on those 24. Some of those other issues also have been overtaken. They were written 10 years ago, so they have been overtaken by other events. But we have had a lot of success. Under Living Well, for example, we've now got the Pathways to Community Living Initiative, and that is for people who are in those large institutions sometimes for decades. Those things have really made a tangible difference to those families and those people.

**The Hon. EMILY SUVAAL:** Yes, absolutely, and we have heard evidence about the merits certainly of HASI and PCLI. My next question is around the Community Treatment Orders that my colleague touched on earlier, and we know that the instances of those have been increasing. We had earlier evidence from the Mental

Health Review Tribunal around their record keeping and the fact that this wasn't digitised. What has the commission done to work with the tribunal in this space, if anything?

**CATHERINE LOUREY:** When the commission was first established we entered into an agreement with the tribunal to undertake some research to then discover that they did have paper records, so actually as part of that project we did fund them to digitise some of their records. That is an ongoing issue, though, and I think one that needs to be done at that broader systems level of funding and resourcing for a whole range of reasons, not only for research to understand what's happening but also it's about an accountability mechanism and transparency. In mental health, transparency and accountability are key. That's why the commission publishes our reports. Previously some of the reports that we wrote because they would go to Cabinet they would be Cabinet in confidence, but now we have arrangements where we can table those.

This is the other thing about having that accountability back to the community and especially in an area like the mental health tribunal that deals with so many different cases of complexity but also to understand that, whether they be civilian cases or forensic cases, if our goal for the commission—but I think it's the goal for our mental health system—is to support people to live well in the community on their own terms and to have the services and supports that they need when they become unwell, then the tribunal is a key player in that. More broadly, the way that the tribunal's information and data can be shared so that we can have those upstream interventions in place so that people do get the care before they come into contact with the criminal justice system and that they do get diverted away from the courts system. It's a large area, but I would say it's important because their clients are the most vulnerable in our community.

**The Hon. EMILY SUVAAL:** Just to draw a line under it, when was the commission established? It's probably in your submission.

**CATHERINE LOUREY:** In 2012.

**The Hon. EMILY SUVAAL:** You started working with the review tribunal in 2012—

**CATHERINE LOUREY:** It was 2012, 2013—something like that. I wasn't there at the time but—

**The Hon. EMILY SUVAAL:** Ten years down the track it still hasn't been done.

**The Hon. SUSAN CARTER:** Thank you for being here today. My question follows directly on. Thank you for that date. I wondered if you could discuss what's changed over the last 13 years of your operation?

**CATHERINE LOUREY:** In the sector?

**The Hon. SUSAN CARTER:** In the needs that are being addressed and in the ways in which they have been addressed.

**CATHERINE LOUREY:** Over the last 10 years what we've seen is increasing rates in psychological distress. But most of what we've seen, I would say, is not only the increased rates of psychological distress; we have seen increasing presentations to emergency departments, demand for inpatient care. We've also seen that, though, across our GP practices, where mental health is now the leading reason why people attend a GP. What we're seeing also, more latterly, is the compounding impact of experiencing numerous adverse events, and I think that in one sense COVID did bring together a whole-of-government approach in understanding that. But I think the big challenge that has really emerged is how do we understand distress, which is different from—

**The Hon. SUSAN CARTER:** Can I just stop you?

**CATHERINE LOUREY:** Yes, of course.

**The Hon. SUSAN CARTER:** Something I would like to explore is if we've been working at this in one way for 10, 11, 12 years and things are getting worse, is that an indicator that we should be thinking about doing things very differently?

**CATHERINE LOUREY:** Yes, is the short answer, and the ways of different working are about bringing people with lived experience into those services to have their voice as part of the shape, and we have seen the increase in the number of peer workers, for example, across the system. But, of course, in mental health early intervention prevention also sits with our primary health networks and it does sit with our GPs, so it is very much about how we also need to explore how to work differently with those. We have great examples of integrated care models, where you will have a GP, a practice mental health nurse, a psychiatrist and a peer worker. And we know that those models work really well. Because not only is the GP then supported by—

**The Hon. SUSAN CARTER:** Could you tell me some examples of geographically where those models exist?

**CATHERINE LOUREY:** I can provide that after the meeting.

**The Hon. SUSAN CARTER:** That would be wonderful, thank you.

**CATHERINE LOUREY:** I visited a couple of them and what you find is that the GP feels supported in managing mental health clients, because it isn't always their area of expertise. They do know that they've got a mental health nurse, a peer worker and a psychiatrist there, but it also means that the client can also, in between visits to the GP, have that specialist support. As I was saying earlier, it's about holistic care. In one of the integrated care centres that I visited, you've got the peer worker taking the person to the dentist. They're going to other health supports, which is really important.

**The Hon. SUSAN CARTER:** I think that ties into your recommendation in relation to employing peer navigators as way finders.

**CATHERINE LOUREY:** Yes.

**The Hon. SUSAN CARTER:** What would this look like? This looks like somebody who accompanies a mentally ill person through all of their health journeys? Or what does that look like?

**CATHERINE LOUREY:** You're just about spot on. But it's not only about their mental health journey; it's about what they need in their life. It could be about housing. It might be going to put your name down on a public housing waiting list. It really is about what supports does that person need to get to where they want to go to. So it can be absolutely through their mental health journey and those services, but it can also be to those other parts of their life that they need. And stable housing is fundamental to good mental health, for example.

**The Hon. SUSAN CARTER:** Does the fact that we need to employ navigators to help people work their way through health and government systems indicate system deficiencies or does that indicate that people with mental health challenges have particular needs?

**CATHERINE LOUREY:** I think it's a mix. The mental health system, as it is, is a very complex system. You've got private, you've got public—

**The Hon. SUSAN CARTER:** What would be your recommendations, given your 10-plus years of experience with the commission, of how it can be made more person-centred and accessible to those who are ill?

**CATHERINE LOUREY:** The way to make it more person-centred is to have collaborative planning and collaborative funding. The earlier question about the planning tool that I was talking about—it's no use having an intervention for someone's mental health if they're being discharged to homelessness or if they are going home and they have no natural support network. So it's about integrated care planning. It's about having an assertive outreach team and follow-up. It's about the person having their own natural supports, and it's about having compassionate, trauma-informed care. Because what we also find is that people will not reach out if they feel they're going to be treated with stigma or discrimination, or if they were traumatised the last time that they were, say, in an inpatient unit. It's about culture, it's about integration and it's about finding a way where we can stop thinking about silos and what we're providing, and about understanding how we can have that ease of access points.

**The Hon. SUSAN CARTER:** And that's the work that you've been engaged in—breaking down those silos?

**CATHERINE LOUREY:** That's the work that we do. Because we don't fund services—but I was talking earlier about a pilot that we did on peer navigation. So we will invest in areas that we think need to be highlighted, and then that provides evidence and a showcase to other agencies. In fact, we funded two peer pilots in Western NSW Local Health District with two Aboriginal peer workers, and they were so successful the LHD now wants to roll that out further. I think it's also about understanding that you can have a top-down approach and a bottom-up approach as well. Because the other complexity in all of this is that every community is different and every community has their own different needs. That's why when I talk about regional planning it really is about what works for that region, because what will work in Penrith won't work in Orange, for example.

**The Hon. SUSAN CARTER:** In terms of the assertive care that you discussed, is there a tension between assertive care and patient autonomy? If there is, how do we resolve that?

**CATHERINE LOUREY:** Assertive care is really about reaching out to people and checking in with them. It's not about surveillance.

**The Hon. SUSAN CARTER:** But if that patient doesn't want to be checked in with, where is the tension between assertive care and autonomy?

**CATHERINE LOUREY:** I totally understand your point. It's not about surveillance per se. It's not about surveillance—I shouldn't even say "per se". It's not about surveillance and checking in on people; it is really checking to see that—

**The Hon. SUSAN CARTER:** But if the person with mental illness doesn't understand that nuance, how do we deliver assertive care, which I think is a very good model, in a way in which the ill person feels supported rather than checked in on?

**CATHERINE LOUREY:** That all comes down to how we do our discharge planning—so if we are talking to people around what they like, how they want to have their services planned—and it also works the other way around. You can have an advance notice about "If my mental health does deteriorate, this is how I would like you to engage with me." It is very much about how we have those conversations. Because you are absolutely right, and it goes back to the point with the CTOs: If people feel that they're being coerced into treatment or coerced to do things, then that is just not good for their mental health at all. It is about having their participation, engagement and listening to their needs. With assertive outreach, it really is about how to support that person in the best way that they need. It's not about saying, "Here's the five steps that we're going to do and you're going to go through all of them."

**The Hon. SUSAN CARTER:** And you think peer workers should be trained in assertive care?

**CATHERINE LOUREY:** The commission very much supports multidisciplinary teams because we do understand that you need psychologists, social workers, peer workers. You do need allied health workers and you do need clinicians. But peer workers can relate to and support people in such a different way because their journey can be very similar. I think it also models hope, because hope is a very important thing in mental health, when you're having your worst day, to know there is hope and that there will be a better day. But also that there is someone who is looking out for you. That's why we've found that over the last few decades, when we have had peer support or other services like there used to be—FAMs and Partners in Recovery—all those services were supported because they were one on one and the individual person could elect how they engaged with those services and supports.

**The Hon. SUSAN CARTER:** Can I ask a practical question in relation to one of your recommendations? You indicate that we should scale up the peer and carer workforce to meet the demands of the population. We've heard a lot of evidence about the real crunch on the workforce. How are we going to scale up the peer and the carer workforce?

**CATHERINE LOUREY:** The way that we do that is by, first of all, training. There's the Certificate IV in Mental Health Peer Work.

**The Hon. SUSAN CARTER:** But how are we attracting people? Who will we get to train?

**CATHERINE LOUREY:** The way that that is being undertaken at the moment—and it has been effective—is by offering scholarships. Basically it is scholarships for people who wish to undertake that training. For example, the commission has funded 100 scholarships with the Mental Health Coordinating Council, because the council is also an RTO.

**The Hon. SUSAN CARTER:** Sorry, over what time period have those scholarships been funded?

**CATHERINE LOUREY:** They were over a two-year period.

**The Hon. SUSAN CARTER:** And they're going to continue?

**CATHERINE LOUREY:** At the moment, they were one-off. But at the moment we've also got Commonwealth funding for scholarships in New South Wales as well. But it does come to my next point—

**The Hon. SUSAN CARTER:** And all those places were filled?

**CATHERINE LOUREY:** Yes.

**The Hon. SUSAN CARTER:** Great.

**CATHERINE LOUREY:** But there are rate limiters, and these are the things that the Ministry of Health very much also needs to engage with. When we have a peer worker or an Aboriginal health worker, they have a placement or they have a trainee position. They really are part of the issues that we need to address because there aren't enough of those. Whilst we could give more scholarships to people—

**The Hon. SUSAN CARTER:** How can we create more placements?

**CATHERINE LOUREY:** Exactly.

**The Hon. SUSAN CARTER:** No, that's my question to you. How can we do that?

**CATHERINE LOUREY:** Well, this is the question that I put to the ministry. These are services that—

**The Hon. SUSAN CARTER:** So it's not an answer that you have? It's a need you've identified—

**CATHERINE LOUREY:** It's not an answer that I have.

**The Hon. SUSAN CARTER:** —but you can't provide the answer to that.

**CATHERINE LOUREY:** Because essentially I would say that those positions need to be funded. They need to be funded by the ministry; and also whether we broaden out from public health to our community-managed sector as well.

**The Hon. SUSAN CARTER:** Sorry, I don't really understand what you said.

**CATHERINE LOUREY:** So the community-managed sector are—

**The Hon. SUSAN CARTER:** No, when you say "broaden out", what do you mean?

**CATHERINE LOUREY:** Okay. At the moment the community-managed sector isn't funded for trainee positions or for placements. You would need to provide that because you can't have people training and going to work without getting an income. That would be part of our solution, that we look beyond the public sector to understand where would we want to see this workforce to be working? It is across that spectrum. We want them in the community, we want them in the community mental health services, we want them in inpatient services, we want them in the forensic hospital and we want them in prisons. This is where we want peer workers. It's not just about what's in this hospital and the local health district. Wherever people who have a mental health issue can get value out of having a peer worker on their team, that's where we want peer workers to be.

**The CHAIR:** Thank you so much again for the time you've taken to give evidence today and to prepare the written submission. The secretariat will be in touch with you with any questions on notice.

**CATHERINE LOUREY:** Thank you very much. I really appreciate the time. Good luck with your deliberations.

**The CHAIR:** Thank you. We have a lot of work to do. For the interest of those in the gallery or streaming online, we will take a break for 15 minutes. We will be back at 3.30 p.m.

**(The witness withdrew.)**

**(Short adjournment)**

**Ms LIZZ REAY**, Chief Executive Officer, Nepean Blue Mountains Primary Health Network, affirmed and examined

**Mr CRAIG PARSONS**, General Manager, Partnerships and Innovation, Sydney North Primary Health Network, affirmed and examined

**The CHAIR:** I acknowledge that while the room seems empty, some of our Committee members are on Webex today watching the live stream of proceedings. I welcome and our next witnesses. Thank you for making the time to give evidence today. Would you like to start by making an opening statement?

**LIZZ REAY:** Thank you. Good afternoon. Craig Parsons and myself today appear on behalf of 10 New South Wales primary health networks, commonly known as PHNs, which is what I'll refer to them as. Primary health networks have three main roles. Firstly, we support general practice and other primary care providers to deliver high-quality care. Secondly, we commission services that meet the needs of the community. Thirdly, we work with others to integrate care so people don't fall through the cracks when they move from one part of the health system to the other. About 50 per cent of the Commonwealth funding that we receive as primary health networks is focused on mental health and suicide prevention, so quite a significant part of our work as PHNs.

Last financial year, primary health networks in New South Wales and ACT commissioned approximately $200 million of mental health and psychosocial programs, providing just under a million service contacts for more than 135,000 people. Each primary health network and local health district, or LHD, has developed joint mental health and suicide prevention regional plans. These are currently being updated to reflect the activities of the new mental health and suicide prevention bilateral agreement. However, the capacity for local health districts to participate in joint planning and also to advance or implement those plans is quite limited, despite a lot of goodwill.

There are limited accountability mechanisms in New South Wales. Our submission outlines the current challenges and major gaps of concern, including lack of investment in mental health services, poor navigation, duplication of assessments, barriers to accessing services by community, and workforce issues. The submission includes 15 recommendations to improve equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales. All these recommendations and the points in our submission are underpinned by a really common theme, and that is the need for stronger commitment, adequate resourcing and better accountability for local health districts and primary health networks to work together for a more integrated mental health system. This is essential if we're looking to maximise the health dollar, reduce duplication and provide better access for people in our community to mental health and suicide prevention care. Thanks.

**The Hon. SUSAN CARTER:** Thank you both for being here and speaking on behalf of your organisations. I wonder if I could take you straight to recommendation 4, which is in relation to disordered eating and eating disorders. As I understand your submission, essentially LHDs outside the cities have no resources for disordered eating and eating disorders?

**CRAIG PARSONS:** I think the provision of eating disorder services, particularly those in the community, is quite minimal. Over the past few years local health districts have increased their capacity, but there is still that gap, particularly in outpatient treatment services, for people experiencing eating disorders. We further see that in the community when people—either before they require hospitalisation and inpatient treatment or following inpatient treatment—find those services in the community are difficult to access and often quite expensive as well.

**The Hon. SUSAN CARTER:** Do you think that GPs are well enough educated and well enough resourced to be able to identify, diagnose and support people presenting with some sort of disordered eating?

**CRAIG PARSONS:** I think there's still a way to go in terms of educating and supporting GPs to be able to identify eating disorders and then appropriately link people to the most appropriate form of care. In the community there's a lack of practitioners, specifically practitioners who will bulk-bill or can provide affordable treatment for people experiencing eating disorders.

**The Hon. SUSAN CARTER:** In terms of lack of practitioners and lack of affordability, in your observation, would that be the same in metropolitan and regional or more exacerbated in regional areas?

**CRAIG PARSONS:** I think it's definitely exacerbated in regional areas. In northern Sydney we have one of the highest proportions of mental health clinicians and psychologists, and even there people will struggle to find a clinician who is experienced and confident to address eating disorders and a clinician who will charge an affordable fee.

**LIZZ REAY:** And as we move west into my area—Penrith, the Blue Mountains, Lithgow, Hawkesbury—it's certainly a challenge. One of the things GPs tell us is that it's not only about their own education. It's about having the appropriate support services because we know that in this treatment it's not just one clinician. It really is a team to make this work, and that's where there are challenges.

**The Hon. SUSAN CARTER:** What would it take to fix it?

**LIZZ REAY:** Like everything, more investment. But I think it comes back to a lot of the things that we've got in our recommendations about trying to reduce the siloing of our thinking and our funding within every sector. You've probably seen today, and in past days, so many different organisations coming with quite similar themes. It's about how we try to facilitate that linking up. There's a finite amount of dollars, but I think we can be a lot smarter if there's some capacity building for us to work together better. That's definitely part of the solution, as well as investing further services.

**The Hon. SUSAN CARTER:** We've had a lot of evidence of the value of peer workers, especially peer workers who might help navigate through. I have a specific question in relation to peer workers and eating disorders, and I understand if you want to take this on notice. I'm aware of some literature in relation to the fact that peer experiences for people with eating disorders aren't always helpful. I wondered if you had any comments about whether peer workers were as appropriate in the eating disorder space as they may be in other areas?

**LIZZ REAY:** That's not my area of expertise. Have you got any comments, Craig?

**CRAIG PARSONS:** I think they can play a role. But, like with any peer roles, the framework in which the peers operate is really important to define—and that model of care, in terms of the type of support that peer workers are responsible for and how that links to the broader care team.

**The Hon. SUSAN CARTER:** Workforce is an issue that you've flagged. Workforce is an issue we've heard a lot about. How do we improve workforce? Any practical suggestions?

**LIZZ REAY:** One of the challenges we're all finding as there has been more investment in mental health is that the rate-limiting factor is often workforce. What we find sometimes is that a new service might start and it's just moving one lot of workforce into that new program or new area, so it certainly is a challenge. One of the only good things that came out of the pandemic was that use of telehealth—people being more comfortable with that. Certainly in some areas across primary health networks, including my own, telehealth psychiatry, for example, has been a game changer for our region. We know that it's a real challenge in that regard. But also the investment now in training—we've seen, and no doubt you've heard about, the state of general practice. We're really pleased now to be seeing an investment in reform in primary care.

We need to do that earlier in every sector to be advancing and forward planning so we don't get to the crisis point where there's no solution for such a long time. I think keeping it on the radar, knowing what we do have—a bit of a census not just across New South Wales health services but across New South Wales, across all sectors. In primary care, where can we better integrate and link up? We know some services struggle, say, to have a GP on site at a mental health service. But can we work wiser and smarter by not having to directly employ but by looking at better relationships and integration and some models that support that? It doesn't just happen. It takes time and relationships, and we need to invest in capacity to do that. That might be a way we can better utilise the current workforce. Craig, you might have other comments.

**CRAIG PARSONS:** In addition to those points, looking at opportunities to really increase the skill set and scope of practice of the clinicians and practitioners that we do have. We've seen great success in northern Sydney specific to drug and alcohol around clinical attachments between general practice and the LHD drug and alcohol services. I think that's a model that could be scaled up and spread across the State for different specialities and different practitioner groups.

**The Hon. SUSAN CARTER:** A workforce concern I have is that we keep hearing about the role of the GP. GPs perform a really valuable role, but it sometimes sounds as if "this will be added to the GP" and "that will be added to the GP". We've heard evidence that the time that GPs need to spend with a mental health patient is longer than somebody with a spider bite to the finger and that perhaps that isn't reflected in the charging schedules. I guess I have concerns as to whether loading everything on GPs, as things are currently structured, is really a workforce answer.

**LIZZ REAY:** Yes, and the reality is that GPs see a lot. I think it really goes under the radar. GPs do a lot of mental health care. Recently I was looking at some statistics around the reporting of general practice. I think it's gone up from 60-odd per cent to 75 per cent of their perception of patients that come in to see them that report a mental health concern. They are already doing a lot, and it's the support that they ask for. I've had GPs say, "If we could have a social worker to help," because we know it's broader than the medical. It's looking at the

psychosocial support as well. Looking at those sorts of roles in general practice might make such a difference. That's one role in a general practice that could have quite a significant impact if we just get creative, rather than building a nice new building and putting services there. Again, it's about how we work with our existing to provide that support to GPs so they don't get burnout.

**The CHAIR:** Can I ask a follow-up question on exactly this topic? I share concerns, as a former GP, of GPs being given responsibility to do things without being given resourcing to do things. I was interested in your submission on page 14. There's a really interesting example of the Central and Eastern Sydney PHN project, which was GP shared care. I was wondering if you could explain in a bit more detail how that works, if you know. I apologise if you need to take it on notice. I'm also wondering if that program has been evaluated?

**CRAIG PARSONS:** My understanding is that it has been, but I will take that on notice and request that additional information from Central and Eastern Sydney PHN.

**The CHAIR:** Thank you. I really appreciate that.

**LIZZ REAY:** GPs love the shared care. Our experience is that it has been really positive because it still gives the GP, who's dealing with—as you know, they're looking after the patient holistically and giving that extra support. We have found with chronic disease programs and mental health programs that it has been something that's a real support for general practice around those shared-care approaches.

**The Hon. EMILY SUVAAL:** Thanks to you both for appearing today. I want to ask you some further questions in the submission around data sharing. I note that was part of your recommendations in the submission. I'm particularly interested in recommendation 3. I found it very interesting that the decision had been made to share the data but had not included PHNs when you're commissioning the local services on the ground. Could you explain to the Committee what impact not having that data has and why it would be important for you to have it?

**CRAIG PARSONS:** I think not having that data means that we don't have the full understanding of what the need is in the community, what is currently being met and what the gap is in terms of what isn't being met. I think without that visibility of what's happening across the system, we can commission services that might meet a specific need but don't necessarily integrate as well as they could with the other services.

**LIZZ REAY:** It is also about measuring impact as well.

**The Hon. EMILY SUVAAL:** We hear lots of issues about integration. Do you know why it was the case that it wasn't extended to PHNs as well? Was there a barrier or a challenge, or was it just not extended to them?

**CRAIG PARSONS:** I don't have information on why it wasn't.

**LIZZ REAY:** In general, data sharing across mental health and all the health areas that we work on is certainly a challenge. It's one of the recommendations from the NSW Health and PHN statewide steering committee. One of the three key recommendations—and we have a statement of commitment, and the emphasis of that statement of commitment is a one health system mindset. We know we are two health systems, but how do we have a one health system mindset? Four parts that came out of that were around data sharing. It is definitely something that we need to look at, particularly when it comes to our joint regional mental health plans, because how do we do joint planning if we can't share data and look at that really thoroughly and then also evaluate the outcomes as well? It might be things like ED data, hospital admission data—those sorts of things. How do we share that confidentially? I think sometimes it just gets a bit too hard, really.

**The Hon. EMILY SUVAAL:** What you've mentioned is a nice segue to the second recommendation, which refers to the joint annual data asset assessment, which you state would be beneficial. What data sharing currently occurs between yourselves and the LHD?

**LIZZ REAY:** Currently, each PHN and LHD work their own data sharing out. We have data-sharing agreements between the local health district and PHN where we can, and probably most would have some level of that. They can vary in terms of the scope of them. One of our recommendations is actually looking at that at a statewide level and what role can NSW Health play there to support that data sharing. Because it is harder for LHDs to navigate that—what can they share and what can't they. It would be really nice to have NSW Health really look at those data-sharing agreements and have an agreed set of data and agreed protocol for how we better share data.

**The Hon. EMILY SUVAAL:** In terms of the data items in your submission—it talks about agreed, up-to-date data items to be shared between governments and commissioning organisations—what would those data items be specifically that you're interested in?

**CRAIG PARSONS:** I think, as Lizz mentioned, it would include hospitalisation rates. We do have agreements between LHDs and PHNs at the moment around suicide data, but that's provided in a very specific way and not necessarily available for forward planning.

**The Hon. EMILY SUVAAL:** So you're looking backwards all the time; there's no forward planning component to the data. It's just, "This has happened."

**CRAIG PARSONS:** Yes, and I guess limits on how we can use that data as well.

**The Hon. EMILY SUVAAL:** Is it captured, anywhere within the data, about circumstances that may lead to an increased proportion of a certain population experiencing a certain mental illness or numbers of, say, first responders in an area, or people that have potentially served in the armed forces or are current veterans? Is that captured anywhere?

**LIZZ REAY:** Not to my knowledge. I think what we'd need to do as part of this is sit down and agree what data sets do we want and what are the key things as well. Because it can be really ad hoc depending on an initiative that an LHD and PHN might be working on together, whereas I think there are some really key elements that we could all agree on, and, yes, there might be differences there. But, yes, to my knowledge, I'm not aware that's captured.

**CRAIG PARSONS:** Some is available through census data, which is primarily what we use. But, again, that's not necessarily in date because there is always a lag.

**The Hon. EMILY SUVAAL:** Yes, there's quite a delay. If it were the case that, say, NSW Health was to create a standardised data-sharing arrangement between the LHDs and the PHNs, could that be realistically rolled out, or is it the case that within each LHD the data they collect looks different or is maybe called something different?

**CRAIG PARSONS:** My understanding is that there is consistency in the data that is collected amongst those LHDs.

**The Hon. EMILY SUVAAL:** That's a good start. I'm interested in learning more about some of this commissioning work that you do locally and whether there are any barriers and issues to that occurring. We have heard earlier today evidence from Headspace. You're obviously a key commissioner, to the local Headspace, of funding and services. What are the current issues that exist with that work of commissioning, and is it always the case that the need that the PHN identifies is able to be met by the person commissioning the services?

**LIZZ REAY:** I think one of the challenges of course with both PHNs and LHDs, and any organisation that receives funds, is that those funds are tied to quite specific parameters. We certainly do, in each PHN, have quite a comprehensive and broad needs assessment, and what we do is either advocate for or look at how we can secure funding to meet those needs. There are times where, yes, there's definitely a lot more need than what we have funding to do—or the flexibility of funding to do, I might say too, because Headspace funding is very specific for Headspace rollout—and so there might be another area of need in that community that we may not be able to address.

But when it comes to working with the LHD—so from the NSW Health perspective—I think we've seen more and more LHDs and PHNs trying to work together to commission better, I'd say, over the last couple of years. The mental health and suicide prevention bilateral agreement will start to embed that. I think it's ambitious, and the practicalities of how we commission together need to be worked through, but we're certainly seeing that that is a really good step in the right direction. One of the challenges, though, is the capacity and the investment of NSW Health in LHDs to be able to do that. Often this falls on a clinician running a mental health unit—the director of mental health—to be turning up to planning meetings. Of course, it is really essential that we're getting people with decision-making, but when it comes to what makes the front pages, when it comes to what the KPIs are that have to be worked on, they're usually not planning. There is not much accountability for local health districts back to the Ministry, so what drops off—it's what's not being measured, it's what's not receiving attention.

That's the biggest barrier at the moment—that there's so much goodwill but really no investment of resources or accountability for PHNs and LHDs to do this. I think the disadvantage of that is that in the long term that's going to be the thing that means that NSW Health will be able to reduce their investment because we're working together. It's that bit of pain—maybe it's one position in each LHD; I don't know—to enable that to happen, because it's really difficult on top of everyone's everyday work, that will have these great long-term effects, where we can have one integrated health system rather than duplication in some areas and gaps in others because we're not working together.

**The CHAIR:** I had a question around your recommendation 8, which was the development of an integrated triage and referral process across primary health care and LHD community mental health services.

I know that many LHDs already have mental health access lines, and we've received evidence about their varying quality. I was interested in understanding what are the barriers to that having already happened.

**LIZZ REAY:** This is a bit near and dear to my heart, because a couple of years ago primary health networks received funding to establish in New South Wales a statewide mental health line, and that, in July last year, I think, went national. So there's a 1800 number that anyone can ring to be directed to mental health care. At the time, we worked with NSW Health around this, and there is a little pilot going on. We've got the assessment that we do in the primary care space. People can ring, be directed and they have an assessment. It's called an initial assessment and referral process. We have clinicians that answer that phone and can do that assessment. Basically, where that stops—the higher end of acuity for that 1800 number—is almost where the Ministry of Health or the NSW Health line starts.

So we've got two lines, and consumers don't know—"Where do I fit? Am I on the lower end, outside of hospital, or do I need hospital?" They're both great. The thing I love about having this 1800 number or this Head to Health sort of concept is that it really shouldn't be up to someone who's in mental distress to decide and know where they need to go. Even for GPs and healthcare professionals, it's difficult for them as well. So it's great having this, backed by a really thorough directory of all of the services in a region. But the challenge is, once we get up to that higher end, to be saying, "Now you need to go to the other line." We need to look at a way that we can integrate both of those much better so that they work together. We have tried. In our local region, certainly, we've got relationships to try and do that, but I think a proper look at that, a proper analysis and options of how we can better integrate those lines is really important.

**The CHAIR:** Are there any last questions? With the last four minutes we've got, I can give you the opportunity to make any closing remarks or draw attention to any other parts of your submission that we haven't raised today.

**CRAIG PARSONS:** I think we haven't spoken to child mental health yet. We do see that as a particular gap in primary health networks. I know that there have been a number of other submissions around it as well. There is that initiative to create four child Head to Health centres across New South Wales, but, really, that is a need that is in all PHN and local health district regions. I think the challenges for parents trying to navigate the system are similar to or even harder than for other adults around navigating their mental health care, because of that paucity of child mental health services, that arbitrary division between what is a mental health issue versus a neurodevelopmental issue, the lack of paediatric specialist workforce and, really, the broader kind of service sector being there for children.

**The Hon. EMILY SUVAAL:** Mr Parsons, in the submissions, you've identified that headspace services are designed for youth aged from 12 to 25 years. In terms of the child mental health services, are you specifically meaning people 12 and under?

**CRAIG PARSONS:** Yes.

**The Hon. EMILY SUVAAL:** There is currently a gap, in that headspace won't see them.

**CRAIG PARSONS:** Yes, that's correct.

**The CHAIR:** Thank you so much for the time you have both taken to come and give evidence today and for preparing the very detailed submission. The secretariat will be in contact with you about any questions on notice.

**(The witnesses withdrew.)**

**Ms JESSICA WHITTAKER**, Delegate, Australian Paramedics Association (NSW), Paramedic, affirmed and examined

**Mr BRETT SIMPSON**, President, Australian Paramedics Association (NSW), Intensive Care Paramedic, affirmed and examined

**Mr JEFFREY ANDREW**, Delegate, Australian Paramedics Association (NSW), Critical Care Paramedic, affirmed and examined

**The CHAIR:** Welcome to our next witnesses from the Australian Paramedics Association (NSW). Thank you for coming to give evidence today, noting that we have Mr Andrew on Webex. Would you like to start by making an opening statement?

**JESSICA WHITTAKER:** Good morning, and thank you for having us, as paramedics, to give evidence at this inquiry. My name is Jess Whittaker and I'm a P1 paramedic at Dapto station. I have been a paramedic for 14 years and I work in the City of Sydney, the Riverina, the Illawarra and, occasionally, in the Shoalhaven. Also giving evidence today are Brett Simpson, who is the intensive care paramedic at Paddington and Jeffrey Andrew, who is an ICP and ECP critical care paramedic from the Bankstown helicopter base. We have all had many years of experience responding to people who are experiencing mental health crises in the community. In some ways, these can be easy jobs for us because there are limited options for us to treat. However, the cycle of simply offering transport to an emergency department, where these patients often don't get the help they need in a timely manner or leave before they're seen, is causing harm.

I work in an area that MHAPP operates in. When this program works, it has been a game changer for us. This referral pathway has been a huge success story in the way we care for mental health patients in the Illawarra. The best parts about it, for me, are being able to learn from qualified mental health workers in the way they interact with people having a crisis; being able to do follow-up visits the following day for patients who can be left at home; the option of doing virtual consults for low-acuity or well-known patients; and being able to phone the MHAPP team before we get to a job so they can take a look at a file, let us know of any red flags and give us advice on how to handle a situation if they can't attend in person or if a job is not suitable for them. The downfall for this program is that it has extremely limited hours of operation, from 2.00 p.m. to 10.00 p.m. The staff are amazing but often seem run off their feet, and, if the jobs aren't close to where they're located, it can be a long time to wait for them to attend.

MHAPP has shown that we can do better with treating mental health patients in the community and avoiding the emergency department, where there are often issues with patients becoming stressed due to the process and, subsequently, needing security. The biggest impact for me is the frustration that people who should be seen in the community and referred on for appropriate care are needing to utilise an emergency resource to transport them to hospital. We know they are doing this because there is no other option for them in a difficult time. It just feels so unnecessary, but we keep doing it over and over again because we are so limited in other services we can direct them to safely. It adds to their trauma, creates a risk for staff and other patients in the ED and uses a lot of resources in security when things escalate.

Another issue is the lack of training for paramedics having to deal with mental health patients. It's all on the job because if we have formal training it is usually to learn practical skills. This has been one of the best things about MHAPP; the mental health officers are so generous with sharing their knowledge and experience with us. We hope the Committee looks at some of the key recommendations in the Australian Paramedics Association (NSW) submission, as these were formed after extensive consultation with our members. These include to invest in community and primary mental health care; to evaluate and expand NSW Ambulance health programs, including MHAPP and MHAAT, to cover regional areas and provide longer coverage hours in areas of higher popular density; and to provide paramedics with better and more regular mental health training. Thank you.

**The CHAIR:** We'll now go to questions from the Committee. I was going to ask about the MHAPP program, but I think you've outlined that in your opening statement. I also had a question about the MHAAT program. There are a lot of acronyms. I understand that the MHAAT program was the one that's operating in Western Sydney and in your submission you talked about the role of the paramedic in that team and particularly the need to have a more senior trained paramedic. I was hoping you could speak to that and explain that for the Committee?

**BRETT SIMPSON:** Previously we've had teams where we've had experienced paramedics operating in response vehicles, one-on-one, with usually a clinical nurse consultant from an affiliated mental health network. I'm aware of one from Cumberland and then in the inner city as well. They would respond typically to mental health patients and mental health calls—people in crisis or people experiencing exacerbations of their chronic

health conditions. Those programs, those paramedics and those clinicians had wildly high success rates in diverting patients away from emergency, I would suggest, particularly because it had the input of not only a first responder, being the paramedic component, but then also the mental health practitioner, whether it be the CNC or similar from within the LHD or mental health network. It effectively broke down the barriers between having NSW Ambulance siloed away from the rest of NSW Health and brought the ability to access records, treatment plans and all that type of thing together and really provided a substantial continuation of care for a lot of what are chronic mental health conditions in the community.

**The CHAIR:** What was the experience of the paramedics who worked in that program? Did they feel safe? Did they enjoy working there?

**BRETT SIMPSON:** Yes, because, as Jess alluded to, the amount of mental health training we get is minimal so being able to share in the expertise and knowledge of those CNCs or mental health nurses was a huge boost for us. Those paramedic practitioners would go back to their stations and share with their colleagues and other junior officers, "These are the resources that we had. This was the technique that we used and it was really great." Because they were able to build a rapport with lot of those patients, I think it was really beneficial. I'm sure you probably had a similar experience with your MHAAT down in Illawarra?

**JESSICA WHITTAKER:** We don't have paramedics and we don't have ECPs or anything working with them. We haven't been part of that trial but, yes, it just makes sense because you need to rule out medical causes and make sure that it's not something else that's causing this that needs to be treated in an emergency department. It just makes sense to free up that ambulance resource and just pair them up with someone with clinical knowledge.

**The CHAIR:** My next question is probably better suited to ask NSW Health—and I will—but given the wild success of that MHAAT and MHAPP trial, why haven't they been done elsewhere, do you think?

**JESSICA WHITTAKER:** I don't know.

**BRETT SIMPSON:** I could only provide anecdotal evidence. I would suggest it's probably more due to funding being diverted to other streams and just purely resource based as well. They are wildly successful programs so it's definitely part of our submissions and recommendations that those programs do get expanded across as many parts of New South Wales as possible. They were just so wildly successful in being able to provide that level of care to the community.

**The CHAIR:** I also wanted to ask about some of the legal issues. I know paramedics are commonly involved in sectioning people under the Mental Health Act and you've provided quite lot of detail in your written submission about the complexity of the various protocols that exist. I know one issue is just the resourcing that people need and the training and the time to do this. That framework of the protocols that exist and provisions under the Act, in your opinion is that working legally? What's the experience of paramedics working within that legal framework?

**BRETT SIMPSON:** I would suggest, as always, more training is definitely required. You could put 10 paramedics in front of you, give them the same scenario and ask what they thought their legal responsibilities under the Act would be, or what their options were in that scenario, and it's likely you could possibly get 10 different answers. In my role as a manager, it's my job to review all of the section paperwork that comes from my team and quite often it's my job to go in and ask for more detail—"Why did you feel it was necessary to section this patient?" or "Under what concerns, in your understanding of the legislation, did you do that?" Often it requires more training for them, and for me to come in and then say, "Well, I think you probably could've taken this option," or "It might not have been appropriate in this instance."

Again, I think it's a real lack of training and, especially with a much junior workforce coming through with recent staffing enhancements—we're recruiting and we have a much junior workforce that just simply don't have the practical hands-on experience that seasoned officers like Jess and myself might otherwise have. Again, it just comes back to as much training as we can get. We know that paramedics are starved for it and we're always hungry for it so as much as we can get is beneficial.

**The Hon. EMILY SUVAAL:** Thanks to you for appearing today and to Mr Andrews online. With the inquiry, after we've proceeded through the hearings that we will hold, we will then go about the process of drafting the report with the recommendations to the Government. I suppose an important process of doing that is weighing up the evidence because there's some evidence which has been very complementary and some that's been, I suppose, conflicting so it's important to have the appropriate weighting placed on various parts of the evidence. In terms of your own workforce—I note you mentioned you've had the extensive consultation with members which is very well appreciated—how many financial members do you have in New South Wales at the APA New South Wales branch?

**BRETT SIMPSON:** The exact number I would have to take on notice because it fluctuates but it's approaching, I'd say, just over 2½ thousand.

**The Hon. EMILY SUVAAL:** Do you have an idea of the total workforce figure? It's a question, again, I could ask NSW Health.

**BRETT SIMPSON:** I would have to take that on notice. I think we get information on that once every 12 months or so and I think we're due to get that figure shortly. I would have to take that on notice, I'm sorry.

**The Hon. EMILY SUVAAL:** Presumably it would fluctuate within that time. Your submission details a raft of recommendations from your own members and one that I found interesting was around the resourcing in local hospitals more generally for more staff in rural and regional hospitals. Can you talk me through a bit more about why in particular that was of interest to your members?

**BRETT SIMPSON:** I would suggest the feedback that I've gotten personally from members—rural and regional New South Wales, as we know, struggles with general physical health and providing equity of services. I think that is exacerbated more so with mental health conditions. I would use the example of, let's say, Moree up in the top of the New England—its closest dedicated mental health facility is Tamworth. If our members up in that part of New South Wales were to have, say, a sectioned patient that would need to have further mental health care they would possibly get immediate work up at Moree Hospital, but would then be transferred down to Tamworth. It might be away from support networks—family and friends. They might not have the resources to then have family come down to support them in Tamworth, which would be their referral hospital. Then it takes the resources for NSW Ambulance out of Moree because the return trip for that type of transfer is approximately six to seven hours. It's really resource intensive to have to do those transfers because we don't have things like mental health services, which might be more appropriately used in certain areas like Moree. That's just one example. I don't know, Jess, if you've got more? You've got more experience working in regional.

**JESSICA WHITTAKER:** I guess the issue with those transfers is that you're tying up two security guards and you're often sedating people for this. It's really inappropriate and awful that we have to do that to people. Bringing them the care in the community, and possibly even avoiding them being in the ED the first place, is the goal.

**The Hon. SUSAN CARTER:** Thank you for being here, and thank you for including the voices of other paramedics in your submission. I think it's tremendous; it makes the points very well. Can I take you back to training? In the initial training that people receive before they become paramedics, how much training is there about dealing with mental health issues?

**BRETT SIMPSON:** I've been a paramedic for 15 years. My first face-to-face mental health training was in my initial eight-week induction back in 2009. The amount of physical face-to-face mental health training I have received since then, I would suggest, would probably equate to maybe six to seven hours' worth, which was part of a paramedic-focused mental health and wellbeing training session, where we also were taught or updated on things like de-escalation techniques and that type of thing. I know that there is some online training that's recently been released by NSW Health and NSW Ambulance around psychological first aid and that type of thing but, again, it does have an internal staff-focused attribute to it. Jess, I'm not sure if you are aware of more that you have done. But, apart from your initial training, it is minimal.

**JESSICA WHITTAKER:** The training I can recall is the mechanics—like using restraints, doing an online course for administration of droperidol or the legalities of a section 20—and not a lot of it is trying to avoid those things. Working with so many people over the years, you can just see how much of a difference it makes, like, how good you are at diverting people and talking them down and doing those sorts of things and avoiding all of that in the first place.

**The Hon. SUSAN CARTER:** How many of those skills can be taught and how many have to be observed and practised?

**BRETT SIMPSON:** It's not so much of a science; it's more an art. We were having the discussion beforehand: I still remember it clear as day, my first interaction with a suicidal patient 15 years ago, and I was terrified. I was terrified for me and I was terrified for the patient. I was worried I would slip up and say the wrong thing. Luckily, I had my very experienced mentor with me and she guided me through that process. It is very much on-the-job, face-to-face training. We can put out as many online webinars or quizzes that we can do online to learn these things but it is invaluable to be able to work with another mental health practitioner, whether it be a senior paramedic or a nurse specialist or a doctor. Any type of ability that we have to have that face-to-face training is priceless. If it wasn't for my mentors that I had as a baby paramedic—the stress that must be on our junior workforce now is immense, so it's crucial.

**JEFFREY ANDREW:** Probably most has been covered in those discussions but the last major update that I recall was around sectioning, when that was first introduced—obviously around the legalities there. I came from a nursing background, so I had the benefit of starting Ambulance with plenty of experience in emergency departments. I think probably the key, if we are looking at paramedics working with mental health, is ruling out organic causes and differential diagnosis. I heard the discussion previously around extended care paramedics and the specialty that is working closely in differential diagnosis and clinical examination.

I am getting a bit of feedback. Sorry, it's distracting me a little bit. But I think the key is they have to be well aligned together. We probably need some practical training. As my colleague suggested, that works really well having time with other mental health team members. If we are going to have these out-of-hospital teams, it's really important to be very specific to the things we are looking for within the mental health presentations so that we are looking for both clinical and particularly for first-time presentations. I think that's the bit that is lacking at this stage.

**The Hon. SUSAN CARTER:** I'm just curious—this is not directly relevant to our inquiry, but do you have, as paramedics, sufficient access to vicarious trauma counselling so you can manage your own mental health?

**BRETT SIMPSON:** There has been a lot of improvement in that space for frontline staff being able to access a variety of counsellors and staff psychologists on staff with NSW Ambulance. So definitely for our staff we have seen huge improvements in support in that regard.

**The Hon. SUSAN CARTER:** That's very important. My last question is on a different topic. I take you to page 10 of your submission, where you talk about inadequacy of referral pathways. What would a good referral pathway look like?

**BRETT SIMPSON:** I'll use the example of my station at Paddington in inner Sydney. It is probably one of the busiest ambulance stations in the State, with a high workload of mental health. We straddle three different LHDs—Sydney, Sydney south-east and St Vincent's—with fragmented pre-hospital referral pathways to the point where it's so varied and so different that it's near impossible for our frontline staff to find an appropriate referral for these patients. That's our first barrier. The second barrier is that a lot of these—

**The Hon. SUSAN CARTER:** Sorry, can I stop you there? That's a significant barrier in the middle of Sydney. Does anybody have any comments about the difficulty of referrals in a regional area and whether it's the same or whether it's lower or higher? Are there any differences?

**JESSICA WHITTAKER:** I haven't worked rural for 10 years but, when I was there, there was none. It was basically the emergency department or nothing. I can't speak to what's there now. I guess it would be varied, depending on how big the town is—what health services they have.

**JEFFREY ANDREW:** I could probably relate. The Central Coast is my home location, and I have worked there in both hospital and pre-hospital settings. I think the benefit of regional areas can be quite strong, with the networking. The local teams will generally know the clients and have a relationship with them. I think this is the key, opposing to emergency services workers in uniform—police—and a very acute response. The things that I've seen go well is where we have had those teams involved early rather than have to convey someone to an emergency department where it's very busy, highly stimulating and there is no anchor point for them to someone they know or who appreciates—we know that mental health conditions are very diverse. We can't box people in. It's very based on their trauma experience and backgrounds.

If we can get any way of tapping into that local resource that is already known, I've found that that's the key to things going well. I think in Sydney the local health districts are very—it can be which street you are in as to which local health district you end up going to. I think it makes it very complicated to refer. Going back to regional areas, I think the community care can be quite good. But then, if they do need to be outpatients, we know that there can be long transfers away from home and away from country and things that aren't a benefit to someone who is already under stress.

**The CHAIR:** I wanted to ask about extended care paramedics. In your written submission, you talk about some of the benefits for non-transport because of the extra skill of ECPs. An obvious example out of the submission might be being able to suture and do wound care for someone who may have self-harmed. I was very interested to read that there are more ECPs than funded positions in NSW Ambulance. We have heard so much evidence in this inquiry about the workforce issues and that, for a number of other types of professionals, there are just staggering vacancies that NSW Health is unable to fill. I'm very interested that this is a workforce that is actually more available than the number of positions. What conversations have you had with NSW Ambulance about this, or what reasons have you been given for the under-utilisation of that workforce?

**BRETT SIMPSON:** I'll make a comment, and then hand over to Jeff, about the skillset and the expertise that the ECPs bring. The Extended Care Paramedic program in NSW Ambulance is designed specifically to keep people out of hospital, out of emergency departments. They have a phenomenal skillset and a phenomenal amount of training to be able to identify complex medical histories, treat complex conditions, all in patients' homes or wherever we might encounter them. However, the program is quite poorly managed and very poorly structured within NSW Ambulance. Out of session, we can certainly provide some more feedback on that because I'm aware of the time.

Again, a lot of our positions are in Sydney. There's a few in Newcastle and a few in Wollongong, and that's it. Arguably where we see the most benefit for ECPs is in regional and rural New South Wales, specifically to try and bridge the gap between health and mental inequality access. We would definitely like to see ECPs and other paramedic specialists, but specifically ECPs, brought out to regional New South Wales and not just in Sydney. We already have a higher range of services here in Sydney. The ECPs are great here, but where we do see their most benefit is in regional and rural New South Wales, specifically for issues like this. I'll go to Jeff. He will be able to fill you in on the clinical expertise of the program.

**JEFFREY ANDREW:** Yes, I guess the strength of the ECP program is two things. It's the training around being able to assess the patient. The other strength is the referral network; in my experience, where we saw the program work at its best was where we had a strong referral network. That would also be the case with our mental health professionals. ECPs have found that over time, working in a single module—some want to rotate through the normal ambulance model as well, and that's often quite a healthy thing. What has happened in the past is if people moved out of the metropolitan area or somewhere where there were funded positions, they were no longer supported to continue their ECP practice. I guess this is a bureaucratic-type funding model that is outside of my scope of how to manage that, but ideally we really want to encourage people to move outside the funded positions and still be able to practise as an ECP, continuing the education program and build that model in various areas around the State. I'll stand by if there are any specific questions about the model or training, but I'll leave it at that for now.

**The CHAIR:** We've only got two minutes left, so I might open that to you in those last two minutes, if you had any closing remarks or if there's anything you wanted to raise out of your submission that we haven't asked about.

**BRETT SIMPSON:** I think mental health resources for paramedics are exceptionally limited. In our submission, tens of thousands of presentations for mental health cases and conditions are brought to emergency departments by ambulance paramedics because we simply have no other options. We know that these emergency departments, the staff in them are highly skilled, highly professional, but the physical environments themselves are just so hostile to these people and when they are made to wait for sometimes hours—and I've seen even patients waiting for days—for treatment and referral out an emergency department to either a dedicated mental health facility, a community outreach program or community care services. It is just heartbreaking.

Unfortunately, these patients become regular contact points for us. They are well known to us in our communities, and we do see their general physical and mental health decline as we see the systems put in place, unfortunately, fail them repeatedly. Being able to consolidate resources for frontline paramedics, referral networks so that we don't have to take these people to an emergency department—where we know it will, more often than not, exacerbate their condition as we are at the most pointy end of mental health treatment in New South Wales—is crucial if we're going to be able to provide more substantial and more appropriate levels of care to these quite vulnerable people.

**The CHAIR:** Thank you again for the time you've taken to give evidence today, for your written submission and also, all of you, for the work that you're doing every day in our communities. It is really appreciated. The secretariat will be in touch with you about any questions on notice.

**(The witnesses withdrew.)**

**The Committee adjourned at 16:30.**