REPORT OF 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 Thursday 15 February 2024

The Committee met at 9:45.

PRESENT

Dr Amanda Cohn (Chair)

The Hon. Mark Buttigieg
The Hon. Susan Carter (Deputy Chair)
The Hon. Greg Donnelly
Ms Cate Faehrmann
The Hon. Emily Suvaal

The Hon. SUSAN CARTER: This is the sixth hearing of the Committee's inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales. We all acknowledge that we are here on the lands of the Gadigal people of the Eora nation, who are the traditional custodians of this land, and we pay our respects to those people and acknowledge any Aboriginal and Torres Strait Islanders who may be joining us today. My name is Susan Carter. I'm the Deputy Chair of this Committee. I remind everybody in the room that they should have their mobile phones turned off or on silent. Parliamentary privilege applies to witnesses in relation to the evidence they give today. It does not apply to what witnesses say outside of the hearing, so 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 and I encourage Committee members and witnesses to be mindful of these procedures.

Dr KAREN WILLIAMS, Consultant Psychiatrist, Ramsay Clinic Thirroul, affirmed and examined

Ms TARA HUNTER, Director, Clinical and Client Services, Full Stop Australia, affirmed and examined

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

TARA HUNTER: Yes, I would. Thank you very much for having me along today. I would also like to acknowledge that we're meeting on Aboriginal land today. I pay my respects to Elders past, present and emerging and any Aboriginal colleagues that are joining us today. I'd also like to acknowledge in this space the over-representation of the impacts of intergenerational trauma, racism and how that impacts on Aboriginal populations and their mental health and wellbeing. I think that's very much linked with what we're talking about today. As an introduction, my name is Tara Hunter. I'm the director of clinical and client services at Full Stop Australia. We have a history of 50 years of delivering counselling and trauma specialist services to people impacted by mostly sexual violence. That's where we started actually 50 years ago in October. But today we provide a range of services to all people impacted by sexual, domestic and family violence.

In addition, our organisation provides a whole range of training and support and we run a national survivor advocate program that was established around 2½ years ago. We have now over 600 people with lived experience that engage with our survivor advocate program. We do a whole range of advocacy across Federal and State governments and in other settings. The work that we do is informed by the lived experience, so today the information that I will be referring to will be based on the clinical experience of our organisation but also that lived experience in terms of some of the consultations we've undertaken in this space.

I'd like to thank you for undertaking this kind of inquiry. I have been a social worker for over 25 years and I have to say I've found the mental health system left wanting for much of my career. When we're talking about people impacted by domestic and family and sexual violence, we know there's a huge over-representation of people impacted by violence in terms of the mental health outcomes but also the potential vulnerabilities for people that are living with a mental illness, so it is very difficult to talk about mental health services and accessibility without addressing trauma and interpersonal trauma. That said, in my experience in trying to refer and work alongside mental health services, often I find that the services themselves are not well versed in screening or working with people impacted by trauma and complex trauma. The workers, and that's not about taking away their professionalism and the absolute demand that they have to work with—also there's not always those specialist skills around acknowledging and working with people's trauma.

In thinking about today, I guess what we would really like to see is a service system that actually is much better resourced from a very practical sense of having better availability of services. We'd like to see services that are not just one issue focused—that it actually takes in people's whole-of-life experience, including a very clear lens on the impacts of sexual, domestic and family violence, and trauma and how that might present in a mental health context. From a perspective of the organisation I work from, we're an intersectional feminist organisation, so part of what we see here when we talk more broadly about mental health services, there are accessibility issues. But when we look at populations such as Aboriginal people, people who identify in the LGBTQ+ communities, people living with a disability, people from non-English speaking backgrounds, and migrants and refugees, they all experience significant barriers to access mainstream services.

So part of what we would like to see is looking at cultural safety more broadly, understandings of trauma and trauma-informed care in mainstream services but a consideration of some of the specialist services that might be more accessible to populations that often remain hidden in this space. Thank you again for having me along and I look forward to answering whatever questions.

KAREN WILLIAMS: I would also like to thank you for conducting this inquiry. If I sit here today before this panel and say that women who are currently being abused or assaulted have poor mental health, that would seem pretty logical, and if I said that women who have been abused or assaulted in the past five years have poor mental health, then that too would also seem pretty logical. In fact, about 50 per cent of women who have been abused or assaulted will receive a mental health diagnosis by a mental health professional. So when a quarter of Australian women have experienced family violence and another fifth of women have experienced sexual violence, there's a lot of poor mental health and a lot of diagnoses, but unfortunately that has not translated to a lot of treatment.

I'm here today because I think it's less logical, less believable, to comprehend that within our public health service, with all the money being spent on mental health, there is currently only one publicly funded psychiatric bed dedicated to treating these survivors; that if anyone of these women are to feel acutely suicidal, there is no public service I can send them to safely; that the only unit completely dedicated to treating abuse survivors providing an evidence-based holistic model of care is a small private hospital that I opened over a year ago; and that the Government at the time agreed to fund one public bed.

Would it be believable if I told you that there are so many referrals from GPs and from women themselves that we don't have the time to read them all, let alone see them all? About a quarter of mental health presentations to the emergency department are trauma survivors and about 80 per cent of them will be turned away without any treatment at all. In the psychiatric wards, 70 per cent of the women have experienced sexual abuse in the past and another 45 per cent of those women will be assaulted whilst on the wards themselves. Every week a GP will see at least five women who are currently being abused. Females attending the GP for any condition at all are 580 per cent more likely to have experienced physical, emotional or sexual abuse in the past. All of these health services that these women are being seen in—the acute wards, the GPs—patients are not receiving any trauma therapy, trauma education or any diversional therapies that we already know are needed for PTSD treatment to be effective.

I'm here because I believe that if we want equitable access to health care, we have to do more than throw money at this system—a system that's not designed to recognise and address the underlying causes of these symptoms. We do need funding for the development of trauma-informed services, but we also need to demand that the current service providers demonstrate how their services are, one, actually effective and, two, not harmful to survivors. There must be accountability on services and providers to follow through with the available research and the recommendations that the Government has already funded in obtaining how to best treat this currently completely neglected population. Thank you.

The CHAIR: Thank you both for being here today to share your experiences and expertise. I have a couple of questions, then I will go to questions from other members of the Committee. My first question is about the current Community Mental Health System in New South Wales as it stands. We have had a lot of evidence already in this inquiry about the fragmentation, the difficulty for people navigating that system, that a lot of services have really strict inclusion or exclusion criteria. I am particularly interested in the impact that has on people who have experienced chronic or complex trauma, and if you could speak to that?

KAREN WILLIAMS: I think that the Community Mental Health services as they stand, as you mention, they are fractured and they have such an overwhelming amount of people that are trying to get in and utilise the service. Their current service delivery model is based on research that has actually already been proven not to work. We've rolled out this Project Air Strategy and all the research that has been conducted has demonstrated that although there was a reduction in patients turning up to ED, it didn't actually improve their health outcomes and it didn't help the patients' symptoms reduce at all. Despite that, that's still the program that is being rolled out throughout the State. The program consists of three sessions with a psychologist and I don't know anyone that can fix mental health with three sessions with a psychologist. But that funding continues and so we're still using the same model, despite knowing it's not working.

For people that are going through the service and utilising and not succeeding and not getting any better, there's a sense of hopelessness. You go in and you do what they say and you're not getting any better and you have no other alternatives, especially this group of people that often don't have the funding to try different things. Because there are some private services out there, my hospital included, but if you don't have the money you can't access it. When a person is repeatedly experiencing that the treatment doesn't work, their trauma actually gets worse because it increases the sense of hopelessness, "I'm broken. I can't be fixed. Nothing I do works." And there's a frustration from those clinicians who say, "We can't offer you anything more. We've done this with you already." The service providers themselves are impatient and overworked and that makes these patients feel even more worthless than they already feel. So it's certainly retraumatising to have a system that is blinded to what that patients actually need and, sort of, not offering any alternative or even an apology for "Well, actually, this isn't the service for you because it's not designed to help you."

TARA HUNTER: In my experience, again, inaccessible services are more generally—I find that it's actually really difficult for people to even get in the door to get those three sessions. So the processes in which I used to intake and assess people, people would have to be at a very acute stage. When I think about community mental health, for me, "acute" should be actually through a hospital setting rather than having—community mental health should be around some of those notions around healing and recovery. But even when people are acutely unwell, it's quite difficult to get an appointment. I would like to reflect on—in terms of the service that we provide. We provide 24-hour phone and online counselling, in the New South Wales context, for people impacted by sexual violence. So we often provide a significant safety net to people impacted that aren't able to access community mental health services.

I would also like to reflect, in particular, on young people. When we look at the impacts of domestic and family violence and really good recent data that says that children who are living in domestic and family violence from the age of six are requiring mental health services, it takes them to the age of 12 to even get access. In my experience of working in a space where we're referring young people to child youth and mental health services, again, the criteria is really challenging. There's a requirement, often, to work with family members. So there's a lack of privacy and safety for young people, particularly if they're having issues within their family setting.

The community mental health services, to me, are not—they're kind of the end of the road, and then we look at the other cohort of services that might be delivered through, say, the mental health care plans, and the waitlists are extraordinary. What happens in terms of the impacts for people—and I think Karen has outlined them, really, very clearly, but the other bit is that people are not seeking support at all. They may be at significant risk in terms of suicidality and self-harm. They do feel helpless and a bit lost about where to go for support.

KAREN WILLIAMS: I would like to add, too, to that. Just an example is that I had a patient who was on my waiting list. The intake for the community team had told them that—and I know this, because I used to work there—"If you have a psychologist or a psychiatry appointment coming up, you can't access us at all. You've already got someone." She had gone in acutely suicidal. It took her nine months to see someone because they had to wait for their private person, which was myself, but they had also been referred to an organisation that was a step down from the acute unit. So we can try there, but they said, "You're too suicidal for us to be involved." So she was shut down at every angle and was holding out to see me, but, still, it was a nine-month wait. She could have died in that time.

That's just completely unacceptable, whether people have been told, "You're not suicidal enough," or "You're too suicidal," or "You've got someone else." Having a psychologist outside of the hospital doesn't prevent suicidality. The appointment time, as Tara said, is so far away that you're waiting for—you get in front of somebody who's a psychologist or a counsellor and you say you're suicidal, they will often say, "I can't manage this. The risk is too much for me to take, medico-legally. You better get to ED." Like I said, 80 per cent of the people that turn up and go into ED saying they're suicidal are going to be turned back. You think of all of the people and all the money spent—they'll be seeing their GP; they'll try to see the psychologist; they'll see the triage nurse; they'll see the mental health nurse; they'll see the ED doctor, the psych reg; and they'll sometimes see the psychiatrist. They might get through seven professionals, which you're all paying for, but they don't actually get any treatment in that time at all. You'd rather see that there's a direct service for them to go to where that same money can be pooled—because we're not spending the money anyway—where they're actually having interactions that are therapeutic, not interactions which are essentially, "I don't know if you're really mine. I think you should go to somebody else."

That's what I found at the community mental health team. We had meetings—and they still do them every morning. We'll have 12 to 15 clinicians sitting around a room going through hundreds of referrals going, "Yes, let's not see that one; they've got a psychologist. Let's not see that one; they've been here too many times. We can't help them." It's so much funding going into just rejecting people, when you think all of those people could actually be out there doing stuff. But because we're trying to tick boxes, fill out paperwork and meet legal requirements, we're actually not getting out there on the ground and helping people.

The CHAIR: I've got one last question. There have been a lot of calls for improving the level of training for workers in the health sector and the mental health sector to provide more trauma-informed or trauma-sensitive care. I'm also wary that health workers really can't stand any more mandatory online modules. What would meaningful and effective training look like for the broader sector to provide better trauma-sensitive care?

KAREN WILLIAMS: That's a really, really good question. It's really hard when there aren't clinicians doing that work a lot, so you don't have a lot of range for people to go and actually get the experience and watching what trauma-informed health care looks like. Like I said, ours is the first inpatient unit. You could get the medical students coming through; you could get the psych registrars also coming through. But there needs to be funding. As I said, we can't see all the patients that are trying to get through this hospital. To get us to then also train other people, the burden on that—I'm talking about the time burdens—is too much.

There are some organisations—Blue Knot is one of them that has developed modules. I think that they must be compulsory modules. You would have spoken to the chair of psychiatry, and you'll speak to the Chief Psychiatrist. There has to be a demand on us as professionals; it's up to us to do it. It's not your problem. If you're going to pay them and they're going to get rebates, we have to prove that we're doing a good job and we're responding to that need. I think that because we're not asked to do it, we don't do it. I would like to see myself be audited on this stuff and all my colleagues be audited. We can't just choose not to do it because it's inconvenient and we don't like doing the modules. We're not allowed to do that with any other condition. I can't say, "I don't want to learn about depression because I don't want to do a module." They have to learn about PTSD in women and children. They have to. It can't be something we refuse to do.

TARA HUNTER: Further to that, I think from an allied health perspective and a broader workforce perspective, there's a whole range of things that we can do. From a university perspective and specialist courses, we are left wanting. There are an increasing number of courses around domestic and family violence and impacts of trauma, but we are absolutely left wanting, even for people that come through undergraduate courses. Let's be systemic and actually highlight this as an issue for anyone that's going into a health or allied health profession that's going to be working on the front line when we look at the prevalence of sexual, domestic and family violence and the impacts of that. It doesn't matter where you work; this is going to be an issue.

If we're looking at mental health, it could be very much part of the orientation process. As an organisation we run two-day training on complex trauma. But, for me, it's also not just the online module or even a two-day training course; it's also about clinical support and clinical supervision within organisations. It's all well and good to sit in a two-day course, but when you're actually working with people on the front line it's about having access to the appropriate clinical support and advice around some of the complexities that might arise.

For me, it's also around the management. Again, it doesn't matter where you're working, the impacts of things like vicarious trauma, where we are, as frontline workers, bearing witness to people's trauma and their stories—and actually having the appropriate acknowledgement around how that might impact on workforce as well. Because all those things—if we have people in our workforce who are already distressed, then they have a shutdown when they are hearing someone else's story. I think it's absolutely not another online module, and I think Karen spoke to that very beautifully. This is an important issue and it's about time we acknowledge that it's not just an extraneous part of mental health care. It's integral to any of the health care that we are providing for anyone who walks in the door. When we talk about trauma-informed care, it is a universal precaution. So it is about having a very systemic commitment to embedding that, including having a trained workforce.

The Hon. SUSAN CARTER: Thank you both for being here today. Your evidence sits with evidence we have heard from other witnesses, especially the difficulty of pillar to post, if we might call it that. One of the ideas that has been suggested that may be useful is if there were people who could assist to navigate through the system. Do you think this would be useful, or do you think the resources really aren't there to be navigating people towards?

TARA HUNTER: It depends. I think there are significant gaps in the system, so it's about where they are getting navigated to. Again, I would probably concur with some of the things that Karen has talked about, where people will attend a service or they will present to ED and they don't get sent to reasonable follow-up care. I think that that would be a great option for people, but we need to have the scaffolding around where people have a good referral pathway to be navigated towards, because then, again, you have more resourcing into something where—

The Hon. SUSAN CARTER: That's not frontline delivery service.

TARA HUNTER: Yes, where you could actually be bolstering up some of the frontline service delivery.

The Hon. SUSAN CARTER: Dr Williams, would you concur?

KAREN WILLIAMS: What I would like to say about that is that I am absolutely in favour of that peer support, because even if the services at the moment are not where they should be—and they are really not—and even if there are no places to navigate to, having another human being that you can connect with is incredibly important to healing. We are just animals, at the end of the day. We are not extraordinary beings. We are humans that are very social, and our bodies do calm down and relax a lot more in the presence of another person. So in terms of therapeutically—and what we know for trauma—if you have another human being next to you that supports you and cares for you, your anxiety levels do reduce.

Just like if you're patting a baby and if you're a comforting person, the baby stops crying; it's the same with the traumatised person. If there is someone there to talk to, to acknowledge the difficulties even, or even to say, "Yes, there isn't anything for you right now," or, "Yes, there is a long wait to see your doctor," that validation and feeling at the moment like, "I'm not crazy. I have hope. I have a place to go"—even if it's waiting, and an acknowledgement that the services are wanting—I have found that that has been, in our hospital, one of the most therapeutic things that has happened. When you have all of these women together, next to each other, talking about how hard it has been, being diagnosed with four or five different mental illnesses and told that they are the problem and they will get better if they take this one tablet or these two or even these seven tablets—having them talk about how hard that has been and then the joys of finding a place that's different and just having a little bit of hope makes such a difference.

In terms of the acuity, I think that that definitely—I have not been able to cure the PTSD in the short time we have been open, but there has been an absolute reduction in people turning up in acute distress to the emergency department. They know, via the service and via the people that they've met, that's not the place to go when you're traumatised; let's wait and see what we can get and try and find the things that are appropriate. But you've got much more empowered women that are saying, "Well, I know that's not going to be trauma informed for me. I'm not going to go there and waste my time and be told, 'We can't help you. Go home.' " They are at least waiting for the things that are going to be helpful and able to make more autonomous decisions. I'm very much for peer support as long as those people are themselves trauma informed, because sometimes you have seen really inappropriate commentary from the peer supports as well.

The Hon. SUSAN CARTER: And the treatment gaps? In your observation, is it because we don't have enough of a sufficiently trained workforce in this area, or is it because there's perhaps an overspecialisation so people feel, "Well, this isn't what I do, and it has to be somebody else who deals with that"?

KAREN WILLIAMS: I think we can't ignore the social and cultural aspects of trauma. When we as a profession—I'm talking about psychiatrists and other mental health professions. It took us a long time, as a profession, to acknowledge that veterans and soldiers would come out of these traumatic environments and have mental health symptoms. It was only in the '60s that we agreed it even happened and then we had to spend time developing programs to respond to that trauma. What we did was write definitions that said the person had to have gone to war; the person had to have almost died to actually even get that diagnosis. The translation of using that diagnosis and the idea of a mental health disorder, or syndrome, or illness—whatever you're wanting to describe it—that has not been used at all for the female population who have been traumatised on a day-to-day basis, even though the symptoms are exactly the same.

So you've got a profession that is really far behind—so I'm just acknowledging that—and then we're the ones that inform where the money gets spent. It's those same professionals that are coming forward and saying, "This is what I need funding for. I need funding for the veterans. I need funding for depression. I need funding for borderline personality disorder." But they're not asking governments for health spending to be put towards PTSD caused from domestic violence. So it is not just a responsibility of any one person. It is a cultural shift that needs to happen and an acknowledgement. Like I said, I think there's a demand for accountability here.

The Hon. SUSAN CARTER: Just picking up on the vicarious trauma that you've both been discussing, do you have any comments on the Royal Australian and New Zealand College of Psychiatry report about staffing shortages and burnout reaching crisis levels in New South Wales?

KAREN WILLIAMS: Yes. Look, I think when you have so many patients with these social issues that we're told are—we've got to note them. We've got to ask a question about poverty. But then, when you see that you've got a person who is homeless or is currently living in an unsafe environment and you've got nowhere to send them, that's a different organisation; it's a different ministry. You do feel really frustrated and depressed and anxious about the fact that you're sending people that you've developed a bond with and you care about. You've got nowhere to send them. You sort of can't—they're saying, "Well, I don't feel good. I want to die"—all of things that they're coming forward to. The only weaponry you have at your disposal is medication, and that's not the thing that's going to help them, and you know it's not. So I do think that it takes such a long time to spend with these patients and get them to trust you and open up to you. The rebates are far less when you're doing that.

You're actually financially penalised to spend a long time with people. You're better off seeing patients every 15 minutes and writing a script than you are to see—you see four patients in an hour and charge a big gap on each one, or you see one person who can't afford to see you and don't charge any gap. But the remuneration is there and there are so many other options, too, where people are getting lots of money to write medico-legal reports or work for workers comp. If you're going to get thousands of dollars to write reports there or you are going to get a lot less and then have no way of fixing the system, you get a shift away from the things that are actually meaningful and you do the shallow work that actually doesn't provide that sort of satisfaction. I think that all of these systems things are definitely contributing to burnout.

The Hon. SUSAN CARTER: So you'd agree with the college that in New South Wales we have a major issue with retention of psychiatrists in the public health system, and that we're reaching crisis levels and it has to be addressed urgently?

TARA HUNTER: Absolutely, and I think vicarious trauma and burnout often live together. It's quite hard. They have similar kinds of presentations. I'll just talk from—I did quite a lot of training around vicarious trauma. Just talking generally to frontline workforces, we know that part of what people experience at that front line is the frustration around the system—so not having enough time, not having good referral pathways and not being appropriately compensated for their time. There is an absolute sense of overwhelm, and it goes back to the question you asked before about training and support. It's all well and good to train people up, but we also do have to have the appropriate recognition in the workforce.

If we're not actually providing trauma-informed systems, trauma specialist care, then there's no acknowledgement of the fact that clinicians are actually being overwhelmed with people's stories of trauma. But none of it's visible. That is absolutely part of it: It is about creating systems. When we create trauma-informed or trauma specialist systems, it creates some visibility around numbers and what are some of the issues, so that you can go from there. But one would argue we don't have a good baseline around that.

The Hon. MARK BUTTIGIEG: Just on some of that evidence, basically you're saying the economic incentives aren't set up to deliver the quality outcomes because it's a function of time rather than quality. Is that because the Government—or whoever is making those decisions in the health service—is not informed by data, which presumably would show that the longer you spend with someone and the more care you give them, in terms of quality, the better the health outcomes? I think if the metrics were there for the decision-makers to say that it's about quality, not quantity, then maybe we could shift that. I'm interested to hear what your thoughts are on that.

KAREN WILLIAMS: The way it's designed is you get to charge per item that you bill. Especially for GPs, they're governed by a manager who wants to see you bring in more income because they take a proportion of each one of those patients' fees that you see. If you're seeing one person you can charge one gap, and then you spend the same amount of time and you'll get $37 an hour, I think—is it?—for a GP. If you're there for an hour with them or if you're there less than that, that's obviously going to be not as financially good for you as if you see someone every six minutes and charge a gap for every one of those. That's why even the manager is going to be pushing those GPs to see more people quickly and encourage those short consults—because they're going to get less. So even if you are a doctor that would like to spend that time with the patient, and you get the job satisfaction and you say, "Okay, I don't care if I don't get paid as much", my manager doesn't want me to do that and will push you out.

The Hon. MARK BUTTIGIEG: It seems to me as though that is a fairly fundamental perverse economic incentive, right? This is a fairly major systemic problem, I think.

KAREN WILLIAMS: Major, 100 per cent.

The Hon. MARK BUTTIGIEG: It sounds like we have to rethink the way that we provide the economic incentive for the consultation.

KAREN WILLIAMS: Yes, I absolutely agree with that. That needs to happen, because it should never cost the clinician to actually give a shit. It shouldn't happen like that. It shouldn't be where if I want to spend time talking to them, calling up—say if I need to call the police—I won't be able to charge for that. If I want to try to ring an organisation and say, "Can anyone provide emergency accommodation?", I'm not going to be able to charge for any of that. For me to actually pay the attention that is needed for these really complex cases, it shouldn't—

I'm okay. I'm not dying; I'm not on the poverty line. But if my income is so much less doing that, you are going to generate—

The Hon. MARK BUTTIGIEG: Yes, of course.

KAREN WILLIAMS: It has been really hard to recruit people to come and work at the hospital that I'm working at because there isn't the income. You're not going to get that income that you would get if you worked for workers comp or for the defence force. The income is nowhere near it. All that happens on the public unit, so the acute inpatient units—there's not enough money in that either and so all the patients get is to sit around like animals in a pen. There is no therapy given to them. There are no activities. There's no exercise. There's no whole-of-body care for them.

If you're a doctor, all you've got to offer is watching these people get put in a locked unit. They're all pulling their hair out. They're bored. They're uncomfortable and arguing about why they should go home. If that's all you see, then who wants to do that work? There's nothing at all interesting about that work. You've got people saying, "I'm nothing more than a jailer here. I'm not able to provide any therapy. I'm not even able to say, 'I need you to go see the psychologist. I want you to go into the art room and do some art. I want you to then go and do yoga.'" This is what I get to do. I love my job because I can watch people get better and empower them. The patients actually get better and get excited about their future and they get into a routine.

You've got to have something that shows that the work you're doing is making a difference. That makes you want to do the job. In site training, nothing is inspiring in the system. It's people going in and out, in and out, saying how much they hate it, how terrible you are and how little you've done to help them. It's the same faces. They get called—"There are frequent flyers back again. One of yours is back again." That lack of seeing that your work is effective and that it makes people feel good—what's the point? You go into medicine because you want to see people get better. That's not happening in the mental health system, the way it stands, and so it's not inspiring new people to do it at all.

The Hon. MARK BUTTIGIEG: Yes. It's probably that the consequences, whilst they'd be similar, are less acute at the traditional medicine spectrum, because you're seeing people and you're giving them a prescription or whatever. There is some sort of utility gain. But in this field, where you need quality time and investment in the therapy, obviously the consequences are more acute. So there is pretty much a one-size-fits-all model—get as many through as you can.

KAREN WILLIAMS: But even with the medications, if you really want to get down to the nitty-gritty, they're not that effective. We actually know that. The research isn't showing really great gains with our medications either.

The CHAIR: Thank you so much again for being here today and for sharing your expertise and your experiences. The secretariat will be in touch with you if we have any questions on notice. Unfortunately, we're out of time. I think we could probably talk about this issue all day. We really appreciate it.

(The witnesses withdrew.)

(Short adjournment)

Ms SHARON GROCOTT, Chief Executive Officer, WayAhead, sworn and examined

The CHAIR: Good morning, welcome.

SHARON GROCOTT: Good morning. Hi, Amanda, nice to see you.

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

SHARON GROCOTT: Sure. I work for one of the oldest organisations in mental health in Australia. We were established back in 1932 during the year of the Great Depression. Our purpose really was around improving understanding of mental ill health and also reducing stigma and discrimination and increasing help seeking. We still do that work today. Unfortunately, our purpose hasn't shifted; there's still a lot of stigma, as you would have discovered, and a lot of discrimination in the community. We were established back then really to improve understanding; mental health promotion is still sort of what we do today. But we also work across—we're an association, so we have members. We're a peak body, and I represent our members today, as well.

We also provide a range of services across the lifespan, so from early intervention in schools through to our anxiety programs, support groups, our forums. We provide really important work in workplaces around wellbeing. Most importantly, also, I know you've been talking about service navigation, and we've been helping people navigate the system since the '60s. We were formerly funded by NSW Health in the 1980s to provide an information service. So we help people through a phone line. We also have a directory.

Most importantly, our staff that volunteers, our board, we have lived experience. I am also here today, like I said, representing our members. Some have contributed to my understanding and hopefully what feedback I can provide. But I also have professional experience. I started back in the early '90s as a social worker. I've worked over many decades in mental health—really grassroots service delivery across peer programs, family support. I've worked in programs that are recovery focused. I've had quite a broad experience and particularly worked with families with really complex mental health challenges. So I bring my professional experience but also my lived experience. I've been a person who's experienced the public system. My two daughters both have mental health challenges. My older daughter, particularly, has a chronic complex mental illness; she has schizophrenia. So I also come with a bit of that carer hat on as well.

The CHAIR: Thank you very much. My first question is about the navigation service that WayAhead provides. I know you have been following; we have had a huge volume of evidence about the challenges of navigating the system and the need for navigation support, so I was hoping you could explain in more detail how the navigation support works that WayAhead provides works.

SHARON GROCOTT: Sure. We provide an information directory. It's very current and up-to-date. We have almost 6,000 services listed, not just in mental health but across community services—so housing, employment and education. It is quite a broad database. We also provide a phone service. We have the mental health carer line. We run a phone service and we also operate the official visitor phone line. But, for me, the system, as you would have heard, is extremely fragmented and very disjointed. I had come with many years of experience, myself, in mental health, and I found it extremely difficult to navigate. When you have a family member with a more complex illness, it's really complicated. I think it took me 2½ years to work out how things work. Despite our best efforts at WayAhead, what we do is not enough. We are not resourced enough. Funnily enough, hearing what you have been saying about service navigation, the Hon. Mark Butler did put out—at a briefing just before Christmas, he welcomed proposals for early intervention.

So I'm about to submit a pilot project for a statewide navigation service in both Queensland, where we have a partner, Raising Minds, and in New South Wales. So I'm about to submit a proposal for a model that's very much trauma-informed—very important, as you've been talking—and culturally informed, but utilising peer workers, people with lived experience, to not just support parents with children four to 17 to navigate the system but also to provide what we've talked about: that emotional support, practical support, but also future planning support, what to do in a crisis, how does the system work, what are psychiatrists, and what do psychologists do—basic things that parents really struggle with. How does the hospital system work? How do the early intervention psychosis teams work compared to when your child then becomes an adult? All of these challenges that we all find that are extremely difficult to navigate and, through my own lived experience, talking to so many parent-carers—for years I have connected with parent-carers, even through a parent body. I am really passionate about actually doing something around this, so we're about to put a proposal in to the Minister.

The CHAIR: Noting that is the Federal Government and not the State Government, would it be possible to share that proposal with us as well, perhaps confidentially?

SHARON GROCOTT: Yes. Definitely my plan is to send a copy also to our Minister, who is wonderful, Rose Jackson. And I am very happy to share that with the Committee.

The Hon. GREG DONNELLY: Welcome back.

SHARON GROCOTT: Thanks, Greg.

The Hon. GREG DONNELLY: You are not a first-timer in terms of your contribution to parliamentary inquiries. I think this is the third one.

SHARON GROCOTT: That's right—actually, the fourth. I actually also had a bit to say at the family law inquiry.

The Hon. GREG DONNELLY: You have become very experienced at presenting and preparing very helpful submissions. Thank you for your submission. It has been received to the inquiry and stands as submission No. 84. Your organisation has a very long and distinguished history. For the time that you have been involved, what is your sense of the way in which mental health has been understood in society? With respect to how we are dealing with mental health—I mean that in the broadest sense, from mild through to very serious, which you have direct family experience with—where do you see falling down in the biggest sense, in other words, the biggest fall, and what are goals that may be being kicked? What is the best and the worst that have you have observed over that time?

SHARON GROCOTT: We're really well known at WayAhead for our work in mental health promotion. We do a lot of work around stigma reduction. Each year we run Mental Health Month in New South Wales, and it's wonderful. I think last year we had 45,000 of our resources downloaded by not just a lot of workplaces but even mental health teams and schools. We had 3,000 packs roll out into schools. I think education awareness is really critical but it's only one—we need a multi-pronged approach. I think having that approach does help and we do hear some wonderful feedback about the difference that it makes for people, even as individuals, in feeling less stigmatised. There's a lot of self-stigma, as you know. I also think that there is still a lot of stigma. We polled 2,000 people last year across the country. We did a survey. I aligned it with the national survey that was undertaken by the National Mental Health Commission. We had some similar questions. I was shocked. I was stunned to see how much discrimination is still in workplaces, for example. I think 78 per cent of people said they wouldn't disclose to an employer.

One of the main concerns I had was GPs were named as one of the main places where—going to their GP—they felt stigma and felt ashamed to talk about mental illness. So I think we still have a lot of work to do across society. I feel that particularly with certain mental illnesses, and we found the same—illnesses I hate to talk about like schizophrenia, which I've disclosed that my daughter lives with—people have this fear that they're going to be dangerous and that they need to be forced into treatment, for example. I was really shocked at some of the views and some of the misunderstanding about the condition. There's not a lot of knowledge about psychosis out there, so people are very fearful of people in psychosis. Conditions like bipolar, for example—that was another condition about which there's a lot of discrimination. I think, as a society, we are organisationally kicking some goals. We see some really positive outcomes and we talk to communities and we go out and see what's happening, but I think we still have a long way to go.

The Hon. GREG DONNELLY: Focusing on those darkest corners where, one would argue, there should be some, almost urgent, attention in terms of policy and ultimately funding, if necessary, what would you identify in that category—dare I say, the worst of the worst?

SHARON GROCOTT: Greg, you and I were chatting in the break about education and, as I just heard, I'm so pleased that trauma-informed practice was talked about because, having worked with families that have really complex challenges, trauma always underpins what's happening. You can't look at a person with a mental illness without having a trauma lens, so I think, particularly, we need to change how society views mental illness. There's not a trauma lens across things.

My experience personally—and even our members have talked to me about it—is that we have a very medical model and not one that sees a person as part of a wider system, where a person is part of a community or a neighbourhood and has extended family and kinship, and is part of a workplace or perhaps even an educational institution. We often, in the system, see a person as an isolated individual. This medical model—I think we really need to shift that. We could learn a lot actually from First Nations practice around culture and connection and understanding that a person sits within a system. They're not just in isolation. I think our whole medical model needs to shift, and that starts with education early on, as you've talked about, and training psychologists, social workers and doctors. There's some really good models around contact—for GPs to actually have contact in their training with people with a mental illness—to build empathy. Empathy is a huge thing, and having more of an understanding and empathy for people would go a long way.

The Hon. EMILY SUVAAL: So nice to see you again, Sharon, and thanks for all the work that you're doing and that your organisation is doing. Whilst we're on the topic of trauma-informed care, would you say that our State services, at the moment, are providing trauma-informed care? What does that look like, or what improvements could be made?

SHARON GROCOTT: Thanks, Emily, that's a really important question. Just from my experience to start with, I was a bit surprised actually. Amber, about three years ago her symptoms started so she was under the early psychosis team through the community mental health team, and I was really surprised at that sort of lack of understanding. She has a disability, so she's had a lot of trauma through her life, and she's very proud that I'm talking today actually and getting some of her experiences across. I was surprised that there was no sort of understanding or insight about other conditions, other experiences that she had had.

Also, even I have heard from families often talk about the lack of cultural understanding, and I've just been talking to 200 low-income families across New South Wales earning under $50,000 about their experience of the mental health system, and a lot have talked about their experience that it's a one-size-fits-all; that it's not a flexible model; it's not individualised; it doesn't understand their cultural, their religious, their community experiences, and I hear that a lot. It's not the first time; having worked with families for many decades, I hear similar things.

So I think the system we have at the moment needs to be more flexible, more individualised. I think the quality of care really doesn't consider, and staffed aren't trained necessarily in having, that trauma lens. But I was also surprised with the public system, that lack of carer-family inclusion. I think it was about six months in when they actually asked us how we were going as a family, and that surprised me. I just assumed the system would think about inclusion of family and carer and what impact that might have but it just didn't.

The Hon. EMILY SUVAAL: Sorry to interrupt you, but why do you think that is? Is there a reason for that, do you think?

SHARON GROCOTT: I think part of it is the high turnover.

The Hon. EMILY SUVAAL: High turnover in?

SHARON GROCOTT: There's a really high turnover of staff. I think we went through four case managers within six months. Every time we went in we had a different psychiatrist. I actually ran out of fingers to count how many we had. Part of it was that lack of continuity of care. The next person didn't know if that previous professional had asked or looked into how a family support was working or how the family was functioning—so I think the high turnover rate, the burnout.

You talked about the crisis point that we're at with psychiatrists; that is a real issue. I think I went through 12 different ones on the phone and all had two-year waitlists privately. Because we just couldn't continue with the lack of continuity in the public system, we decided to go private. We had already experienced three different private ones because none of the professionals quite understood disability and how that disability is impacted by schizophrenia. They didn't quite understand the functionality aspects or how the two interplay together. It's particularly hard to find a psychiatrist with a specialisation. It's very rare to find one. I think for families, the cost as well is prohibitive, but the public system and just that lack of continuity of care and the turnover, that really impacts having that sort of family-informed, trauma-informed, being able to really have that support of a family's holistic needs. Even that recovery focus was lacking; it was just really a medical model.

The Hon. SUSAN CARTER: Thank you very much for being here today and taking the time. I'm interested in your comments in your submission and in evidence in relation to continuity of care and the effect of the difficulties in retaining psychiatrists in the public system. I'm aware of the comments made by the college. Your experience sounds as if the burnout of psychiatrists isn't just an issue for the workforce; it's a real issue to do with patient safety; it's a real issue to do with the ability of people to recover well and build a strong recovery path because of the difficulty of public hospitals in retaining psychiatric staff.

SHARON GROCOTT: That's absolutely spot on really with what you've said. I think building trust—I know that has been talked about earlier—is a key, so if the patient is able to build trust with the psychiatrist, really build that engagement, have that continuity of care. We've talked about, funnily enough, medications, and to be frank I think I saw some evidence from the New South Wales Mental Health Commission that only 49 per cent of patients have efficacy and that they're pretty much not effective for many people. I'm not saying that they're not important. And don't get me wrong. My daughter—I think we're on the ninth antipsychotic medication, and we've got three more options before clozapine.

I think that that importance of care—it's not just about medication and treatment, but the person, the psychologist, really needs to be involved in that recovery planning. I know, for my daughter, for example, equine therapy probably has more positive outcomes than some days of what her medication is having. Having art therapy, having social interaction and inclusion and feeling like you belong to a community has a huge outcome for people. The problem with the current situation is just trying to find a psychiatrist is near impossible, let alone retaining one and seeing the same person.

The other challenge, too, for people is that I've discovered for us—because we live with a chronic condition with Amber—unless we have a psychiatrist in a hospital, it's near impossible to get hospital beds. At times, we have waited two weeks for a hospital bed. We have been managing her in quite an acute state. By "acute", I mean she hasn't been able to shut her eyelids for weeks. She can't sleep. It causes her to be distressed, pacing up and down the house. Amber would have hallucinations, visual ones, delusions where she thinks that the neighbours are going to come in and that someone is going to assault the family—like, really frightening, very scary, at times self-harming and suicidal.

Families are left to manage that because there are just not either hospital beds available—the experience of the emergency system is traumatising. We have stood there for 12 hours at a time where Amber is in an acute, distressed state, waiting to be seen. Then I've been told by the staff that she would be safer in the psychiatric emergency care unit, because the adult ward is frightening for someone with an intellectual disability. Even the staff have advised me that I'm better off going home. That's sort of what carers and families are living with. I think, "Gee, I'm a person with clinical experience, and we're struggling. How are other families going that don't have that clinical basis and they don't have that knowledge?" I have worked with people with extreme behavioural challenges. And I'm not saying—I mean, people like Amber are not dangerous. If anything, it's more fear of danger to themselves, not to others. But it is really challenging to manage with the current way that the hospital system works.

The Hon. SUSAN CARTER: What I'm hearing from you is that the burnout of psychiatrists affects the workforce; it affects the patients; but it's also having a very big impact on families. How do you get supported to keep on caring for your daughter?

SHARON GROCOTT: Sure. My husband is amazing. He has never had any—he has come from a finance background. He worked in a whole different industry. He has been sort of forced to leave his job. One of us had to stop working, so he is now her 24/7 carer. At times he manages extremely well. He has a respite group. He goes to a carers group on a Friday and talks to other parents, which is really important. But at times—last night, for example, he was at crisis point because she had been sick with a vomiting bug for a couple of days and hadn't been able to take her medication. So her mental illness was spiralling the last couple of days, and he was sort of at breaking point. So carers are constantly having to manage these situations, often with little support and without respite. Even the NDIS, I'm told, won't cover things like 24-hour respite. We are fortunate that we have a daughter who also is a young carer, who steps in at times. She's an amazing young woman. But for families that don't have that, I don't know how they would manage. It must be extremely difficult.

The Hon. SUSAN CARTER: I am interested in the comments in your submission and earlier in relation to the family as being seen as part of the support system.

SHARON GROCOTT: Yes.

The Hon. SUSAN CARTER: It would be interesting to explore your experience of why the family, perhaps, hasn't been brought in as a support system. Do you feel that you have been adequately listened to by medical professionals in the care of your daughter?

SHARON GROCOTT: No. On the whole, no. It's interesting, the Productivity Commission talked about this back—2020 the report came out about the exclusion of carer families in the system. Don't get me wrong, I have worked with families with really complex challenges and occasionally a family might not be the best support mechanism, but on the whole families very much are, and we're there to provide practical support. We can see when our loved one is becoming more unwell. We can see the signs, the red flags. We can identify early. We can support their treatment, their medication, make sure that they're taking their medication. We can support them going to appointments, medical appointments. We can help them facilitate recovery. As I said, other ways that someone can recover that are non-medical, having more of a wholistic care plan in place. Families are so pivotal and yet they seem to be excluded and not have a voice. Often it's at the point where—my daughter's an adult, so now I can't even go into a hospital ward when she's admitted. I have to get guardianship now so that I have a right and a say in her personal care. We're very much excluded.

The Hon. SUSAN CARTER: Could your daughter adequately access medical care to support her without your active support as a family?

SHARON GROCOTT: No. If we weren't there, to be frank, her personal care, her medical care, that would all be at jeopardy and she would probably end up back in a hospital.

The Hon. SUSAN CARTER: Yet you're not directly included as somebody with insight and able to provide support for her recovery?

SHARON GROCOTT: No. Even with a Community Mental Health team, we attended every session, either Rohan or myself. We were very engaged in making sure she got to those appointments, and yet we were not really included. I think training of professionals to understand the role of carers, understanding that we can have that really pivotal role in overseeing and seeing those red flags with our loved ones, but also providing all those practical, emotional and other supports is really important.

The Hon. SUSAN CARTER: If you see the red flags and you can identify early that difficulties are emerging, are you listened to by the medical professionals?

SHARON GROCOTT: At the moment we have a new psychiatrist, so we've had to go through the private system with a psychiatrist attached to a hospital and she very much listens. We've found gold. We've found someone—like I said, I'd hate to count, but I'm sure there's over 20 psychiatrists now that Amber has seen over her last 3½ years. But we've now sort of struck gold with someone who does listen more and is very engaged. Having said that, for the average family affording that, I don't know how they'd afford it. We are pretty much using our retirement funds and the cost of even a hospital bed, for example. Amber was in Gordon Private for a number of weeks. I was shocked and stunned to see the real cost of $16,000 a week. We were lucky that Medibank would pick up, apart from an excess. I don't know how families can afford to pay even Medibank Gold, for example. It's extremely expensive to access the private system. But for us, we didn't have an alternative. We were, as I said, pretty much told by the staff themselves in the community mental health team, they were fearful of her going back into the adult ward, and they were actually advising her that it wasn't a good choice for her.

The CHAIR: In your written submission you touched briefly on a conversation that you'd had with the Community Mental Health team about outreach, about being able to actually receive care somewhere other than a clinical setting. What difference would that have made for your family and for Amber?

SHARON GROCOTT: I think it would have made a huge difference, and I know myself, having come from an organisation that provided counselling before I started at WayAhead, we were providing counselling in a park or in a school. Even for, for example, First Nations, we were going out to community places that were comfortable for people. I think being able to provide care out of a clinical setting would actually break down barriers. It would increase engagement. It would actually take away the medical model and the perspective that it's a medical model that we currently operate in. I think people would feel more comfortable. Culturally it would be more appropriate for many people. I think that it would change up what currently is happening with this sort of—and not just medical model, I have to say quite a patriarchal system at times, where you're told, "I'm the expert. This is what you need to be doing. This is a plan." There's no inclusion or holistic view of what the family might think or what the young person themselves thinks is best for their care. There's no inclusion of that; it's a very much patriarchal medical model.

The CHAIR: We are out of time. Thank you again for sharing your personal experiences and your professional expertise with us. It is really valuable.

SHARON GROCOTT: Thank you for having me. I really appreciate it.

The CHAIR: The secretariat will be in touch if there are any questions on notice.

(The witness withdrew.)

Mr WILLIAM CAMPOS, Chief Executive Officer, Independent Community Living Australia, sworn and examined

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

WILLIAM CAMPOS: My background is I have been in the sector for about 25 years, both as a clinician, carer, executive and I also did some work around research in the area, so I have got lots of different—a wide range of, I suppose—exposure to the sector. My principal work at the moment is an executive, as a service provider, but in the past I have actually taken on commissioning roles for community sectors and working at a primary health network, as well as transcultural mental health services at NSW Health. I am currently registered as a clinical psychologist. I have been practising a number of years as a clinical psychologist in private practice as well, previously—not so much now.

Currently, I am representing both as a carer, through personal experience, and I also have some experience with providing advocacy for the services that I provide. The focus of my work has been around four key areas. At the moment, with my organisation, we're very much focusing on developing a lived-experience peer workforce. We also focus very highly on the ability to provide what are called prevention and recovery services. Part of my work at the moment is we are a housing provider, so we do a lot of transitional housing and supporting the homelessness sector. Lastly, we're also a disability service provider, so we do a lot of work intersectioned with the psychosocial disability services, particularly around long-term care in terms of supported independent living.

I very much have numerous ideas a little bit about what the Government could do. Contrary to, I think, a lot of things that have been said in the past, my opinion is that things have progressed over the past 25 years since I've first been interacting with hospitals and mental health services. But I think there is a lot more that can be done and there are different areas that I think the Government should look at, to try to leverage, to have those services much more consistently coordinated.

The CHAIR: I have one question and then I'll go to questions from other Committee members. In your written submission, you talked about psychiatry liaison services and you mentioned one from New Zealand and then another one that was trialled in Western Sydney. Could you explain that in a bit more detail?

WILLIAM CAMPOS: Sure. When I was working at the primary health network, one of the concerns that we had—we had a lot of GP practices, particularly in Western Sydney or in disadvantaged areas, who had an enormous amount of workload associated with mental health, and we could see by the Medicare billing items that they were struggling, I suppose, in some ways to provide quality care with the volume of people. One of the things that we were fortunate enough—we had some ability to commission some services and look at innovative services that can help. Part of that consultation process is going to the GPs and understanding what they think they would need.

What we did at that time, we did a bit of research and we found that in New Zealand they do have what they call a psychiatric liaison service. We went down to South Auckland to do a bit of research around a particular area where they employed a psychiatrist predominantly that would work in a hospital setting, maybe one or two days a fortnight or week, and then the rest of the days they would be going around to GP practices and supporting the GP practices, either with the people who had been discharged from those hospitals or maintenance, supporting those patients who had some severe mental illness but needed to actually be supported at the community level.

There was another element to that psychiatric liaison service, too, which I though was really interesting. There was also a component of training psychiatrists. It was a very senior psychiatrist who was obviously anchored to a hospital setting, but then he had about 10 GP practices that he would be liaising with to support both the GP nurses and the GP practice team to be better informed, to educate them and also offer some sessions within the GP services around those complex needs. Then a part of that was that part of his training of new psychiatrists, not only at the hospital but also within the GP services.

We saw this model as something that we could be trialling out in Western Sydney. It was something that I think was well received, particularly with some of the GP practices that we highlighted were a very big need. We highlighted 10 GP practices that potentially had a very large volume of demand and we hired a psychiatrist through a not-for-profit organisation because we didn't have the mechanisms to actually hire through NSW Health or the local health district. We hired a psychiatrist who had previously worked in the Western Sydney Local Health District's hospitals, who was then able to coordinate care across the GP practices. From memory, that service went for about four or five years until the funding ran out, but the experience was that once a GP practice was well supported and had the skills to understand how to support people with complex mental health needs, that psychiatrist would then also be able to move to other GP practices in the region that had pressing demands.

The Hon. SUSAN CARTER: Thank you very much for being here. I'm very interested in your comments in your submission in relation to navigation. I note your recommendation in relation to the app, which seems like a good way of information-sharing. I'm just wondering if you have any thoughts about the other side of navigation, which is really finding and locating the right services and also the available services. Do you have any comments about whether someone who is mentally ill is able to manage that navigation themselves, and whether family should be directly and explicitly involved or a support person? Do you have any thoughts around that?

WILLIAM CAMPOS: I probably have a lot of thoughts around that. I guess the first point that I would say is the navigation system is very convoluted. There is various different information out there. There is an element, in my experience, that you do need to do a little bit of effort in terms of understanding what services are available before you actually buy into the service and engage with the service. I think there is always an element of "try before you buy" with services until you feel as if you're comfortable enough and the service that you're engaging with meets the need of the person that you are supporting.

With navigation, if I could break it down to thinking around what I see as problematic, the first one is that there is a commissioning cycle of services that are both by State and Federal government that often put money into the community and promote a particular type of service. In two or three years' time you often find that either that service is not able to meet the demands or not able to continue because of a lack of funding. Every three years there's an evolution of services coming in and out of the communities because of the way the commissioning cycles happened. There is an element there that is always changing. The sector is always changing, which makes it difficult.

The second thing about navigation is that in order to support some navigation, the navigator needs to be well informed. Because of the plethora of services out there, sometimes a lot of navigators don't have the capacity to really know and understand all the service's availabilities and what the service offers related to a particular individual. I think the previous person who was here talked about that it is good to have a person on the side who you can connect with. Part of navigation is to do with supporting someone to walk through and discover the services that are available to you. But I often find that that particular service or that navigation type of service is better done by, usually, peer workers or lived experience or a group of support workers that have some experience.

I'm a big fan of a service called recovery colleges, where people go in and learn about their condition, but they also get to interact with other like-minded people who are also going through similar services. It almost becomes like a support group through that mechanism. The navigation role for me is very much not professionally based services; it is more to do with community-based support. The last thing I would say about the navigation is that it's also very unique, because every individual with a different mental health need has a very specific, unique need. In order to navigate, you probably do need to go with someone you can trust—often that person is usually family or someone who is very close to family—before they can navigate with someone who is a caseworker or a community peer worker.

The Hon. SUSAN CARTER: Do we need to do some more work to ensure that services are happy making appointments via a nominated navigator, rather than with the patient themselves?

WILLIAM CAMPOS: Yes. The ease of engaging with services is really important. I think one of the suggestions I made in my submission was that, with the app, there is visibility and transparency about availability and when things can be connected. It allows the consumer who is navigating through the system to have the ability to organise and coordinate the services they feel they need to attempt to engage with. But the key question then becomes: Is that person well informed about the services that are available to them?

The Hon. SUSAN CARTER: Thank you also for your very careful discussion of telehealth and the benefits and the limitations. I'm very interested in the reference that you've made to research indicating a lack of adherence to treatment over the long term when we are talking about telehealth, because we don't want to go down a path and find that it's ultimately not successful. Could you maybe talk a little bit more about that research and issues of adherence to treatment over the longer term?

WILLIAM CAMPOS: The research that we found in terms of what I'm referring to is that there is some really good evidence that technology allows almost immediate access to services or connection with someone who can probably provide help, so it's quite reflective of the need to respond to a need, whether it's an acute presentation or some sort of immediate assistance. But what we found is that, over time—and this is going back to some of the work I've done many years ago with helplines—there is a tendency also for people not to go from an engagement of an online platform to a face-to-face service. Sometimes there is that element where people will either continue to engage online or with a helpline and never go to the process of what they call "recovery", where they are addressing some of their needs.

The other thing too is that there is an element of—when you go to a face-to-face service, people usually invest the time and resources and energy to go and engage and test and develop a relationship with a service. With some of the online services, there is the anonymity, and often there is the ability for people to test those services but potentially not invest in their recovery. So my discussion here is around how there is a need to try to collaborate both of those—the online environment with a face-to-face service. That eases those transitions of care much more holistically. I think there is quite a bit of evidence where you can combine a few online tools that can coordinate that quite easily.

We have a prescribing system where the doctor can have some access to understanding where the person is interacting with an app, understand a little bit about checkpoints, about how the recovery is, and there are some checkpoints about how the person is navigating through their recovery, and if acute levels of need happen, they can actually engage with a helpline. With a closed system of an app, you can assist people to easily navigate between the services. An important point about the digital platform is to also support the family's involvement. So when a person can't engage services for themselves, there is a nominated person who can actually look and support that navigation as well.

The Hon. SUSAN CARTER: My last question is in relation to your discussion about the psychiatric liaison service, which was trialled in Western Sydney. It was discussed as perhaps a measure of dealing with the shortage of psychiatrists in rural and regional areas. Given the difficulties we have of retaining psychiatrists in the public health system, do we have sufficient psychiatrists to provide a liaison service to regional and rural GPs so that there can be an outreach service to the very under-serviced regional and rural areas?

WILLIAM CAMPOS: If you're asking me in terms of enough bodies of psychiatrists to do that, I'd probably say no, there wouldn't be. I think that's where the online environment—and I do know that there are some online psychiatric support for GPs that are currently developed. But I guess it goes to the point that was raised earlier about—it's the fulfillment that the psychiatrist needs to have in their role. I often find when you're talking to hospitals, if you have a psychiatrist in a hospital setting, they are constantly looking at the acuity levels and are very short-term intervention. Often they're working at their very high level of qualification, which is to do with managing a crisis or a psychotic episode or something along the nature of the emergency department. If you have a psychiatrist who's working there five days a week, 365 days of the year, you often find that there's not a fulfillment associated with that role.

I think one of the things that psychiatric liaison officers are looking at is the ability to enhance the psychiatric profession of not just supporting the acuity levels of distress but also the continuity of care and that community liaison where, potentially, you can actually see the whole lifecycle of the journey of care for the psychiatrist who's treated that person maybe in this hospital but has also got touchpoints in the community with the GP and other areas in the community. So if you can actually get a restructure about how you engage with psychiatrists in a hospital setting, you find that there is more incentive for them to actually start delivering services in the hospital. Most of the interactions I have with psychiatrists, it's not all about money. I know there were some discussions about economic incentives. I think there's also fulfilment in their role and the ability for them to see that recovery process and journey of care. I think that's what the hospital setting doesn't provide psychiatrists and that disincentivises.

The Hon. EMILY SUVAAL: Thanks so much, Bill, for attending today, for your evidence and your submission. I'll start with inviting you to comment on how important community-based care is.

WILLIAM CAMPOS: It's a very big discussion around community care, but I think the central part of community care is family. My experience has been often we talk about treating the individual who has the condition; but often professionals and services don't really engage well with the family. I think there was a comment here that potentially there may be times where engagement with family is not appropriate, but I think on a whole—the majority—the family are the ones that actually have the best knowledge and support.

I also think community-based services are really important because that's the one place where you can actually ease some of the traumatic experiences of people going in and out of hospitals or the intersection between when they go into high levels of acuity where, potentially, that leads to police involvement, ambulance and, potentially, other hospital admissions. If you have a strong enough—and areas of visibility and the ability to provide respite for family at that early level, you often find that that would alleviate that traumatic experience into the hospitals. I think that's particularly important for the younger cohort. So in answer to your question about the community, it has an enormously important part to play, but it's a matter of that coordination of care between hospital, community and the primary sector that needs to happen.

The Hon. EMILY SUVAAL: Just on that note of integration, is there a need for greater investment to improve the current integration between systems to ensure a more meaningful care journey or outcome for people?

WILLIAM CAMPOS: Definitely, yes. If I could show you the example, and this is one of the, I suppose, parts of the services that we provide. We deliver a service called prevention and recovery centre, which is a short-stay residential service which is often known as step up or step down. We find that that service for us is important. The way we designed it we found was really important. We designed it in such a way that it is a community-based service, away from hospital. So it's a home. People can stay there for up to 30 days, overnight, whether they're stepping down from hospital and transitioning back to home or whether they're known to the local health district and they're starting to have high levels of acuity. Prior to them getting to extreme acuity and be called to hospital, they could potentially be self-referred back into the step-up PARC service before they get to hospital. What I wanted to highlight about that particular service is that it was really important for us to be based in the community, away from the hospital, in a house setting, and also be predominantly supported by lived-experienced peer workers.

What we found was that if you take away some of the treatment focus of the medical model and focus a little bit on the personal narrative and understanding how they can navigate their own personal circumstances and be better informed about the care that they need to take for their condition, you often find that there's a better outcome for them in the longer term. Running this particular service here in New South Wales for the last three years, we are particularly proud of the fact that there is some good evidence to say that those people who've gone into hospital for the first time, usually a younger cohort—18 to 25—who then go through a step-down process, are able to much better engage and be informed about the service.

What we do at the Prevention and Recovery Centre is support them up to 30 days. It's a voluntary service. In that 30 days, we can engage with family and give them some referrals to a recovery college or community-based services in that setting. When they transition back to home, they are potentially much better informed, the family has much better awareness about their condition and already there are a lot of referrals through to other community services within their home. I do know they have a lot of these services in Victoria.

The Hon. EMILY SUVAAL: The Committee did a visit yesterday to a HASI Plus in Western Sydney. Obviously that has a different staffing model. As you say, people are predominantly supported by peer workers. I'm quite interested to hear about how this model you're talking about is different and whether this would be appropriate for all people?

WILLIAM CAMPOS: There are different levels. For this particular case, it's more of a step up or step down. HASI is usually for a longer term. We offer services which support independent living under NDIS, which is 24-hour care. There is a different need in some ways for people with a chronic mental health condition, where they need to be supported over a long term. That has elements of an intersection between clinical services and the touch points between family. What we focus on is recovery, to try and get the person back and involved in employment or back into connection with community or families. With the Prevention and Recovery Centre and the peer workers, I think it's more to do with—particularly with a younger person who has gone through the first time—giving that personal narrative of understanding, "You've gone through a psychosis. You may have a condition that you need to be aware of." They then navigate that person, who is saying, "How do I go back home and talk to my mum and dad," or my girlfriend or my employer. "I need to have a some understanding of how I can re-engage back into the community without necessarily being stigmatised by certain understandings of that episode."

The Hon. EMILY SUVAAL: You have one of these services connected in an LHD.

WILLIAM CAMPOS: Yes.

The Hon. EMILY SUVAAL: I'd be interested to know what the demand was like for the service and whether there is a need for more of these services elsewhere.

WILLIAM CAMPOS: I'm being biased here because I support one of these, but I do see this as a cornerstone. One of the keys things is that once a person is known to the local health district as a person who has chronic or complex needs, what you want to do is support them in their home as much as possible. One of the things that families often do is they will pick up symptoms quite early. Often they have to manage that at home without necessarily much support. It's not until an acute episode or something happens—often the default position is sending them straight to hospital, either through ambulance or police. If these services are available where the family is known to the hospital and known to the community, they can refer into a 30-day respite care, which gives the family some respite but also, hopefully, gives the consumer an understanding of working in a non-clinical environment—to understand and better support their needs—with lived-experience peer workers who have been through those sorts of scenarios. In some ways it destigmatises the need for treatment, which is sometimes very traumatic, and also alleviates some of the concerns that the person might have with a family in terms of giving them respite as well so that when they go back to the family there is that respite and that engagement process that happens.

The Hon. EMILY SUVAAL: So why is it that people are still falling through the cracks? It sounds like a great service, and having the option to then self-refer back into the service. Why is it that we have heard other evidence about people still falling through the cracks and still having difficulties in accessing the care that they need when they need it?

WILLIAM CAMPOS: It's a bigger question. In my experience there are a lot of services out there. I think one of the key things is that people are not aware of the services. Often when people say they have missed the gaps, it is because people are not aware of what service is available.

The Hon. EMILY SUVAAL: How do we improve that? As government, how do we improve that?

WILLIAM CAMPOS: I'm going off on a tangent here but I think it's worthwhile for this discussion—one of the things that I think the Government should focus on. When I was part of the Western Sydney PHN, when you're commissioning, we approached the community as a region—a commissioning approach as a regional community. And then if you look at it—getting Housing, the Department of Community Services, the GPs or primary health networks or local health districts and look at managing and supporting a community or that regional level—you often find that you can accelerate the ability to engage with services at a community level and get the cohorts that you would need to address and support much better but also you get visibility on different services in different communities.

One of the things we did at Western Sydney, which I think probably wasn't praised enough, was that we got the education department, the health department, the Department of Juvenile Justice together and said, "Not only can we commission services but are we able to actually be responsible for regions and look at data-informed care, a little bit about where are the hotspots in that region that need to have better care?" When you start doing that, you get visibility but also you get an understanding that services get to where needs it most, and that's where the funding level should go. I think there is a real way that government should focus on understanding how they regionally commission services and bringing services together. That might be a much better return on investment in terms of your funding and commissioning processes.

The CHAIR: In the last couple of minutes I have one last question. In your written submission you made a passing comment about the effectiveness of community treatment orders, and I suspect we'll be having an in-depth discussion later today. You made a comment that they were generally effective but that you had seen them used based on deficiencies in resourcing, follow-up and assertive outreach. Could you expand that comment?

WILLIAM CAMPOS: Yes. It is a good tool to use, particularly when we have people who are really unwell. As a family member, I think one of things that has been really useful is to actually engage with a care treatment order and then go through the process. But I have witnessed—and I won't say names or which regions—there are times when you have different health departments or community mental health departments where they just don't have the resources and you can see them struggling with just being able to actually get some appointments, two or three telephone appointments, after someone is discharged.

Often, depending on the acuity levels or the risk associated with that individual going back into the community, I think sometimes there is a default position to say, "Okay, one way of capturing that risk is to put someone on a care treatment order so at least that way there are some formal processes in place that go outside the community." They may not necessarily be the most appropriate way of managing continuity of care after they are discharged from a hospital but I think the mechanisms are good if they're used well, if that makes sense.

The CHAIR: Thanks, that's helpful. Thank you so much for your time today and for the time you've taken to prepare your written submission. We really appreciate it. The secretariat will be in touch if there are any questions on notice.

(The witness withdrew.)

Dr CLARE SKINNER, Former President and New South Wales Faculty Board Member, Australasian College for Emergency Medicine, affirmed and examined

Dr TREVOR CHAN, Chair, New South Wales Faculty, Australasian College for Emergency Medicine, sworn and examined

The CHAIR: Thank you for making the time to appear today. Would you like to start by making a short opening statement?

TREVOR CHAN: Yes, I'll do that, thank you. ACEM is the peak body for emergency medicine in Australasia and has a vital interest in ensuring the highest standards of emergency care for all patients. ACEM is responsible for ensuring the advancement of emergency medicine in emergency departments across Australia and Aotearoa New Zealand. All persons seeking mental health care have the right to access timely care when and where they need it. ACEM is committed to advocating for a mental health system that has entry points to meet people where they are on their mental health journey.

The CHAIR: Do you have a statement, Dr Skinner?

CLARE SKINNER: Having listened to the evidence already in this session, I just want to acknowledge that we know the care provided in emergency departments isn't perfect. But we're deeply committed to trauma-informed therapeutic care in emergency departments and also working with other stakeholders across the system to make sure people get that care. The points that have already been made about navigation, integration and fragmentation across the system bear out in emergency departments, which often serve as a safety net for the rest of the health and social services systems when other elements of them fail.

The CHAIR: I was interested to read a recommendation in your quite detailed written submission around emergency department staff having pathways for referral into community-based services. You mentioned things like housing and drug and alcohol services. What might that look like in practice?

CLARE SKINNER: I hope you don't mind if I open, Trevor. I think the thing that's really tricky in emergency departments is people don't come with a diagnosis, and people come in varying states across the spectrum. I've been very heavily involved in mental health in emergency departments now for a number of years, and I would tend to refer to psychological distress or psychological crisis, or acute severe behavioural disturbance. Those might be due to a mental health issue, but they might also be due to a number of other medical issues or social crises, so it's a really complicated space.

Like the previous witness said, I do believe that this has improved over the time that I've been working in emergency departments in New South Wales. There are now more services available. There's more of a spotlight on addressing stigma and bias. We've seen some attempts to educate around trauma-informed care and we have seen improvements in the emergency department environment too, so we form better linkages with psychiatric and mental health care services. But we've also seen increasing fragmentation of those services, so that's what I would refer to as a lot of wrong doors.

I observe in my clinical practice, from the emergency department perspective, people ricocheting around the system. They sort of aim for one service and they might get told, "No, that's the wrong place", and then they get fired off to another service—"That's the wrong place". We are not very patient centred in the way we do that. We tend to set up all these services, whether they be physical services or virtual services. But they focus more on managing risk and the exclusion criteria than they do on receiving the whole person, who comes with not only their mental health issues but also a whole range of social and other physical issues that aren't addressed by that particular service. I think, from the emergency departments' perspective—and we are proud acute generalists in the system—we see a lack of focus on the whole person and a system that's increasingly difficult to navigate, despite the proliferation of services that has happened in the space.

TREVOR CHAN: I'll probably add a comment also in the context of up-to-date and available knowledge for both the carers and the families and the patient that are provided for people at different parts of their journey. Often in the emergency department you may be meeting the patient for the first time, the carer for the first time and the family for the first time. Really trying to both establish a relationship with the family and the carers and the patient in that context can be difficult. The availability of knowledge that helps from all aspects, the clinical side and the family side, is imperative—and keeping that up to date. That doesn't just include the medications that they are on or what treatment they have, but it includes those other aspects that previous speakers have talked about, in terms of family and carer and difficulties and access. That also adds to the ability to help navigate, I think.

CLARE SKINNER: There is another critical aspect here, which is the way our health systems are governed. Mental health services sit outside the way that—often, within the LHDs, the acute hospital services are governed in one stream and the mental health services sit outside that. From the patient perspective, that hopefully shouldn't create a barrier, but it creates a major governance barrier when there are two systems with different recruitment methods, different KPIs, different reporting lines. That means when someone is in the emergency department and you are trying to navigate them across services, you've got services that sit in the community sector, run by the Federal Government and you've got community services run by local government. Also, even within the acute hospital system, the mental health set side will be governed separately; it's not under the control of the general manager of the hospital. So it's really complex from a governance perspective as well, and that, I believe, is something that we haven't addressed enough and potentially is some low-hanging fruit.

The CHAIR: We've also had a huge volume of evidence sent to this inquiry about the value of peer workers. People with lived experience have told us that they really value that contribution, and also noting the extraordinary wait times that people often face for mental health assessment in the emergency departments. Do you think that there is a role for peer workers in the emergency departments, or how might that work?

TREVOR CHAN: Yes, I think there is a role. I think it's really based on how that best integrates and the availability of those peer workers. Often, it's the case of are they there at the times of days that people come seeking help? I think it all adds to the ability to then offer the best treatment plan for the person and help them understand the system that we have already talked about as being difficult to navigate.

CLARE SKINNER: Just adding, I really enjoyed working with peer workers, and I find them valuable. I think they understand the system from a perspective that's really important, and I found them very useful in emergency department settings. If I reflect on the difference between the way we might manage a more physical condition and a more mental health condition in the emergency department, the pathway to senior decision-making is much longer on the mental health side. I worry about adding a peer worker in, who then speaks to a clinical nurse consultant, who then speaks to a psychiatry registrar, who then speaks to a psychiatrist, and lengthening that pathway. My plea here is I think multidisciplinary approaches and a lot of people with experience, particularly lived experience, are really important, but we need to make sure that they're empowered in the decision-making hierarchy in an adequate way.

The CHAIR: That's really useful feedback. My last question, coming from your written submission as well, was about the vicarious trauma to ED staff that arises from not actually being able to provide people with the care that they deserve. I acknowledge that that's a significant issue for recruitment and retention as well. Other than the broader work we're going to try to do to get people mental health care where and when they need it, what do ED staff need to help address their vicarious trauma?

CLARE SKINNER: I think, as we have described in our written submission, a lot of what we see in emergency departments in the mental health space reflects a failure of community services. There is always going to be a role for emergency departments managing acute severe psychological crisis or behavioural disturbance. That's what we do; it's the right environment to do that. That requires resuscitation-level skills and senior emergency physician training. But we see a lot of stuff increasingly that's not quite that acute but there is literally nowhere else to go. That becomes distressing because we don't have the right therapeutic spaces. We don't have the right skills. Yes, we could learn skills, but we're generalists—there is a limit to where you can maintain skills. But we also feel that those referral pathways are lacking.

When we refer someone for a psychiatric assessment, that person remains accommodated in the emergency department. We know that the longer you wait in the emergency department, the more likely you are for your distress to heighten; the more likely that you are to abscond from the emergency department, which is high risk because you might come to harm after you leave; and, unfortunately, the more likely you are to require seclusion or restraint to keep you safe. It is highly distressing as a clinician, who has chosen to train because we want to help people, to be having to administer restrictive practice, like seclusion and restraint, within the emergency department or have police in the emergency department and have episodes of occupational violence, when what we want to do is provide a therapeutic environment, use our skills and help people. I just want to make sure as well that we don't equate mental health with occupational violence in the emergency department. The vast majority of consumers who seek care in emergency departments with mental health problems behave well, and occupational violence comes from a broader spectrum. I think that's been a big part of stigma in emergency departments, that fear of violence, but it is not this group, necessarily, who commit it.

TREVOR CHAN: I'll just add a comment or so in regard to patients who do come often and repeatedly to emergency departments. That can be hard on staff as well because you're not always seeing a progression in the patient's care and health outcomes that help prevent them coming. So I think if there are ways that help address that, then that certainly helps support staff to know that when they've helped provide some acute care, there's still the ongoing community care that is helping the patient's longer term journey.

CLARE SKINNER: Particularly the silos, we see—I'm trying to refer a whole person and we hit a silo around particularly alcohol and other drug care, social supports with social work, and addressing other social conditions like NDIS support et cetera, and also neglect and child-at-risk issues. There's a lot that plays out in this space and we are just inadequately supported to address all of that, both with time and space and senior staffing.

The Hon. GREG DONNELLY: Thank you both for coming along today and thank you for the very helpful submission. Can I first of all ask some questions around the issue of fragmentation that you specifically raised? It just seems to me that—I'll use the phrase that it's a bit of a wicked problem, and others might disagree. But we have what appears to be a tension. It might be more than one group, but I'll put it in these terms: We have some manifest shortcomings in the way in which we deal with mental health in our State and in our communities; therefore, we need to see what we can do to lift the boat up across the State of New South Wales because mental health has no geographic restrictions. That clearly has a cost for government or a cost for the state to do that, to increase, at least on the face of it.

There is then the set of arguments that I do understand. I do understand the impulse for these arguments, and the arguments themselves that we need to deal with mental health in the context of specific population cohorts; that they're identified cohorts that we all know, and we have known for some time; and we need to provide some specific attention to those and treat them as a cohort that requires that particular type of, dare I say, tailor-made attention. Is that the fragmentation that you're talking about, or your fragmentation is a much larger melee?

CLARE SKINNER: That's a fantastic question. There are groups that require special attention. I would like to acknowledge that First Nations people have worse outcomes in emergency departments and have worst outcomes when it comes to interacting with mental health services, and that intergenerational trauma is not addressed. A large part of this is socio-economic. If I had a magic wand, I would address the socio-economic determinants of mental ill health. That's just acknowledging that. I think the trouble from the emergency department perspective is the services are based around a particular diagnosis or around a particular age group and, increasingly, are private. There are issues of who can pay and referral pathways as well.

I don't have great visibility. I'm someone who's deeply interested in this and has done a lot of additional learning over my specialist qualification in emergency medicine in this space. I couldn't outline the services available to people who come to my emergency department. It's not visible to me and it's not available to me to learn about that. There are a number of people who, I think, come to the emergency department—

The Hon. GREG DONNELLY: Sorry, can you just pause there for a moment. That just seems to me to be, for someone who's so well qualified and has just said that they've done and made a deliberate attempt to inform themselves and become more clear about what's possible, you're saying you don't—

CLARE SKINNER: For example, if someone presented to the emergency department with chest pain, I wouldn't have to refer every patient into a mental health service. I would be able to deal with a lot of that myself. I'd feel confident in my decision-making. I would have tools and education available to me to support my skills in that space. But I would also be able to refer that person for follow-up testing, outpatient cardiology referral or a chest pain clinic without having to seek a specialist opinion, wait for a specialist opinion, to do that because I have visibility and I'm empowered to refer to those services. Because the mental health system sits outside the acute hospital system, I don't have access to that in the same way as an emergency clinician. I think that's solvable, but I also note that a lot of the mental health services have wrong doors.

We have seen some really good things happen and they're models that we support at the college—so things like the rise of Safe Haven cafes, the PACER system et cetera. There have been a lot of good things. They have been designed to support people and be a form of early intervention. But if there is nowhere to go from those systems and they come into the emergency department, we become a catch-all and then we're having to navigate a lot of wrong doors on the way out, which becomes really frustrating but also really damaging for patients who are anxious and in crisis, and we can't navigate it either.

The Hon. GREG DONNELLY: You made the very interesting point in your opening comments, Doctor, that the whole person comes through the emergency department entrance and upon diagnosis and treatment it is identified that there is a mental health element to their circumstances, but then there is "the other". Based on your experience and study—and Dr Chan might like to add to this—is there any way of easily summarising what "the other" is, or is "the other" so large that it's almost a universe unto itself and very hard to break down?

TREVOR CHAN: Yes, it is. It is very large, and we know that those people with mental health conditions also can suffer other physical conditions and present later and present sicker, and it's really important, that focus to ensure that when assessment occurs it covers all those aspects, and the ability to communicate, for example. Otherwise, symptoms that Clare talked about—chest pain and other things—may not be as obvious. So there is the additional effort that needs to be taken in order to try to find out that information.

Someone's distress may actually have a physical cause to it and that actually needs to be worked up in conjunction with the mental health background because it may not be the mental health background that's causing the symptoms at the time. The preference, obviously, is that assessments in both spaces occur concurrently so that the emergency department looking at some of the physical and medical treatment aspects occurs in conjunction with the mental health aspects of assessment. Sometimes some aspects take a greater priority, sometimes they take other, but that's worked out between the clinicians so that the patient has the best outcome in the shortest possible time.

CLARE SKINNER: Trevor has made an excellent point, which is we know that people who live with chronic mental illness are politically marginalised and they don't have good access to other health services. There is a significant health gap there. In terms of the emergency department, there is a major crossover between people who present with mental illness who also have issues such as homelessness, drug and alcohol issues. They are self-medicating because they can't access or afford mental health care. They self-medicate with drugs and alcohol. Also disability, unfortunately, and also, chronic pain. But that becomes very hard to navigate. All of those services are very specialised. They are all under pressure. Trying to navigate all of that from the position of the emergency department, we're working on a model that was designed for people to be under our care for less than four hours. That's just impossible and it must be impossible from the position of a general practitioner working in the community as well.

The Hon. GREG DONNELLY: One final question, quickly. It was put to a witness earlier today that the intrinsic framework that GPs operate under in terms of the way in which they deal, dare I say—and this is no reflection on GPs—the gearing of it in terms of charging obviates against the sorts of treatment that such individuals who do have an acute mental health problem actually need. It was a rhetorical question. If that proposition is accepted, is there anything that can be done about that?

CLARE SKINNER: I have no doubt that episodic fee-for-service care doesn't work for chronic, longitudinal conditions. We know that a multidisciplinary longitudinal care pathway is the best for anybody with a chronic condition and that's not the way our current system is set up, either in the acute hospital system or in private community-based general practice. I would look to the ACCHO model for a good model where you have—

The Hon. GREG DONNELLY: Sorry, which model?

CLARE SKINNER: The Aboriginal Community Controlled Health Organisations—ACCHO—where you have salaried practitioners, admittedly, working against targets and KPIs but working holistically together in a multidisciplinary team but paid a salary so they can actually develop longitudinal relationships and don't have to work on that episodic basis. That's also true of psychiatry, I believe, as well. But another factor here is that being a generalist is really hard. It is hard in general practice; it's hard in emergency departments; it would be hard in general psychiatry. As people feel under pressure, the tendency is to specialise—to find a niche and expertise and get really good at that. That's a way of controlling your workload and feeling, I guess, safer with what you're doing. We have seen that happen as the systems come under more and more pressure. We need generalists, but I think we need to recognise that general psychiatry would be very hard.

Emergency medicine is very hard. We are seeing fragmentation and diversification with our workforce, and I think that's something that, in general, the New South Wales Government needs to bear in mind: People working in generalist positions need to be judged as generalists, not as subspecialists. Increasingly we're seeing subspecialist frameworks applied to generalist models, and that is very, very hard to do. It doesn't make money and it means people are subject to burnout when the expectations of their services are too great.

The Hon. SUSAN CARTER: Thank you both for being here today and for your submission. I note from the evidence you have already given—and it is reinforced by your submission—the difficulties with the intersection between the psychiatric care model and the medical model in ED. You have highlighted the fact that the ED is a 24-hour environment, but psychiatric services may only be available during business hours. Are staff in emergency medicine adequately supported by access to skilled mental health staff so they can do their job well and provide the best care for the patients who come to see them?

TREVOR CHAN: I think it could be better in that space. There is definitely support. It will vary across the State because of the different size, scope and availability. It will vary depending on the hour of the day as well. When people come to the emergency department, whilst you can average out the numbers for a day or a week or a year, the timing when they do arrive may be more clustered. It's mechanisms that help manage the clusters where the resourcing at that particular time may not actually match up, and that makes it tricky because if you're waiting on an individual to help with your assessment, for example, but there are three or four people all waiting, then inevitably there are going to be delays. So it's a question then about how the individual services develop strategies to help minimise that risk.

The Hon. SUSAN CARTER: I am interested in your comment about differences in the time of day and differences through the regions. How much support is available from psychiatric staff in an ED in country and regional hospitals?

TREVOR CHAN: I can give a general comment in that space.

The Hon. SUSAN CARTER: Perhaps you could also explore how that compares to the support available in city hospitals.

TREVOR CHAN: I think there's probably no doubt that some of the city hospitals have more access in terms of physical people. We're dealing with workforce shortages in general, and so that makes it more difficult. I think aspects there, where there is a component and use of some of the telehealth, virtual side—I know there have been comments before about the risks and benefits, and that's acknowledged in different spaces as well. But it's an option that is available to a certain degree and does need to be utilised as the system tries to improve the workforce side.

The Hon. SUSAN CARTER: Would telehealth be an adequate support in EDs in regional and rural hospitals for patients who present exhibiting acute symptoms, potentially creating risk for themselves and others?

TREVOR CHAN: It's not a substitute for face-to-face care. I think that's probably important to note. It's an adjunct in that space. It also looks at what's the alternative in the current environment that you're able to provide. There's no doubt you have what you prefer and like in terms of face-to-face care, and I think that's still the preference, particularly in mental health assessments, because so much more can be added there. But it does probably have a role I think in the adjunct space, and I think that's really where you will be looking at how do you do it. It adds benefits in the context sometimes when patients themselves have to move around the system in order to get perhaps the face to face and making better use of that.

The Hon. SUSAN CARTER: Just picking up on that comment, "patients moving around the system", does that indicate that patients who present in a rural or regional setting may have to move to the city to get adequate psychiatric support?

TREVOR CHAN: Maybe not the city, but to other aspects depending on how remote your presentation is and what's available within the regional space.

The Hon. SUSAN CARTER: So the services wouldn't be the same offered to every patient in New South Wales?

TREVOR CHAN: I'd probably have to look at that more generally in the context of what each individual local health district has. It's probably more a question to the system as a whole and that's by access to what they have offered, depending on where you present and when you present.

CLARE SKINNER: Taking that on a little bit further, just to give you an example, if you landed in Nyngan with an acute psychosis you would probably have to get into Dubbo. Where I see the telehealth is useful is to help support that decision-making around who needs to be transferred for definitive care and who doesn't, because you don't want to be transporting people across vast distances away from family and country unless you have to. But we also know that a warm referral is really important, particularly in a drug and alcohol—

The Hon. SUSAN CARTER: Sorry, what's a warm referral?

CLARE SKINNER: A warm referral is where you meet someone who will be involved in your ongoing care. Something we do often in emergency departments is send someone home with nothing but a business card and a number for a crisis. But we know that if you've met someone and talked to someone who's reassuring and is a presence, you're more likely to follow through and seek further care with that service.

The Hon. SUSAN CARTER: I guess I'm trying to explore whether the experience is likely to be different for patients in regional hospitals—

CLARE SKINNER: Very different.

The Hon. SUSAN CARTER: —than in city hospitals? What deficits might regional patients experience compared to their counterparts in larger towns and cities?

CLARE SKINNER: They're less likely to have a trained mental health clinician on the ground.

The Hon. SUSAN CARTER: Less likely to have a trained mental health clinician on the ground in country hospitals?

CLARE SKINNER: Yes. There is an issue of gazetted facilities. For example, someone who's under the Mental Health Act can only be assessed in a gazetted facility. That's fairly easy across Sydney. Not every emergency department is gazetted. You might be surprised to learn that. But if you look at rural New South Wales, it could be vast distances to a gazetted facility. Someone who, for example, is experiencing psychosis, police might be called, and they would need to be transported off hundreds of kilometres to get to a gazetted facility if they are under the Mental Health Act.

The Hon. SUSAN CARTER: Who manages that transfer?

CLARE SKINNER: It's a combination of police and ambulance, depending on which service is initiated first. And that's another big cause of inequity, which is depending probably on the knowledge of mental health issues and also probably the socio-economic status of the person who calls the emergency services. Some will define an acute, severe behavioural disturbance as a medical issue and call an ambulance, and others will define it as a criminal issue and call the police, and that can label you for the rest of your journey in the system.

The Hon. SUSAN CARTER: Going back to the role of the ED physician, is an ED physician in a regional hospital likely to have adequate human support from a clinically trained psychiatrist to help them?

CLARE SKINNER: Workforce is incredibly difficult in rural emergency departments. The range of people employed in rural emergency departments in the medical space is very varied. Some of them will be fully trained specialists, emergency physicians like Trevor and I, some others will be GPs with an interest in emergency medicine. Usually they've done additional qualifications as well. Some of them might be locums.

The Hon. SUSAN CARTER: And will they be adequately supported by access to a psychiatrist?

CLARE SKINNER: I haven't worked in that environment enough, but from what I have seen the little I have worked is it's incredibly variable and there's a lot of fly-in fly-out psychiatry that happens and it happens much more in the longitudinal outpatient space than it does in the addressing and supporting and acute crisis space.

The CHAIR: That brings us to the end of the session. Thank you again for all the work that you are doing day to day, and the time you have taken to prepare the submission and taking the time to share your expertise with us. It's really valuable.

CLARE SKINNER: Thank you for the opportunity to speak with you.

The CHAIR: The secretariat will be in touch if there are any questions on notice.

(The witnesses withdrew.)

Dr ANNA BROOKS, Chief Research Officer, Lifeline Research Office – Government and Stakeholder Relations, Lifeline Australia, affirmed and examined

Dr TARA HUNT, Deputy Chief Research Officer, Lifeline Research Office – Government and Stakeholder Relations, Lifeline Australia, affirmed and examined

The CHAIR: I welcome our next witnesses. Thank you for coming today. Would you like to start by making a short opening statement?

ANNA BROOKS: We would. Thank you, Chair, for the opportunity to speak with you today. My colleague Dr Hunt and I are pleased to represent Lifeline Australia in this important discussion about equity of access to outpatient community services in New South Wales. By way of a little bit of context about Lifeline, our network has 16 centres located across the State. A number of those are based in the Greater Sydney area. The network ranges south to Lifeline Albury-Wodonga; west out to Lifeline Central West in Dubbo and Lifeline Broken Hill; and north through Lifeline Mid Coast at Port Macquarie-Kempsey, up through Lifeline North Coast at Coffs Harbour and to Lifeline Direct in Lismore. Our centres deliver a mix of digital mental health services, including our helplines, for which we're best known—our 13 11 14 voice service is probably the one that most people know Lifeline for—as well as face-to-face community services, including suicide bereavement support groups, aftercare for people who have attempted suicide and financial counselling services for those experiencing financial distress.

Lifeline is a not-for-profit with a vision of an Australia free of suicide. Day to day, when we are designing and delivering service, our fundamental approach is to keep the help-seeker at the centre of all that we do. From people with lived and living experience—and consistent with the recommendations from a number of inquiries—we've heard loud and clear that ease of access to services is a key issue. Knowing where to go and how to navigate the system once there is incredibly challenging for people at the best of times—and even more so when they are experiencing distress. It's because of this that Lifeline's role as a front door to ongoing or additional service access is a key issue of focus for us. To support us in that, as you will have read in our submission, we recommend system enhancements, including prioritising a mix of services both digital and face to face, supporting additional services tailored to priority groups, enhancing connections between support lines and the broader mental health system, and workforce planning that includes volunteers. We look forward to the opportunity to discussing some or all of these issues and challenges with you today. Thank you.

The CHAIR: I have a question coming out of your very detailed written submission; thank you for the time you've taken to prepare that. You mention that Lifeline has "a new system to provide seamless, appropriate and tailored referrals". As you'd probably know, we've had a huge amount of evidence about the need for that sort of system in various contexts. I'm keen to understand in some more detail, if you're able to share it with us, how that system works and how you're using it.

ANNA BROOKS: Sure. In terms of providing referrals—and I will speak now to the helplines, so our call, chat and text services—we have what's called a service finder. The crisis supporter, who is the person on the end of the phone when people call in, is able to, based on the content of the engagement with the help-seeker, if and when appropriate, look up additional services that might be fit for purpose, pending the issues that the help-seeker's raised. Obviously the crisis supporter's looking not only for services that are actually subject-matter relevant but can also look at what's geographically proximal to the help-seeker. The crisis supporter uses that to help navigate the system with the individual who's calling for help in that helpline context.

An additional and new aspect to how we provide referrals to people reaching out to us for support is via our self-support toolkit, which is available on our website. The self-support toolkit is designed so that people can self-navigate. They can find information based on how they're feeling, rather than trying to self-diagnose and they can talk about what's going on for them. The self-support toolkit guides them to information that's going to be helpful to that individual and also provides referral points that are relevant to the presenting issues that the person has engaged in with us. The exciting part of that self-support toolkit referral system is that we can then track whether people use that referral that we've provided to them. That's given us an additional capability to look at whether the referrals that we're providing are actually accessed and by virtue of whether they're accessed, we get a gauge on what's helpful and what's not helpful in terms of our onwards referrals.

TARA HUNT: Just to add to that, that system is constantly being developed and refined, particularly with the support of the Lived Experience Advisory Group. They have given the very firm and clear guidance that it's really important for referrals to be provided in a range of different ways that are appropriate for the needs of the person. While one person writing down a number has been, for a long time, the case, and is the preferred way, other ways are receiving that SMS message. Using this system, about 65 per cent of calls to Lifeline do end up in a referral to a range of services, as Anna has said.

The CHAIR: I'm also interested in your experience managing a significant volunteer workforce. I think that's fairly unique in the sector. There's obviously really broad workforce challenges in the mental health sector generally. Could you speak to some of the benefits and also the challenges of working with volunteers?

ANNA BROOKS: Sure. Starting with benefits, I think that the Lifeline approach of being "of the community and for the community" really helps in terms of the trust that people place in the Lifeline service. When you speak to a Lifeline crisis supporter, typically it's going to be someone who—the person doesn't have to be trained specifically in mental health. It isn't necessarily a clinician that you're speaking to; in most cases it's not. It's someone who has decided that they want to make a difference to their fellow community members and has put their hand up to do so. It's a rigorous training process that we provide but it's a training process that's not dependent upon having qualifications in mental health in particular.

I think that the fact that people are talking to other folks who are regular community members across the country and who, albeit well trained, are not necessarily mental health clinicians is a really powerful part of the value proposition of Lifeline. It's a non-clinical service. It's regular people helping out other people who are in distress. Again, I think that the huge advantage to that is that we're very visible in communities and people know that there are people within their home towns who are Lifeline crisis supporters. There's good awareness of the community roots that our service has. That's some of the key benefits to our volunteer workforce.

In terms of challenges, as you will know, recruiting and retaining volunteers—particularly in the current climate where cost of living is a real issue for many people—is super tough. Like other volunteering organisations, we're really having to look at how we bring people in to become crisis supporters and then, if we can get them to join us, how we keep them as part of the Lifeline workforce. It's challenging. We're looking at a number of different ways that we could possibly try and adjust, given that it is such a challenging environment. That's a bit of a work in progress for us.

One of the things that we raised in the submission was that we would have liked to have seen the volunteer workforce considered in the National Mental Health Workforce Strategy. Unfortunately that's not quite the way it worked out, but we are looking at ways that we can try to rethink how it is that we structure our training to make it easier and more accessible for people to become volunteers—just noting that it is really tough to get people. When they're having to do paid work in order to pay the bills, how is it that we encourage people to actually put up their hand to invest the time in being a volunteer at the moment?

The CHAIR: Thank you. That was really comprehensive.

TARA HUNT: I think the thing that I would add is that over the 60-year trajectory that Lifeline has had so far, we have come a long way and we're quite responsive to developing technology. For a long time, the telephone was that modality and required a person to be in the room at a centre. With the emergence of tech-based technologies, I guess that formula is a lot more flexible to the time and capacity and geographic location of the person. While a person might really want to give back to their local communities by being a volunteer for Lifeline and talking to people like them who are in crisis and experiencing distress, being on the phone in a centre might not be an option for them, but using the text service, which is a remote service, might be more accessible for them. Working within those challenges with the use of technology has definitely been one of the ongoing pieces of development for Lifeline.

The Hon. SUSAN CARTER: Thank you very much for being here and thank you for your submission. I'm very interested in the figures that you provided under the heading of "equity of access to outpatient". You look at the Medicare benefit scheme. Under-utilisation—people living in very remote areas, 3 per cent relative to the 11 per cent—do you have any more thoughts about that? Is that simply because services are not available to people living in regional and remote areas, or does it indicate robust levels of mental health in those areas?

ANNA BROOKS: I think that there's probably a number of factors at play. I think the availability of services is probably one of them. We know that people in regional and remote areas, in terms of the mental health area, there are particular challenges: greater levels of distress and indeed in rates of suicide. That's something that, unfortunately, is a robust phenomenon in the data. There are a number of evidence-based reasons for that being the case. Some of the protective factors for rural and regional people are community. People often know their neighbours and engage with their neighbours and will help their neighbours out. That's one of the things that can be really protective. But some of the things that can be particularly challenging for mental health for people living outside of metropolitan areas are things like—access to means is an issue, familiarity with means, particular stressors around socio-economic disadvantage and, of course, in that mix is access to services as well. So it's multifactorial, I would say. But, yes, being able to—the previous people were talking about face-to-face services in many cases being the preferred approach to supporting people, but one of our key services is delivered by the telephone.

There are opportunities, I think, to use, as Tara mentioned, digital services to do some of the heavy lifting around supporting people's mental health. In some cases the anonymity that's provided by being able to do it from a distance is an advantage. Farmers, for example, in a community in which stigma around mental health is a significant factor sometimes will express that they prefer to be able to engage in ways where they don't necessarily have to front up and say who they are in a community where they're known. There are contexts in which digital service provision, as a complement and as a way, I guess, of providing a universal broad level of support, can be incredibly useful. There are opportunities that certainly the Lifeline network provides both via face-to-face and digital service provision to reach rural and regional communities. But, certainly, those challenges remain for those people.

The Hon. SUSAN CARTER: And I note in that respect your comments in paragraph (g). I respect your opinion because you're probably the pioneers in the provision of telehealth, in a sense, but the idea that it needs to be part of a mix and that we can't just say to people in regional areas, "Well, you've got a telephone. What else do you want?"

ANNA BROOKS: Yes, agreed.

The Hon. SUSAN CARTER: Thank you for that. I wanted to follow up the experiences that you're having in relation to the referral system that you've developed and the tracking facility that has. I understand that you may not have the data available, but I would be very interested in receiving updates on this because, from the witness evidence and the submissions that we've been receiving, part of the navigation problem is finding the service but part of it is also making the appointment, which if somebody isn't well can be quite a barrier. It can be getting the appointment. I wondered the extent to which your service was able to facilitate that or, from the follow-up data that you are gathering, whether that's perceived as an important part of any navigation service.

ANNA BROOKS: It's definitely a challenge, and I think the previous speakers noted that warm referrals are always better than giving someone a telephone number or the name of a contact. It's challenging, though. Lifeline, we have a number of services under our banner, and within our service ecosystem we can do a lot more in terms of trying to make it a seamless transition for people. They might ring 13 11 14 and then, pending how they present, the crisis supporter might decide that perhaps MensLine is a service that will meet their needs and that, in addition to being able to speak to 13 11 14, MensLine is going to add value to the service provision to this person.

Within those services under our control, it's still challenging, but that's something that we can do a lot more easily than we can to warmly transfer someone to a service that sits outside the Lifeline umbrella. It has forever been a challenge. It remains one. We're working on it, but technically it's quite tricky. I mean, 13 11 14 is open 24 hours a day, seven days a week; many, many, many other services, as you would be well aware, are business-hour services. When you have someone who calls in at 2.00 a.m. and would benefit from support from another service, it's well-nigh impossible a lot of the time to actually do a warm transfer at that time. It is a significant challenge.

The Hon. EMILY SUVAAL: Thanks so much to you both for appearing today. I just wanted to start, if I can, with a question about your call centres or text service. Who operates these?

ANNA BROOKS: So the Lifeline network, it's spread across the nation. We'll just focus on New South Wales. We have 16 centres across New South Wales. Not all of the centres deliver the helpline services; most of them do and most of them will deliver not only the helplines but also, as I mentioned earlier, community programs, things like suicide bereavement support groups, financial counselling. Tara and I both sit within the national office, which is based here in Sydney, and it's the role of our organisation, Lifeline Australia, to enable and facilitate the centres located across New South Wales to provide service to people.

The Hon. EMILY SUVAAL: With those 16 centres, does Lifeline run them all or are they various—

ANNA BROOKS: They're members of our organisation. The Lifeline network, broadly speaking, comprises Lifeline Australia as the national office and then we have members who are the centres, who sit across the different jurisdictions. We have a federated model, and so they're members within our federated model.

The Hon. EMILY SUVAAL: But Lifeline is responsible for running them, so it's not outsourced to another sort of not-for-profit in the area or anything like that?

ANNA BROOKS: That's right. We form partnerships with organisations. We have one with Headspace where we'll deliver a program that is the community collaborative program. We do service provision in partnership with other organisations from time to time and as needs demand, but the services that we deliver through our network—our Lifeline services—we don't outsource.

The Hon. EMILY SUVAAL: Beautiful. Thank you; that helps. In terms of the 65 per cent of calls that you said end up in a referral to a service, I'd be interested to know if you have any information around what happens to that 65 per cent. You provide a referral, but we've heard about the limitations when it's not a warm referral. What happens from there?

TARA HUNT: As we were saying earlier, at the moment it's a challenge to know what exactly happens at the conclusion of a call. We can provide the referral but, at the moment, our ability to track the impact and the uptake of that is limited. So the crisis supporter works with the help-seeker to empower them to make the next steps that they need, and that may be a referral. We are definitely working on our capability to be able to have more of an understanding of what exactly happens at the end of the call, but one of the limitations inherent within a one-off crisis support service where the benefit is anonymity and confidentiality, that adds a significant challenge to us, in terms of continuity and knowing what happens at the end of the call.

The Hon. EMILY SUVAAL: Do you measure levels of distress with people—ask them at the start, ask at the finish? Do you have any data around that?

ANNA BROOKS: Not consistently. Outcomes measurement is one of the areas we're looking at, at the moment. One of the challenges in providing a crisis support helpline is that expectation. One of the things that is advantageous is that people know it's a low barrier to access service. You don't have to say who you are; you don't have to provide any information about yourself. So we're always very conscious of adding in surveys and data capture points because we don't want that to serve as a barrier to people using service. The other consideration is that we're essentially an ambulance service. A lot of people ring us in a state of extreme distress, and we try to get them to a crisis supporter as quickly as possible. Again, in the process of getting to a crisis supporter, adding in points where we capture data is something we're very careful about just with a view to not adding any time in between someone making that call and someone speaking to a crisis supporter. So something we're looking at, but there are some reasons that we've been very cautious in our approach to applying an outcomes measurement framework.

The Hon. EMILY SUVAAL: Thank you; that's helpful. How have you found the availability of Safe Haven and the ability to refer to them, if there's anything you want to talk about there?

ANNA BROOKS: Broadly speaking, I think Safe Haven is a fantastic development. I think the amount of lived-experience consultation—or the work that went into devising the approach—is very encouraging. I think it's wonderful to have—you've probably heard at length some of the challenges around trying to support people in the emergency department environment. It's noisy; it's busy. It's probably one of the worst environments that you can have for someone who's experiencing significant psychological distress. So I think having Safe Haven as a physical option, somewhere people can go where there are peers available who can support them when they're doing it tough, is a positive development. In some ways, it's a physical manifestation of the sorts of things that Lifeline does. It's essentially peers that you're talking to, people who have training in the Lifeline context but are not clinicians. You can just check in when you feel like you need to in order to try to support your mental health, if you're experiencing distress. I think, broadly speaking, Safe Haven is a terrific development. I don't think we can speak to specifically how often we refer to them, but they are part of our service finder, our referral database.

The CHAIR: I was interested in your written report. You talked about a project underway with the University of New South Wales on how to support people in acute distress in public places.

ANNA BROOKS: Yes.

The CHAIR: I'm very interested in that work. Are you able to speak to it at all in any more detail?

ANNA BROOKS: Not to the results. It's still sort of in train, but broadbrush strokes, if that's okay?

The CHAIR: Please.

ANNA BROOKS: We're partnered up with the big data centre at UNSW. We've got a great team we collaborate with there. That project is focused on attempting to identify people in distress in public places. As part of that consideration, we have built into that project a very specific set of ways to devise what a best practice intervention looks like. So if you do identify that someone's in distress in a public place, what does it look like in terms of the best possible way to actually intervene. It's a challenging one, as I'm sure you're aware. A lot of people have traumatic experiences with being, I guess, intervened with by the police in the past. So what does it look like to actually be able to approach people and intervene if they're in distress or considering suicide in a way that has positive outcomes for that person—or maximises a positive outcome for that person?

I don't know what the answers are going to be yet, but certainly the research approach is very heavily based on a deep engagement with people with lived experience of that particular circumstance. So I think it's going to be very interesting to see where that goes.

The CHAIR: Absolutely. I think that's of great interest to the work that the Committee is doing. Do you have a sense of the time frame?

ANNA BROOKS: I think within the next six months I'll be able to give you some answers. If it would be helpful I'm very happy to share, as the data emerge, what that project tells us.

The CHAIR: Thank you, I'd be really interested. You mentioned in your written submission some of the challenges posed by short-term contracts, particularly from government or through government. What's the ideal length of a contract?

ANNA BROOKS: I think that's sort of "How long is a piece of string?", in a way. Longer is better. Centres that aren't based in metropolitan areas all tell us that attracting workforce to those areas is particularly challenging. When the contracts that they can offer are sometimes a year, sometimes 18 months, for people to uproot and move to a town where they're not sure if they'll have employment on an ongoing basis is challenging. I think I would just say the longer the better. It does present significant challenges to our centres being able to attract the staff that they would love to have.

The Hon. GREG DONNELLY: Thank you very much for your attendance and submission. A previous witness and others have spoken about the challenge about fragmentation of services and being able to even locate a domain to go to to find services. Is that an experience that Lifeline has had—a challenge to just know what's out there? This is a New South Wales parliamentary inquiry, so is there a repository of that information anywhere about services for the State of New South Wales, or is it ad hoc and spread out by local health district? What are your observations?

ANNA BROOKS: I can't remember what it's called, but our service finder is based—there is a repository that we access to support that service finder function I was talking about before, but it's challenging because a clinician can be there one day and then not be there the next. It's a challenging thing to collate the data, but even more so to keep it up to date. As I said, there's a service that we access, and I might take that on notice and let you know what it's called, but I think it's imperfect. It really is one of those issues that's a tricky one to solve, just because it is a constantly shifting environment, so it needs to be updated very frequently.

TARA HUNT: I think the thing that I would add, from coming to this from a community and non-clinical perspective, is an issue of language about the words we use to describe our personal experiences and whether they actually match up to what the services say they offer. So what exactly is that? We know that about 54 per cent of our callers call with more than one presenting issue impacting them in their lives, so where to even start? They often contact Lifeline before they have, really, even a conceptualisation about what that primary issue is, or they've actually expended all of their other options and they don't know where else to go. That, again, is one of the real challenges in terms of trying to find the services as well: How do I conceptualise and communicate what I need to be able to find that referral? And that service that we use—I believe it's called Ask Izzy.

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

The CHAIR: Thank you so much, again, for the time you've taken to prepare your submission and appear today, and also for all the wonderful work that Lifeline is doing every day. We really appreciate it. The secretariat will be in touch if there are any questions on notice.

(The witnesses withdrew.)

(Luncheon adjournment)

Mr BRETT COLLINS, Coordinator, Justice Action, affirmed and examined

Ms LILLIE MELLIN, Mental Health Spokesperson, Justice Action, affirmed and examined

Mr TODD DAVIS, Solicitor in Charge, Mental Health Advocacy Service, Legal Aid New South Wales, affirmed and examined

Mr CALLUM HAIR, Senior Solicitor, Mental Health Advocacy Service, Legal Aid New South Wales, affirmed and examined

The CHAIR: Welcome, everyone. Thank you for being here today. Is there a short opening statement from Justice Action?

BRETT COLLINS: Yes. First of all, I acknowledge the traditional owners of the land and Elders past, present and emerging. We are particularly addressing issues in terms of reference (c), (f), (g) and (i), and the piece on the crisis intervention will be addressed particularly by my colleague. We are hopeful that this inquiry will offer something fresh in an area which is actually a place which is quite negative. For our people—and I am talking about our people who are actually the ones who are subject to psychosocial challenges—they have been treated very harshly by the health system, contrary to what one would expect. They are left feeling damaged, feeling fearful and, in fact, it is no question that it's worse to be mad than bad. There's no question about that. We've done many cases over the last few decades. In fact, we had seven people for whom we are primary carer. We've been at least 60 times before the Mental Health Review Tribunal. We've been four times to the Supreme Court. We feel in despair that there has been no change in this space, because these are our people who are being directly affected.

We've put together, before the Committee, a number of documents. Quite a significant amount of research has gone into those documents. Additionally, today, we also included a letter from the Friends of Callan Park in support of the Callan Park proposal. What we'd like to point out is that there is a document which we launched. It's called *The Our Pick Report*, and it proposed—it's launched in 2010 and it's referred to in the documents that we've offered to you. This document was launched in Belfast and also at the Forensic Hospital in 2010, and at the beginning it says:

> The OUR PICK Report accuses the Australian health industry of corruption and proposes the empowerment of mental health patients and prisoners to achieve effective delivery of services.

And the first proposal is:

> … a fixed percentage of 0.1% of the mental health budget be set aside as mandatory funding of independent consumer groups;

What we are saying we are finding consistently is there is no-one who is prepared to defend the consumers and not be fearful in that process. We've had to run the case, as I say, four times before the Supreme Court, and on the last occasion we were actually able to achieve that agreement with the Mental Health Review Tribunal and come up with this particular document, which has been created with the Mental Health Review Tribunal, called the mental health consumer information sheet, to which a number of benefits go to the consumers. When it comes to actually presenting before the Mental Health Review Tribunal, the benefits of those agreements are never carried out in place.

Before this hearing today, we have prepared. We had two meetings with Legal Aid, with whom we are sharing this presentation. We had two meetings in preparation to try to come to some agreements about the things that we believe are important, where we think that the people who come before the tribunal can be better presented and can better respond to the community treatment orders applications that are before them. Two things we said were, could we expect, at least, that the Chief Psychiatrist's communiqué, which is contrary to the law—which is direction to clinicians that we get support from them—actually be withdrawn. That's one. And two, we've said, can we adhere to procedures which have been agreed to and which are on the website for the tribunal which allows the consumer—the person before the tribunal—to see what is said against them in order that the order should be created.

We're talking about the front line, where the actual decisions about community treatment orders should then be considered, and we're saying, can that person see that document as they're entitled to—which is a part of the procedures that are up on the website of the Mental Health Review Tribunal—and be given a chance to respond to the issues that are raised in the document. It's normally a three-page document. Can they see that, please, as has been agreed and which we had won back in the year 2014 with the case of Saeed Dezfouli in the Supreme Court? The Lindsay judgement laid that down.

In fact, we had an agreement for two weeks notice for all the information that comes before the tribunal to be given to the person who is affected by the order. In fact, what happens is the person who is affected by the order never sees the document. We asked, "Can we make sure that that is actually available to the person?" After all, that is the document that affects their future. We didn't get an agreement. We're asking that there be enough time for that document to be shown, as is the entitlement which we fought for before the Supreme Court. We didn't get agreement on that. We are looking for support at least for the law to be maintained. The procedures that have been agreed to should be adhered to.

TODD DAVIS: We are on Gadigal land. We acknowledge the Gadi people, the traditional custodians of this land. We pay respects to their Elders and extend that respect to all Aboriginal and Torres Strait Islander people present. The Mental Health Advocacy Service is a specialist service within the civil division of Legal Aid NSW. Through a combination of in-house, MHAS and Legal Aid solicitors and members of the private profession, we provide representation in over 11,500 proceedings annually conducted before the Mental Health Review Tribunal, of which over 1,500 involve community treatment orders—usually applications for orders. Our submission draws on our experience as well as the criminal law division of Legal Aid and the coronial inquest unit of Legal Aid.

We acknowledge the Committee has heard from many people with lived experience of mental illness. We value the opportunity to hear directly from them regarding their experiences of community mental health care in New South Wales. We also acknowledge the expertise and commitment of those who provide care and treatment to our clients, including members of NSW Health, carers, families and friends of clients. We appreciate the productive working relationship we have with the Mental Health Review Tribunal.

Our primary concerns, which are highlighted in our submissions are, firstly, the paucity of evidence regarding the use and efficacy of community treatment orders as a means of providing the least restrictive form of care capable of providing safe and effective care. That may be addressed through funding a multidisciplinary independent project to determine those issues. We also propose a number of statutory amendments ensuring the principle of least restrictive care is adhered to. We are concerned that often community treatment orders are used as a means of ensuring people are provided care and treatment, or the appropriate level of care and treatment. If a CTO was not made, the person would not receive that care or treatment or the level of care or treatment that they would otherwise receive.

Thirdly, we note limitations in the provision of community mental health care in regional areas of New South Wales. Fourthly, we note the need for the community transition team in Justice Health to receive greater funding and be able to service all correctional centres in New South Wales. Finally, we note the need for PACER to operate in all police area commands in New South Wales. If there are any questions that the Committee would like to ask, perhaps I will tend towards issues that involve community treatment orders and Legal Aid policy, and Callum would probably be most suited to the balance of questions in relation to those other issues. Of course, we will be in a position to assist the Committee together if needed.

The CHAIR: Thank you to all four of you for taking the time to prepare quite detailed written submissions as well as being here to speak to those submissions today. My first question is to Legal Aid. In your opening statement you touched on that you had some suggestions around amendments that could be made to ensure that CTOs are actually used as least restrictive means. Could you perhaps speak to what those amendments could be in a bit more detail?

TODD DAVIS: Could I just touch on, in a broader sense, that the legislation was brought in essentially, from our understanding, as a mechanism to allow people to enter the community in a controlled manner as an alternative to being in a hospital environment under coercive powers there. Therefore, at that time there doesn't seem to have been a great deal of research or thought in relation to whether that was an effective mechanism. There weren't studies done to see whether that was an effective alternative to remaining in hospital and what the results would be. What was the purpose? Callum, would you like to add the specifics?

CALLUM HAIR: One matter we raised in our submission is potentially providing in the Act that the tribunal shouldn't have regard to whether or not a patient is going to receive a better level of service under a community treatment order than if they are not on a community treatment order. Of course, our belief is that community mental health services should be funded adequately to provide services to people in the community, depending on the nature of their illness and their willingness to engage, and it shouldn't require a coercive order to ensure that people receive the assistance that they need. That's probably the primary point that we make. In addition, in our submission we address the fact that in other jurisdictions that have perhaps lower rates of community treatment order use, they often have different criteria to New South Wales.

That's why we are talking about, potentially, suggesting that the New South Wales Government fund a multidisciplinary project where we can look at what those other jurisdictions have in place. One suggestion being that there could be a serious harm test built into whether or not a community treatment order is or isn't made. At present, if you are in the community and there is an application for a community treatment order, there is no requirement for the tribunal to be satisfied that you pose a risk of serious harm to others; whereas, if you're in an inpatient setting and you go before the tribunal at your very first appearance at what is called a mental health inquiry, for a community treatment order to be made at that point of the process, there is a serious harm test built in. Most community treatment orders are actually made when people are in the community on an almost rolling basis for many people. Most of them run for six months at a time, but very often it's six months, six months, six months, without really turning their minds to the efficacy or the need for the order.

The CHAIR: Thank you. That's helpful. While we're on the topic of community treatment orders, I invite Justice Action to add anything. I know that they are working directly with people with lived experience of having been on a community treatment order.

BRETT COLLINS: Yes, absolutely. The proposal for the withdrawal of the Chief Psychiatrist's communiqué is extremely important. In fact, it doesn't quantify any of the risks. It avoids the issue of serious risk entirely. That is really worrisome. In fact, if we look at the—causing emotional harm, causing financial difficulties and a whole range of things like that could be included as a guide to the clinicians to apply for a community treatment order. That's contrary to the law. In fact, we put before the Committee what the law says, actually. We've examined quite carefully what the basis for community treatment orders should be according to the cases that have come before the court. It is a risk to life, a risk of being raped or a risk of causing psychological harm to the point of causing psychosis. Yet the clinician's direction from the Chief Psychiatrist's direction is actually—it misdirects it. It gives the encouragement to clinicians to impose or ask for a community treatment order.

The issue about whether or not serious risk should be considered—the first community treatment order requires the question of serious risk, which I just referred to a moment ago. Continuing ones don't have the same demand, but they still have the need to consider the least restrictive care. That's a really significant thing. Because if you look at what the medication is, the medication always continues after. It always is part of a community treatment order. The authority is given back to the treating team—the psychiatrist, whatever—to do whatever treatment, as according to the Act. I think it's 85 of the Act. They can decide whatever medication is to be administered, and that's the decision not of the tribunal but of the treating team. The power is then to medicate people, and that always is carried out.

What we've encouraged and talked carefully to Legal Aid about is to look carefully at the damage that statistically is proven to receive the medication—that over a longer period—for crisis intervention, there may well be some particular role. But over the longer period, longitudinal studies indicate that it is six times less likely that a person who is on medication will maintain their functionality as a person who doesn't have the medication, apart from the side effects—the side effects are enormous. What we propose is that, instead of the forced medication, which follows the community treatment order, what we would expect from Legal Aid is that they offer things like, for example, peer mentoring, which is actually working with the person and not having a coercive interaction with them. So that is what we propose, and we've actually put that to Legal Aid that they should see that as being an alternative way of dealing with an application for a CTO.

The CHAIR: My second question might be for Ms Mellin, because you hinted in your opening statement that she might want to speak to the ways that we can improve crisis or emergency responses to people in a mental health emergency.

LILLIE MELLIN: Yes. Our position is that the PACER model should not be adopted in New South Wales, and we have taken an evidence-based approach to our suggestions here. In particular, the Victorian Mental Illness Awareness Council recently released a resource entitled *Police apprehension as a response to mental distress* where they state fairly unequivocally that, wherever possible, police should not be part of a mental health response because of a variety of factors such as police intervention being shown to make people feel criminalised, stigmatised and intimidated, which the research is fairly clear on in this area. This research on police intervention is supplemented by various case studies throughout the years. For instance, we focused on the case of Clare Nowland, the 95-year-old who was fatally injured in an aged-care facility during a mental health crisis. Those form the basis of the reason that we don't believe that PACER should be rolled out.

We would also like to note that PACER has received criticism from mental health experts and the New South Wales Police Association themselves. For instance, the mental health Minister, Rose Jackson, has stated that PACER is not up to the task and that the way we respond to acute mental health crises in New South Wales needs to change. The Police Association has also called for alternatives to PACER on a variety of bases—but, essentially, that it is not the best option for anyone involved in these mental health incidents. We ultimately believe that a model similar to that of CAHOOTS, that is currently implemented in Eugene in the United States, should be implemented in New South Wales because it showed vast efficacy on a variety of factors. It has reduced the workload of police by diverting the vast majority of mental health calls to CAHOOTS.

Service users have described positive experiences throughout the process. They have also displayed extreme cost-effectiveness in reducing the cost to the city of Eugene and the Eugene Police Department. It has been in operation for over 30 years, so it was implemented in 1989. The research is extensive on this program, and that is part of the reason why we suggest it, because it has been around for so long and it has shown this efficacy throughout the time that it has been in operation. We also call for the implementation of peer workers during mental health crises, which could be implemented in collaboration with or within a program such as CAHOOTS.

The Hon. EMILY SUVAAL: Thank you so much for your evidence and for appearing here today. I might continue with you, Ms Mellin, if you like, on this line of questioning. I wonder if you could comment more on what the current experience is like with the PACER model and why, for example, a model like CAHOOTS would be different?

LILLIE MELLIN: Definitely. From our research, the experience with PACER is that the police are still attending to the mental health crises. The consumers of the PACER model have stated that police intervention during these crises increases intimidation, and the presence of the uniformed officers and the police car inherently stigmatises them and causes them to feel negatively about the whole experience. The presence of the crisis worker or the medic, whilst it has been beneficial, is hindered by the presence of the police officer in cooperation, which is why we believe that the CAHOOTS model is better, because it's a model of non-police intervention and it addresses those concerns that the individuals experiencing mental health crises have expressed.

The Hon. EMILY SUVAAL: My next question is more directed to Legal Aid. You mentioned in your opening statement statutory amendments, which my colleague touched on earlier. I wonder if I could invite you to expand on that further, and whether or not the statutory amendments that you are suggesting or that you are seeing need to be made are just in relation to CTOs or whether there is a broader need for anything else?

TODD DAVIS: With what Callum mentioned in relation to the test of risk of serious harm, there's an imbalance when a person, as Callum said, goes before the tribunal on the first occasion. That is a mental health inquiry. Around about 800-odd CTOs are made at a mental health inquiry. There is that test that needs to be satisfied in relation to risk of serious harm. But 6,500-odd CTOs are made in New South Wales each year. That test doesn't apply to the balance of those people who go before the tribunal. There are reasons why that occurs, but it doesn't seem to be an equitable application of legislation that that test applies at one stage and it doesn't apply at the other stage.

The Hon. EMILY SUVAAL: When you say there are reasons why that occurs, what are those reasons?

TODD DAVIS: Historically, the reason why there's a mental health inquiry is to determine that the person has been brought before the tribunal in a proper way—the system has been complied with, the admission process and so forth. The tribunal has to be satisfied that that person has been a mentally ill person as defined under the Mental Health Act. Once that has been satisfied, if the person continues to be detained at a mental health inquiry under an order, if they then go back before the tribunal in relation to further orders to be detained, that's a review process. So at each of those other hearings, it's just reviewing whether they are there properly. It's not that they've been presented in accordance with the Act.

The Supreme Court investigated that in a decision some years ago, in the decision of Harry. Also, the test to be subject to a community treatment order at the moment under section 53 of the Act seems to be quite low. I think it would benefit the community if the test involved that the person, if they aren't subject to that coercive order, would pose a risk of serious harm to either themselves or others. The courts have invested what that means—risk of serious harm. It's quite well known. There is a bit of a problem in some respects in relation to these concepts—risk of serious harm—not being defined in the Act. We think that's correct. There are comments on it in some decisions. But it involves such a subjective measure, because the risk of serious harm to one person, such as their reputation—a person's representation is dependent on their circumstances and who they are. In some respects we're seeking that the bar be increased, to some degree, as a productive measure.

CALLUM HAIR: I was just going to add that the studies, as I mentioned, of the jurisdictions that have lower rates of community treatment orders show that they generally had a test that required there to be a specific significant or substantial risk of serious harm, as well as there needing to be evidence of a therapeutic relationship, if the order was made. Coercive orders, generally speaking, the literature shows, undermine the therapeutic relationship between a clinician and a patient. If CTOs are being made in circumstances where that relationship is being undermined, then one must ask whether or not it's a good idea to proceed with a coercive order as opposed to perhaps trying to use non-coercive measures.

The Hon. EMILY SUVAAL: What I am trying to get at in my head is whether it is an issue with the Act as it's currently drafted or if it's the interpretation or how it's being applied.

CALLUM HAIR: There'd be two ways of amending the Act, potentially, but this is part of what we consider should be done as a full research project on the efficacy of CTOs. One is you could ensure that serious harm is added as a test prior to the making of any community treatment order, but also that the tribunal is satisfied that there is a therapeutic benefit in that clinician and patient relationship. Having said that, to a certain degree the tribunal can take that into consideration at the moment. What we're referring to is the tribunal needs be satisfied of certain criteria prior to making a CTO. But that only engages their discretion to make a CTO. Even where the tribunal is satisfied of those matters, you could technically argue they should exercise their discretion not to make the order on the basis that it's going to damage a therapeutic relationship, which is not in anybody's interests.

BRETT COLLINS: Can I respond? There are just a couple of things I would like to pick up on. I just noticed that Todd was referring to "reputational damage". That's within the Chief Psychiatrist's communiqué. It's definitely not mentioned at all in any case around serious risk of serious harm. I think that's really important because you get caught up in the language of, in fact, the Chief Psychiatrist's communiqué, which is contrary to the law that has been laid down. And also, talk in terms of being unsure about what these terms must mean, what "serious risk of harm" actually means, is not true because the cases have come before the Supreme Court and it has been determined as risk of life or death, risk of rape, or risk of and causing psychological damage to the extent of it causing psychosis. That is what serious harm is defined as, according to the case.

Just one more thing too, and I think it really is an important issue. If an order is made, it always means that the person receives medication—it always does. To say other than that is quite incorrect. And so, therefore, it does require an examination of the medication itself. We actually have been very carefully into the use of medication. There is a quite an important, clear document which we have examining what the benefit, what the result, of that medication is, and it's damaging in the long term. In the short term it may have some benefit, but in the long term it's not. Our concern is this: At the moment there is no data collection of chemical restraint. The term "chemical restraint" has been very carefully defined by the Commonwealth and by the States, and chemical restraint does not include the term "treatment".

So if a psychologist says this is part of my treatment, then it doesn't become part of the data collection. We've examined that really carefully and we've given that to the Committee as part of our paper on chemical restraint, and what we're asking for is that that be properly examined and the term chemical restraint include any coercive use of treatment that the person doesn't want. So it's affecting their behaviour—and we're looking carefully at the definition now—and, therefore, it must be seen as chemical restraint. Therefore, what we're asking is that that be included in the data collection, so then, at the very least, that means that people are aware of when medication is forced on them and then, of course, the whole question about whether medication is a good thing or not arises.

The Hon. GREG DONNELLY: My question, if I could change track slightly, is to Mr Davis and Mr Hair. I take you to page 22 of your submission, which is dealing with your thoughts and comments around the PACER program. The recommendation speaks for itself, but my question is with respect to the PACER program as it currently operates in New South Wales. Noting that there are other jurisdictions—Victoria, for example, and maybe South Australia as well, I'm not sure, and there may be others—that have an alike type of program, do you have any suggestions for refinement of PACER in New South Wales? In other words, how can what has been operating be refined further? Or are there some, dare I say, more than minor tweaks that you think would improve it? I am interested to know your thoughts. You obviously have a lot of experience dealing with the program.

CALLUM HAIR: Yes. Look, I am no expert in what's happening in other jurisdictions, but what I would say is one limitation that we are aware of is the fact that PACER isn't able to respond to incidents that are deemed high-risk incidents or incidents that involve the use of a weapon. We think that that's something that should be looked at and reviewed to see the reasons why that limitation exists because, quite clearly, if someone is experiencing a mental health episode, mental health clinicians are trained to respond to those high-risk scenarios and in fact they do, day in, day out, in civil mental health facilities around the State. So that's probably one thing that we would say regarding the current model.

Naturally, of course, it's only operating in, I think, 13 out of 45 police area commands. That's why we made the recommendation that it should be rolled out statewide. Having said all this, we're aware of Minister Jackson's comments, I think in estimates late last year, that all of this is subject to review and, I guess, Legal Aid would love to be consulted in relation to that when the time comes. But I think the primary thing I would say about the current model is simply just around the funding and around not being able to engage the PACER model when there is a high-risk incident.

The Hon. GREG DONNELLY: You may not have the level of detail about how PACER works from an operational point of view but, if you do, this is the question: If a phone call is made from—take a hypothetical example—someone in a block of flats that there is someone living next door around them that does have what people commonly understand or assume is a mental health condition of some description and things get pretty rowdy—this is a hypothetical question—things are getting thrown around, it's noisy, the person picks up the phone and rings somewhere to indicate there's a disturbance that they're aware of or believe is taking place, do you know where that goes? Because what I've always wondered—and perhaps this is more directed to the Police Force—is if 000 is rung, how then does it work through the system to activate the decision and who makes that decision about whether or not that is a PACER-style event, if I can use that phrase, or incident that would then invoke the whole PACER operation?

CALLUM HAIR: Unfortunately I can't answer that.

The Hon. GREG DONNELLY: That's okay.

CALLUM HAIR: There may be people appearing this afternoon who will be better informed than I am.

The Hon. GREG DONNELLY: That's fine.

The Hon. SUSAN CARTER: I wonder, Ms Mellin, if I could take you back to CAHOOTS. Thank you for the information about CAHOOTS and STAR; it's very interesting. Are there any other cities in Oregon other than Eugene which have adopted the CAHOOTS model?

LILLIE MELLIN: To my knowledge, there aren't, but there was a bill in congress for similar programs to be initiated throughout the United States. But as far as I'm concerned, CAHOOTS as it stands is only in Eugene.

The Hon. SUSAN CARTER: So there's nowhere else we can look at whether it works or not other than one city in Oregon? There's a similar program in Denver I believe, the STAR program. Is that still running or did that finish?

LILLIE MELLIN: Also to my knowledge, the STAR program is still running. It was launched in 2020.

The Hon. SUSAN CARTER: Is there anywhere that you're aware of where this type of program has been rolled across something as big as the State of New South Wales, as opposed to two individual cities in two different states?

LILLIE MELLIN: No. It appears to be a fairly locally implemented program because there's the high level of collaboration between the Police Force and the medic teams, and I know that they did have issues with staffing, the medics and whatnot, and that was a barrier to implementing it in a larger area than just Eugene, which forms the basis for our suggestion of peer workers also being involved.

The Hon. SUSAN CARTER: Do you have any comments about the difficulty of rolling out something like this in a non-metropolitan area?

LILLIE MELLIN: I'll pass over to Brett, if that's okay. He has more expertise in the rural and regional space.

BRETT COLLINS: My understanding of it in fact is there is some Federal support for that as well. I thought actually there was something a bit wider.

The Hon. SUSAN CARTER: United States Federal support?

BRETT COLLINS: We had some document I thought. If you like, we could send that to you.

The Hon. SUSAN CARTER: That'd be interesting because the examples we have are two examples in two cities in two different states, and of course we're looking at a statewide response. I wonder if I could just ask a couple of questions to Legal Aid. I'm very interested in the material at section 4 of your submission. You point to the situation in release from Bloomfield; you point to the situation in Broken Hill where there's no permanent psychiatrist and the closest Justice Health nurse is 700 kilometres away. Is this, perhaps, an example of the real difficulties we're seeing because psychiatric services are under-resourced in the regions?

CALLUM HAIR: I think that's broadly correct I could guess. Just to start with to refer to Bloomfield Hospital, we regularly deal with what's called the Macquarie unit, which is a specialist forensic mental health unit at Bloomfield Hospital. Broadly they do a very, very good job at ensuring the reintegration of forensic patients into the community in a considered manner. The community mental health teams there also do a great job at managing those patients when they're in the community. But our concerns are around the fact that they're so under-resourced that there have been instances where we've had patients who have said, "I've been discouraged from settling in this area upon my release", which is quite unfortunate because the process of being released involves getting a gradual and substantial amount of leave, integrating yourself in the local community, and then you're forced to be uprooted.

The Hon. SUSAN CARTER: If I could just stop you there for a minute, to the extent to which you're aware—and you may not be—what happens to those people who can't stay in the Orange area because the mental health support isn't available for them? Where do they go?

CALLUM HAIR: I guess they work with their treating teams around what might be another area of New South Wales where they would like to reside, and they'll fall under the community mental health team that manages that particular area. Probably the advantage of remaining in Orange—the other thing is it's a special forensic psychiatrist who actually works in the community team there, which isn't the case in every single community mental health service around the State.

The Hon. SUSAN CARTER: If there's a Justice Health nurse in Dubbo, does that affect communities other than Broken Hill? Because there would be a number of local courts in between Dubbo and Broken Hill, I think.

CALLUM HAIR: I'll have to take that on notice. I don't have an answer to that question before me.

The Hon. SUSAN CARTER: Could you explain a little bit more about the issue of locum psychiatrists and no permanent psychiatric support in Broken Hill, in relation to how that affects prisoners and people on bail getting adequate treatment?

CALLUM HAIR: That was a reference to the fact that, obviously, when a magistrate diverts someone to the local hospital to be assessed, if that psychiatrist perhaps doesn't have a knowledge of that person's history—of course they have the clinical records, but if they don't have the knowledge of that particular individual coming in before them—then it may impact on their particular assessment around their mental state and whether or not they are or aren't what's referred to as a mentally ill person within the definition of the Act. Perhaps there are questions over whether or not a person might have a drug-induced psychosis versus an underlying diagnosis of a psychotic illness, for example.

The Hon. SUSAN CARTER: I'm very interested in your comments about navigation, which has been a big issue that we've been exploring, and your support for the community transition team. Are you aware if there are any barriers or reasons why it can't be rolled out more broadly across the justice network?

CALLUM HAIR: No, not really. Obviously, primarily funding. I guess one barrier may be the fact that Justice Health doesn't have a presence in every prison in New South Wales, because at the privatised prisons—which, as I understand, are coming back into public hands at various points over the next few years—obviously Justice Health doesn't have a presence there, so they're limited in what they can do. But as for why they can't or they don't have a presence in other Justice Health prisons around the State, yes, I assume it's just a funding issue. Having said that, they do support people to return to wherever they wish to reside around the State, but they only support those inmates from Silverwater Women's Correctional Centre; MRRC, the Metropolitan Remand and Reception Centre; and also parts of Long Bay Correctional Complex.

BRETT COLLINS: Can I just respond to that issue of the community transition teams? There are two points I'd like to make there. One is we're concerned that at the moment there's linking of the use of medication to the person who's being released. We want to make sure that there isn't a requirement that the person submits to medication in order to maintain and hold their housing and get the other sorts of supports, like education services and things like that. We're concerned about that.

The Hon. SUSAN CARTER: Sorry, could you just explain that a bit? If there's been a medical assessment that medication is required, why would there be release without the medication?

BRETT COLLINS: The person, upon release, wants to remain out. If it's required that they have to accept the treatment order and submit to whatever is required by the health department to retain their housing, we think that's a bad thing. We think the person should be able to make—

The Hon. SUSAN CARTER: Are you suggesting there are incorrect diagnoses being made as part of the treatment order?

BRETT COLLINS: No, we're concerned that—we were involved in a consultation with the Kirby Institute about maybe three years ago where there's the whole question about the optimal treatment of prisoners upon their release. This became a really significant issue about the requirement that a very large number—we were told 2,000 people—of psychotic ex-prisoners were being released each year. That seems an amazing figure. But we were concerned that that expansion of that, those mentally ill people, was an attempt to reduce the recidivism rate by dulling them down and making sure they received medication.

The Hon. SUSAN CARTER: So you're arguing that people are being wrongly medicated?

BRETT COLLINS: Yes, being medicated and—

The Hon. SUSAN CARTER: Do you have any evidence of the fact they're being wrongly medicated?

BRETT COLLINS: Do I have any evidence of the—

The Hon. SUSAN CARTER: Of the fact that they're being wrongly medicated.

BRETT COLLINS: As I say, we had significant consultation about three years ago where that was definitely an attempt to reduce recidivism by in fact some—

The Hon. SUSAN CARTER: So you have evidence that NSW Health is forcing people to take medication not for their own benefit but to avoid recidivism?

BRETT COLLINS: Oh, absolutely. That was the whole basis of the consultation. I'm very happy to show you the documents that is the basis for that consultation.

The Hon. SUSAN CARTER: Yes, thank you. I would be interested to see that.

BRETT COLLINS: It was very significant, only a short time ago, three years ago, run by the Kirby Institute. We also think that the support given by those community transition teams shouldn't just only be for people who have mental health problems. It should be also for everyone. To accept that you're mad, a "spinner" in prison, makes you a person of little worth, according to the culture of prisons. That's a shame if people have to be released in order to get that sort of support when they're released. The other thing I'd like to raise in response to the question of outlying areas. We're really keen that e-health should be available widely, also including inside prisons, but also out in the community. Having access to a psychiatrist by e-health we've found is a very useful thing.

Also, an issue that we think is really important is to maintain their telecommunication rights. At the time they're actually—if they are picked up by the police and by the ambulance, they should also carry with them their phone as a matter of right and be able to maintain contact with their families while they're away. So we have championed the Nairobi Declaration for Detainee Telecommunications Rights, which is just to support that as a right. We would like the Committee to support that idea that it continues to be a human right of communication. Even if a person is seen as being mentally ill, that should be retained as one way of maintaining connection with family and support outside of the hospital support.

The CHAIR: Thank you. That brings us to the end of the time for this session. The secretariat will be in touch about any questions on notice. Thank you again to all four of you for the time you've taken to be here today and share your expertise. We really appreciate it.

(The witnesses withdrew.)

Ms CARA VARIAN, CEO, NSW Council of Social Service, affirmed and examined

Ms ANDREA ANGELES, Police Lead, NSW Council of Social Service, sworn and examined

The Hon. SUSAN CARTER: Thank you very much for joining us today. Do either of you or both of you wish to start with an opening statement?

CARA VARIAN: I would like to start by acknowledging the traditional custodians of the lands on which we meet today, the Gadigal people, and pay my respects to the Elders past and present. The NSW Council of Social Service thanks the Committee for the opportunity to provide evidence today. As you've just heard, my name's Cara Varian. I'm the CEO. We are the peak body for non-government organisations and the health and community services sector in New South Wales. We work with about 400 members to progress social justice and shape positive change towards a New South Wales free from poverty and inequality.

Since our submission to this inquiry, NCOSS has released two additional reports that we think are relevant to your terms of reference. The first report is called *Beyond roads and bridges: Critical social infrastructure for South West Sydney*, which focuses on social infrastructure in south-west Sydney. It highlights the unmet need, both today and the expected unmet need in the future. We chose to focus on south-west Sydney because it's a high-growth area, as everyone on the Committee knows, but also because there is a high concentration of people who are experiencing socioeconomic disadvantage.

The report was commissioned by NCOSS and produced by Impact Economics and Policy. It shows an immense amount of unmet need in the community-based mental health support area. On a per capita basis the New South Wales Government spends the second lowest of all States and Territories on community mental health services. While the New South Wales Government is currently spending about $155 million per year on community health support in south-west Sydney alone, our research estimates that between 31 per cent and 59 per cent of need is unmet at the moment. We expect that need to grow and the Government will need to almost triple its current investment to be able to meet all of that need by 2041.

The second report that we have released is called *An Exploration of the Experiences of Virtual Care in NSW*. Our findings were generally positive. We found that it was important for choice to be part of the patient care but, when choice was provided, virtual care can bolster and improve patient outcomes and overall quality of care. But not everyone has access to virtual care. Our most vulnerable and disadvantaged community members are disproportionately impacted. We need to, as a society, and the New South Wales Government needs to prioritise equity of access for those most excluded and invest in the community sector's capability and capacity to improve access and use of virtual care.

Finally, I would like to highlight the submission provided by the Mental Health Coordinating Council. They are an NCOSS member and a peak body for the community managed mental health organisations in New South Wales. As outlined in our submission, we support three of their recommendations that relate broadly to social service sector needs: recommendation 5, which is to provide adequate indexation that responds to the inflationary impact of salaries and service delivery; recommendation 9, which is to invest in wellbeing support for all mental healthcare workers; and recommendation 19, to provide community managed mental health organisations with five-year contracts so that they can offer secure employment and improve sustainability. Joining me today is Andrea Angeles, one of our policy experts at NCOSS. She assisted with the submission that we put through to the inquiry and the development of the virtual care research. I thank the Committee again for the opportunity to be here today and I look forward to answering your questions.

The CHAIR: Thank you for taking the time to prepare your submission, as well as appearing today. Mrs Carter opened this session, so she should go first with questions.

The Hon. SUSAN CARTER: Thank you both for being here today. I was very interested in your comments in relation to telehealth and issues around access, which aren't often highlighted. I wondered if you could perhaps explain some of the access issues which some people in our community might face using telehealth.

CARA VARIAN: We did the research based on, I guess, the big change that we saw during the COVID period and how communities responded to that. The access to telehealth in regional and remote communities was particularly valued, but there was a concern that access to telehealth options would hide the other needs that regional and rural remote communities might find, such as being able to have physical appointments with GPs or local specialists. But in conjunction with those physical in-person appointments, it was a really valuable experience for people, particularly in rural and regional New South Wales. But also carers found it really helpful, and casual workers, so they had a bit more control over how they spent their time and they could work around their other commitments.

There are also significant access issues for those members of our community that are not technology literate or don't have access to reliable internet or a device. For people who are working or living in an area that is particularly crowded, it can be really hard to get good care through a virtual appointment if there is no privacy for them to have those conversations. They were some of the issues that we found but, overall, there was a lot of support for virtual care.

ANDREA ANGELES: Cara, if I could add on to that, sorry, from our findings we found that virtual care relies heavily on access to high-quality digital infrastructure. It's often people who are socially isolated or digitally excluded who are most at risk of not being able to access virtual care, as well as those in low-income households. They simply can't afford digital technology or even access to data. That's also something that we found in our research.

The Hon. SUSAN CARTER: I note your support for recommendation 9 of the Mental Health Coordinating Council submission, in relation to wellbeing support for mental healthcare workers. It talks about "vicarious trauma education". Do you think that vicarious trauma education is enough, or do those workers actually need, given their daily workplace, support for vicarious trauma counselling?

CARA VARIAN: When we provided support for that recommendation I think it was more global, I guess, than just the education. We provided the example of vicarious trauma education, rather than that being the only thing we think is necessary. Certainly over the COVID period and since COVID we have seen, and members are telling us, that demand has grown. Because funding has not really changed significantly, or not enough to meet that demand, they're under a lot more pressure. That risk of burnout and the lack of support is really being felt by those frontline workers and the specialist healthcare providers.

The CHAIR: I have a couple of questions seeking to clarify the recommendation around indexation. You noted in your submission that the contracts funded by the DCJ and the ministerially approved grants have a 5.75 per cent indexation rate but that many grants to relevant organisations haven't had that level of indexation. I wanted to clarify which departments we're specifically talking about that haven't yet applied that indexation.

CARA VARIAN: We can see that the Government has made a great commitment for that particular area, but there hasn't been indexation across any of the other community services sector. In terms of departments, we're looking at, I think, DCJ, which we're going through a commissioning process with at the moment, but I will have to come back to you on other departments.

The CHAIR: I'm happy for you to take it on notice.

ANDREA ANGELES: I can also acknowledge that late last year, I believe, NSW Health did approve an indexation rate of 5.75 per cent for ministerially approved grants as well as other NSW Health-funded organisations, applicable for 2023-24.

The Hon. EMILY SUVAAL: Thank you both for appearing today. I have a question at the start. I apologise that I haven't had the time to look at your most recently provided reports; the answer may be in there. You stated there was—was it 31 to 59 per cent of unmet need?

That's a really broad figure. If it's only 31 per cent, then that's one thing, but if it's 59 per cent, then that's quite something else. Could you explain why there's such a big variance there and whether there is anything more you could shed light on in terms of that figure?

CARA VARIAN: The report that you're talking about is our "Beyond roads and bridges social infrastructure".

The Hon. EMILY SUVAAL: Yes.

CARA VARIAN: Basically, that figure comes from the researchers who have done the economic analysis. I guess what that really would represent is the fact that we're getting different pieces of information from different providers in south-west Sydney, and the two figures represent the upper area and the lower band of unmet needs. So if we're being conservative, we can kind of definitely say that we're not meeting 31 per cent of need right now. But looking at what we expect to see in the future, it's potentially up to 59 per cent. I guess no-one can see into the future and so that's the range of unmet need that we're expecting to see up into 2041, so the next 25 years.

The Hon. GREG DONNELLY: Thank you very much for coming along and thank you for your submission. Witnesses to this inquiry, in fact even some today, have commented about the fragmented nature of mental health services and have posited that that's in and of itself a challenge for people trying to source what is the best service for them to consider. I'm just wondering whether you have any thoughts about that? That, in fact, the navigation—I mean, it seems to be hard enough when you have someone who is working in the area to help navigate a person, a client or a patient, let alone the ones with the unmet need that we sort of have spoken so well about. I asked another witness on another occasion about the sourcing of information. Is there a repository of information that can be gone to which can help people source or navigate through what appears to be a labyrinth of information to access the mental health information that they may need? I'm just wondering if you would agree with the statement that that's true, number one, and, number two, it acts as somewhat of a challenge for the whole system and really does need to be addressed at a very fundamental level.

CARA VARIAN: The power of NCOSS is our ability to join those dots across different parts of the social services sector. I say what I'm about to say from that overall perspective. We are often seeing that the different parts service providers struggle to be able to connect—and certainly we've heard from our members that in the mental health space there can be a disconnect between inpatient and outpatient service delivery. There can be a disconnect between public health-provided mental health services versus community health services, and also what's happening in the GP environment versus what's happening in the community mental health space. I think what you're suggesting with the disconnect between the different segments of the mental health sphere is certainly what we're also hearing from our members. Exactly how difficult the labyrinth is or whether there's a repository of information, we don't have visibility of that from an NCOSS perspective.

The Hon. GREG DONNELLY: It was put by witnesses earlier today that, at least in their assessment, the major factor, or certainly a contributing factor, is that mental health stands separate from—this is essentially paraphrasing them—the mainstream health system. It's there but it's separate and doesn't operate along the same lines. It has a greater inherent complexity about it, and that also is a contributory factor. I don't have the answer. For example, how does the New South Wales Government—if you just take this example, if it was agreed that this would be a worthwhile task in and of itself or a great project in and of itself, how does it create some repository of information? Of course, the other challenge is it being kept updated on an ongoing and continuous basis, because obviously services come, services go, and people come, people go. Is that just literally a fantastic hope that could never be done and the best you could hope to do is try to keep things up to date as best you can at the local level and it will trickle down and people will get to hear about it?

CARA VARIAN: I think there are two parts of the question that I want to address. One of them is about that co-location, so the access. If you've got physical health services and mental health services co-located, it obviously makes it vastly easier for people to access physically. I think that's very important for our rural and remote community members but also for people that are socio-economically disadvantaged, being able to navigate the public transport system, and also, of course, community members with disability. So that physical co-location, I think, is very beneficial from a patient care perspective. Again, our members have told us that co-location also helps to build trust with the people that are receiving mental health care, because they're going back to the same places and seeing similar people. The issue of managing data and being able to provide a repository that everyone can access at the same time—

The Hon. GREG DONNELLY: Or information. I guess it's several terms. We're talking about a very comprehensive, thorough but updated directory of what might be available.

CARA VARIAN: I can't think of a more helpful thing to include on our to-do list, but exactly how to achieve that, I'm not sure. Obviously, going back to first principles, information is power.

The Hon. GREG DONNELLY: Of course, yes.

CARA VARIAN: Being able to provide our clinical service providers with information to service their patients would be a fantastic start.

The CHAIR: You have also noted the MHCC recommendation about five-year contracts. We have heard that from a number of different witnesses to this inquiry. But, I suppose, with your broader perspective across the whole social services sector and not just direct mental health service provision, what's the impact of the funding cycles that are shorter than five years?

CARA VARIAN: I think we've all been a recruiter at one time in our lives, and just the recruitment process alone takes a long time. If we're not providing our service providers with certainty, then they can't provide their staff with certainty. When they are not well paid and they don't have certainty, that means that it's not an incredibly attractive workplace, and those staff will then move on. We do hear regularly that people are having trouble recruiting staff and keeping staff, and then the staff that are there have burnout.

I think the other part of it is that operational and corporate strength and resilience is often not invested in if there's not a long-term gain to be able to play. If you're constantly going through a process of applying for and waiting to hear whether you're going to get a grant instead of being able to plan for staff development or investing in the infrastructure of technology or even leases—being able to take on a longer lease and, therefore, being able to get a cheaper rate—all of those things mean that we're taking time and effort and thought away from service delivery and clinical practice.

The CHAIR: I don't have any further questions. Further questions from the Committee?

The Hon. GREG DONNELLY: Thank you very much. That was helpful.

The CHAIR: Thank you so much again for sharing your time and expertise with us today. The secretariat will be in touch if there are questions on notice.

(The witnesses withdrew.)

Ms ANGELA SCARFE, Senior Policy Adviser, Australian Association of Social Workers, before the Committee via videoconference, affirmed and examined

Ms KATE O'BRIEN, Member, Australian Association of Social Workers, before the Committee via videoconference, affirmed and examined

The CHAIR: Our next witnesses are representing the Australian Association of Social Workers. Thank you so much, both of you, for giving the time and your experience to our inquiry today. My name is Amanda Cohn. I'm the Chair of the Committee. Would you like to start by making a short opening statement?

ANGELA SCARFE: Good afternoon. Thank you, I would. The Australian Association of Social Workers is the professional body representing social workers throughout Australia. We set the standards for the education, practice and ethics of the social work profession. Social work is a tertiary-qualified profession, recognised internationally, that pursues human health and wellbeing, social justice and human rights. To be qualified as a social worker, students must have completed either a four-year Bachelor of Social Work or a two-year Master of Social Work qualifying degree.

Social workers aim to enhance the quality of life of every member of society and empower them to meet their full potential. Social workers look at the whole person within their environment, considering all the biological, psychological, social and cultural factors. This means that we include their strengths and their resources as well as their needs. People's past experience of the system and that of their families and carers are included in a social worker's considerations. Social workers build a respectful and collaborative partnership with people through which they can, together, work out a response tailored to that person's situation. By including all aspects of a person's circumstances, social workers are always striving for a response that's appropriate to people's culture, language, lifestyle, ability level and gender identity.

In terms of people with complex and intractable mental health needs, I want to mention an important subgroup of members. These are accredited mental health social workers. They are members who satisfy a range of requirements in terms of their experience in clinical mental health, continuous professional development, professional supervision and demonstrated competence. They're required to maintain their skills through continuous professional development and professional supervision, and we're really pleased to have Ms O'Brien joining us today with that qualification. These members are recognised by Medicare as being able to provide focused psychological strategies under Better Access. They also are able to take on specialist clinical roles in health and mental health settings.

For the purposes of this inquiry, our message is twofold. Firstly, we believe that community mental health services are terribly under-resourced, and this is preventing them from fulfilling their really important role in New South Wales. Secondly, we believe that social workers, particularly accredited mental health social workers, are an underused element of the mental health workforce. Because social workers can wrap a tailored and multifaceted response around people, social workers are critically important in helping people maintain their safety and the safety of their community and their family members and really hold someone in a community setting while also attending to their clinical and therapeutic needs.

So we really believe that social workers could be playing a really important role in the community mental health system. Remembering what I've said about our holistic and affirming approach, this also makes the social worker profession adaptable, like I said, to people of all ages, abilities and identities. We commend our members to this inquiry. We're really pleased to be invited and to be able to talk to you, and we look forward to being part of the solution in improving mental health services in New South Wales.

The CHAIR: Thank you very much for taking the time to share your expertise with us today. We really appreciate it. You said in your opening statement that you believe the social workforce in New South Wales is under-utilised. I would be interested to explore in more detail what the specific settings are where more social workers should be deployed and what that would mean in terms of recruitment?

ANGELA SCARFE: Sure. Remembering that I said that if you're an accredited mental health social worker you're able to provide exactly the same services as a clinical psychologist under Better Access, lots of mental health services in New South Wales, when they are advertising a clinical and therapeutic role, they specify a clinical psychologist, whereas that is a role that could also be done by an accredited mental health social worker. When social workers are employed in that service it's because a social worker has successfully applied for and secured a position that was actually advertised as a generalist mental health worker or a generalist community worker. So they might be working alongside people of other professions, and, in that role, many of our members are not fully using all their social work skills, because it's actually a generalist—kind of like an outreach role or a generalist support role. I'm wondering, Kate, if you want to give an example of actually having seen that in action and the difference that could have been made on either side of that distinction.

KATE O'BRIEN: Yes. To add to your point, Angela, I suppose there's also opportunity for collaboration with accredited mental health social workers who are working in other practice settings, for example, within private practice settings, who—at the moment, the system feels a little bit clunky, and, often due to under-resourcing, there's not a lot of communication that happens between services. I've had examples of that where I've left messages for workers, and they just haven't ever been returned. I assume that's actually, from my experience, been because of the fact that they have so many clients and not enough hours in the day, ultimately, to get to everything that might be on their work schedule.

There are a lot of examples I can think of, and I'm very conscious to de-identify information that I'm providing today. But even, just as an example, seeing someone as a whole person and seeing them within the context that they exist is extremely important. I think that's something unique to the social worker lens and approach to mental health—not simply pathologising or seeing someone within a diagnoses, but also seeing them in their context. For example, when working with someone who might be waiting for a protection visa, they are not eligible for other services, and we can understand that, actually, that context around them is also going to be very stressful and significantly increase their mental health symptoms across that period of time. I think in terms of understanding actually what's happening for a person, their culture, their lived experiences, their gender, their ability, their socio-economic status—all of these things are extremely important and inform and shape those social determinants of health.

ANGELA SCARFE: In terms of how they could actually be better used in the system, what's happening is that because people like the people that Kate was just describing aren't getting help early on with their mental health, what happens is that they end up further down the system, either being picked up in the acute hospital setting in an emergency or, as we've heard earlier this afternoon, in inappropriate responses led by the police and things like that—which are terribly stressful for people and which then actually make their condition worse because of what we've heard about the traumatising nature of that forceful nature. It's partly to do with the profession being able to work at the top of their scope, but it's also partly to do with the preventive and early intervention sections of the system being able to work to their capacity. We believe that having social workers earlier on in the system would make the early bits of the system more effective.

The CHAIR: Just to follow that up—and I appreciate this one may need to be taken on notice—do you have a sense of the numbers of social workers in New South Wales, if there was a push to suddenly employ more?

ANGELA SCARFE: Absolutely, yes. Yes, yes, yes. We looked at the Jobs and Skills Australia website and I counted up, because I had to do it by region, so I had a great geography lesson in New South Wales. Remembering that not all social workers have to join the AASW, because we're a professional association, Jobs and Skills Australia estimates that there about 11,000 qualified social workers in New South Wales. We have just under 4,000 members in New South Wales and, of them, 761 are accredited mental health social workers.

The CHAIR: And of your members who are accredited mental health social workers who live in New South Wales, how many of them are employed directly in a mental health role?

ANGELA SCARFE: They're all employed in a—well, I shouldn't say "all". A majority of them are employed doing mental health somewhere in the system. Some are in private practice and some are in the public system, and I haven't, at my fingertips, got that breakdown.

The CHAIR: That's all right; I prefaced that with it being a difficult question to answer off the top of your head. I'm interested because we know that for many other types of mental health professionals there is a genuine shortage in New South Wales. If we suddenly created extra psychiatrist positions overnight, for example, they wouldn't be filled, so I'm really interested to understand the numbers of people that we actually have to fill those roles if they were to be created.

ANGELA SCARFE: In our submission we talked about the fact that we have surveyed our accredited mental health social workers to work out whether they have capacity, and we are finding out that our accredited mental health social workers who are in private practice do have some capacity. I can't speak for the accredited mental health social workers who are employed in the public or the community sector.

The CHAIR: My last question arises out of your written submission. You mentioned that social workers are ideal to lead social prescribing programs, and I was hoping you could expand on what you mean by "social prescribing".

ANGELA SCARFE: We're talking about several initiatives that are happening in Australia and overseas that are in the public sector looking at a broader range of solutions to people who present with a mental health problem or need. "Social prescribing" refers to a whole lot of initiatives which connect people back into community-level activities and facilities and programs that might not necessarily have been designed as mental health interventions. We can send you more information of actual examples and case studies, if that would be helpful. But also, Kate, do you want to talk about some examples of programs like that that you have seen?

KATE O'BRIEN: I suppose I probably can't speak to programs specifically as well as you can, Angela. But what I would more like to point out in relation to that is, traditionally, a lot of mental health services have been within a medical model and in a hierarchical kind of setting. A lot of the benefit of that is, of course, it's got an interdisciplinary and a multidisciplinary approach to things. There's been a big focus on assessing, diagnosing, providing medications and making sure that people are linked into their bare essentials—things like housing, Centrelink, if needed, and all of those sorts of things. They're very important, but I think that they're really just a bare bones or foundation of what a human being actually needs, in terms of thinking about recovery and what that actually might look like for people. Again, we're thinking about someone as a whole person and their social world and what's around them. As an example, support groups of all different kinds, even educational groups—there's a whole bunch of different things that are going on. Even thinking about social sports or things like that, there are lots of different ways that we can support individuals and be looking after their mental health.

The Hon. SUSAN CARTER: Thank you very much for being available. I understand that you may not have the answer to this, but since you indicated that you'd learnt a lot about the geography of New South Wales, I wonder whether you had any sense of the spread of the mental health social workers throughout New South Wales—and to what extent there may be availability in the regions?

ANGELA SCARFE: You won't be surprised that what I came across is a real concentration around Sydney and the big regional areas. There are areas that on the map that look very large with very low numbers of social workers. I know that the Committee has been interested in telehealth and initiatives like that as well. I was really interested to be listening to what NCOSS was saying, to take telehealth with a grain of salt—that it's not the panacea for everything. That is also the experience of our members. We are a profession that actually has a heavier weighting towards regional and rural centres than some of the other medical professions, but we still find the shortages in those locations. Our members tell us that people in those locations would prefer face-to-face contact and that in some uses—for example, counselling—doing it over Zoom feels second best. Yes, we know that the way to get services to vulnerable people in rural and remote regions is really serious. It's a complicated problem.

The Hon. SUSAN CARTER: This is just a practical question looking at the provision of outpatient mental health services, so those not delivered through a hospital setting. It appears—and I apologise if I don't understand properly—that there are social workers in private practice. To what extent are Medicare refunds, health fund rebates or any fee support available for accessing mental health social workers?

ANGELA SCARFE: There are, through Medicare and Better Access—what we hear from our members, and I think Kate can describe this better than I, is that that is a different set of needs from the people who need community-based outpatient services.

KATE O'BRIEN: Yes. I think that there is some crossover. Unfortunately, as you would be aware, after COVID the Federal Government reduced the Medicare rebates to being appropriate only for 10 sessions per calendar year, per person, whereas during the COVID years we had up to 20. That means that the scope of practice within private practice is significantly being impacted there. In private practice, social workers also provide under some private health insurance—some like Victims Services NSW, WorkCover, there's a number of different programs. However, the specialty of what community mental health provides is actually more acute presentations—when people are acutely psychotic or suicidal, for example. What that entails is that workers are sometimes able to make home visits and they're able to provide a combination of a psychiatrist and a therapeutic and a casework kind of response to people, which is that sort of wraparound response. People in the private practice sector could absolutely have capacity to be doing a bit more collaborative work in that service sense. However, the need for the specifics of community mental health is unique in a sense in itself as well.

The Hon. SUSAN CARTER: We've explored the issue of navigation because it is a series of complex and interlocking and overlapping systems which, if you are robustly well, can be challenging to navigate, but if you are not, could be completely overwhelming. To what extent would social workers or mental health social workers be the right person to help people navigate their way through the system?

KATE O'BRIEN: I will just jump in there, Angela. I hope that's okay. I would say that a lot of people actually find themselves in community mental health by being referred by social workers who might have met them through another meeting point. For example, people suffering from significant postnatal depression might be picked up through screening and then referred in. Through emergency departments it is also social workers who often provide that immediate response to people who are acute in the emergency department alongside, say, the mental health nurses and psychiatrists. As an example, though, someone might be presenting because of domestic violence. A social worker comes in and makes a response and they also might be noticing, though, that they're acutely suicidal and needing some specific wraparound intervention around all of that. I think already social workers are kind of on the ground often with people and facilitating people into appropriate services and making those assessments.

Similarly, in private practice, I can speak for myself in that setting at the moment, having had experience in NGOs and government and community health in the past. Clients can sometimes have flare-ups of different things going on. Psychosis is an example. You might be working on going with, say, through the Better Access scheme and someone actually is at a more pointy end and needing more support. I guess what's useful about that as well is that we are trying to then find ways to keep people out of hospital because that's significantly expensive and often not in people's best interests, unless absolutely necessary. There may be circumstances where that, of course, is the case. But community mental health is kind of filling this bridge, I suppose, between an inpatient setting and just fully out in the community without more sort of specific kinds of supports in that way. I think social workers are already there and I think it's more thinking about what role they can play in community mental health more specifically.

ANGELA SCARFE: I was listening this morning and Mr Kamper was talking about navigation needs to be done by somebody who's informed about the system and somebody that the person trusts. I think what Kate has illustrated beautifully is that rather than having a separate role called "navigator", the people that Kate is talking about already are in a trusting relationship with a social worker who does know their way through the system and can help do a warm referral to an aspect of the system that will look after them. It's what we were talking before about working out the individual tailored response for that person, taking into account all aspects of them, including, for example, a previous history of sexual assault and their particular cultural background.

I always worry when I hear the term "navigation" because I think it's an unhelpful metaphor. I think if you think about the times when you need to navigate somewhere, it's because you know where you're going and you know that you have to get there, avoiding certain wrong turns or traps or pitfalls, whereas I think that's thinking about what a social worker does from the wrong end. I think what Kate has shown really clearly is that we start from where the person is and build something around them rather than assume that there's one perfect slot for this person that they have to be put into. Navigation suggests that someone knows the end point for that person whereas I think—yes, go on Kate.

KATE O'BRIEN: I was also just going to jump in and say I guess my other concern would be that what you're really talking about is a psychosocial assessment, which is the core business of social workers, Angela, exactly. I think that a navigator is fine, but there need to be enough appropriate services there for when the person finds their way into a service. And actually, if there are not enough people to do that work, which there currently isn't, it's not very helpful in and of itself. I agree that there are things that can be confusing about navigating the system and I think if you're an individual thinking you might need that service, absolutely. The ways that people, in my experience, tend to come into community mental health is by referral through inpatient settings, emergency departments and private practice or other services where social workers are already working, as I said.

If you're an individual that is not currently involved with those services, I guess a lot of the time it could be through GPs and that would be another route that tends to come in. So possibly it's also about educating people. I guess there is also a question of the scope of community mental health—if it's too narrow, if it's too broad, what does that actually need to look like? I suppose, because it often has, in my experience, been focused on the most acute presentations, that also means that there are almost eligibility kinds of criteria that people need to meet to actually access that service as well. So I guess that might be another thing that the Committee is exploring and thinking about.

The Hon. SUSAN CARTER: So we're looking for scaffolders rather than navigators?

ANGELA SCARFE: I like it.

The Hon. SUSAN CARTER: Thank you.

The Hon. EMILY SUVAAL: Thank you to you both for giving up time to be at this important inquiry. Can I ask you about social models in mental health care and whether they are adequately recognised and promoted currently?

ANGELA SCARFE: That's a very good question. I'm a national person and I deal with health, mental health, the NDIS, the aged care system and I think that's an issue across all these systems. The word that Kate was just using was what we said—the biopsychosocial. We look at all aspects and I, personally, would like to see a holistic way of looking at people and that's sort of what we're getting at with the social prescribing. In terms of this inquiry, though, I think, Kate, you can probably be more specific and—

KATE O'BRIEN: Yes. To answer your question very succinctly though, no, I don't think that they are, I guess is the short answer. But I suppose in that sense, I know that on the ground there are a number of community mental health services that have done partnerships. I have also worked in sexual assault counselling roles where education around that is appropriate for lots of people in terms of thinking about a trauma-informed way of operating and thinking about social models of care altogether. But, unfortunately, that's quite patchy and quite dependent on the specific local health district or the specific service. I would also just say that I think that, as I've said before, community mental health is often within a medical model, which means that, I guess, that focus is not necessarily on those things and I think that is something of value and something that social workers do bring.

The Hon. EMILY SUVAAL: I might ask also whether the current Federal schemes that are available—I am talking about the Medicare benefit schemes—support the delivery of therapeutic services by social workers and whether they enable public faith in a multidisciplinary team?

KATE O'BRIEN: You can answer first, Angela, if you like.

ANGELA SCARFE: Well, it is interesting, isn't it, because, yes, they do fund some therapeutic services. But the multidisciplinary teams is still quite difficult and that's to do with the specific regulations in Medicare. For example, even though a GP can make a mental health plan with somebody they're seeing and can refer them to have some work with an accredited mental health social worker, at the moment it's only the GP or the psychiatrist who can actually convene a case conference around that person. It might be that the social worker is one of several people that that person is seeing, including a generalist social worker, a drug and alcohol counsellor, and a housing worker or a specialist health worker for a refugee. Any one of those people might think that it would be really helpful to have all of them having a discussion so that they're all on the same page, but the regulations for Medicare only let the GP or the psychiatrist convene that meeting. So that's something obviously beyond your scope, but it is something that the AASW is working on in different forums.

KATE O'BRIEN: Yes. Just to add as well briefly that of course for referral to occur to an accredited mental health social worker, say in private practice, for those only 10 rebates, that actually needs to be referred by a GP or a psychiatrist in the first place. I guess there is a level of collaboration but it's often fairly fleeting and more of a referral pathway than actual collaborative care—

ANGELA SCARFE: Collaboration, yes.

KATE O'BRIEN: —compared to community mental health, which is actually a setting housing all of these people together to work with the same clients.

ANGELA SCARFE: Can I just build on that because getting back to the question of rural and remote locations, if you have a community where there is only one GP or there's no GP, that's a real barrier to those people getting services under Better Access, so they are reliant on the community mental health system. A lot of our members are dealing with—for example, in a country town where there's only one GP and there is violence in the family or a young person who wants to be sexually active, those people feel that they can't go to their GP because they know that the GP sees the other family members. So those people are really at the moment blocked from getting appropriate health care and mental health care. So, again, the community sector is really important in providing health care for people with those specific needs.

The Hon. GREG DONNELLY: Thank you very much for your submission and making yourself available today. Can I just go to page three of the submission, if you've got it in front of you? If not, I can read out what I wanted to refer to. It's specifically the recommendations on page 3 about halfway down. The recommendations are couched, if I put it this way, to bring AMHSWs—these are my terms—more into the fold of mental health engagement with the community. The implication is, I think, that at the moment as an organisation and the members of your organisation who are mental health social workers, they are sitting a little bit apart from or next to mental health. I'm struggling to understand why there just hasn't been that almost—if you take, for example, Ms O'Brien's experience and the work that she's doing, I would have thought that effectively you would be almost automatically just absorbed into the mental health workforce. So I'm just trying to work out why that hasn't happened almost in an organic fashion. That's my first question.

My second question is has there been resistance to, if can I put it that way—and be as frank as you like—embracing mental health social workers as to, in effect, be included in the count, if I could use that sort of phrase, for the purposes of understanding what is the totality of our mental health workforce, particularly at that more elite level where there is obviously significant training that has been done.

KATE O'BRIEN: I think that part of the reason is that they haven't been advertised specifically for the role. Accredited mental health social workers—there's kind of no incentive, I suppose. There's no room for growth for a social worker in community mental health, if they've only started in a fairly generalist kind of role, to continue to grow their skills and experience within a service like that. And so I think, to Angela's point earlier about the advertisement and the incentive there, that would be important. Also, just generally, I don't know that there has been active resistance, but I think that within a medical model and the hierarchy that exists within there, that is slowly changing over time. But I do think that that may also be a factor as well.

The Hon. GREG DONNELLY: This is just a suggestion, and maybe it has been tried without success, but in terms of meeting your recommendations, I can see that there are some things that the Government can do or the State can do to help support and get behind your recommendations. Is there more that you're cable of doing to facilitate yourself or doing concurrently with the Government, if the Government adopted this idea, to proceed with this better integration so you've got that standing within mental health treatment?

ANGELA SCARFE: One complication of this is that the sector generally looks to the professions which are registered with AHPRA as the medical professions. As it happens, social workers are not registered with AHPRA. We are the constituting body of the profession. That's something that we are working very hard to change. But, for example, a shorthand for who are we going to employ will often be, "Well, we'll get the health-regulated professions to work in our service." So that's one element of why—for example, what I was talking about, about a clinical psychologist being named when, in fact, an accredited mental health social worker could do the same work.

The Hon. GREG DONNELLY: That was an interesting point, I have to say. I'm glad you, in fact, raised it. I didn't quite appreciate that. It's a very significant point that you have raised. Just finally, has there been any resistance by government at State, Territory or Commonwealth level to, to use the phrase, get onboard with what you're trying to do as an organisational initiative to get that, dare I say, greater integration?

ANGELA SCARFE: The sector is so varied, and there are so many aspects of it. For example, Kate was talking also about the compensable schemes. A lot of our work as the AASW is to raise awareness of what social workers can do and how they could be used. I'm reluctant to generalise across the board about acceptance of social workers or otherwise. There are areas where people say, "Oh, that's fantastic. Come and work here," and there are other areas of the sector that need a bit more information and things like that.

The CHAIR: Thanks so much again. We are out of time for this session. We really appreciate your time and expertise and all of the work that you're doing every day. The secretariat will be in touch if there are any questions on notice. We will briefly break for afternoon tea. We will be back at 3.30 p.m.

(The witnesses withdrew.)

(Short adjournment)

Ms REBECCA GRASSO, Chair, Western Sydney Health Alliance, sworn and examined

Mr GLENN COTTER, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, sworn and examined

Ms ANNE GALLOWAY, Mental Health Manager, HealthWISE New England North West, sworn and examined

Ms LOUISE INGALL, Manager of Strategy, Research and Engagement, HealthWISE New England North West, sworn and examined

The CHAIR: You have all travelled a reasonable distance to be here today, which we really appreciate. Thanks so much, also acknowledging you are on a panel together because you represent a diversity of regions. Would you like to start with an opening statement?

LOUISE INGALL: Good afternoon Chair and Committee. Thank you for the opportunity to further contribute to this inquiry. Firstly, I would like to acknowledge the traditional custodians of the lands and waterways we are meeting on today, the Gadigal people. I pay my respects to Elders past, present and emerging. I am based in Tamworth, one of the rural and regional locations from which HealthWISE provides services in Aboriginal health, allied health, mental health, primary healthcare nursing and supports recovery from and preparedness for natural disasters. HealthWISE supports care at every stage of life. This support addresses physical and mental health, including perinatal services.

We are specialists in delivering outreach services. Across 2022-23 our team delivered over 15,000 mental health consultations. We focus on priority cohorts, including First Nations people, newly arrived people, especially Ezidi people in the community of Armidale, and since 2019 we have partnered to deliver primary mental health access, so referral intake and allocation to mental health services in our region. In addition to these programs, we deliver community-based suicide prevention services on behalf of the New South Wales Government. Our written submission to this inquiry contains the reflections of our clinicians and lived-experience workers. HealthWISE operates as an interdisciplinary team that's composed of mental health social workers, mental health nurses, psychologists, mental health occupational therapists and mental health lived-experience workers. We refer to them as mental health clinicians as a group.

We have been delivering this type of service for over 15 years and we see this approach as an avenue to improve delivery of mental health services in rural and regional areas. We are on the ground and we have co-designed a model that is fit for our communities and it may be transferable. Our teams understand the interrelationships between mental health and other streams, including allied health and holistic care, and most importantly, the value of social connectedness. If an outcome of this inquiry was the capacity for mental health providers to deliver care which was inclusive of social prescribing and addressing the social determinants of health within their contracts, we believe that this would positively impact recovery in our communities.

Dr Cohn, when your invitation was put out to the community to participate in this inquiry you referenced identifying the most effective way to acquire the skills of a variety of healthcare workers in New South Wales. The current mental health funding environment favours large, national providers and digital health solutions, rather than place-based, experienced, interdisciplinary teams like ours. Accessibility in delivery of mental health services in rural and regional Australia is impacted by funding cycles. In 2020 the Productivity Commission recommended funding cycles for community mental health services should be for a minimum of five years, with providers aware of funding decisions at least six months ahead of the end of this cycle. This is far from the current reality in 2024. The current reality impacts the experience of patients and carers accessing mental health services in New South Wales.

GLEN COTTER: Firstly, I would like to thank you very much for the opportunity to be here. Coming from a regional area, it's not often we actually get to be at these things. I really am honoured to be here. I'm here on behalf of the Bega Valley Eurobodalla Suicide Prevention Collaborative. I sit on the executive steering committee and was part of the original consultation group to put it together. The collaborative is a coming-together of over 30 local organisations, community members and people with lived experience of suicide, which was formed in 2022 to take on a whole-of-community approach to preventing suicide in our region.

As I said previously, I'm based in Bega. I'm a lived-experience peer worker. I guess my qualification is that I have a lived experience of suicidality, or a living experience of suicidality, and I work as a peer worker offering face-to-face support for people straight out of a suicide attempt. I'm one of only two lived-experienced peer workers working with an NGO organisation across the entire region. I'm the only one in the Bega Valley region, and there's one in Eurobodalla. What we'd like to highlight for the Committee today is the need to continue to shift our thinking about suicidality as only a mental health issue—it is not—and to look at some of the specific challenges with support in regional and rural areas for people and for the workforce. That's why the collaborative was put together, so that we could get together and work through these challenges.

Suicidal behaviour is not only a mental health issue. A person's social and life experiences are just as relevant to risk of suicide as mental health issues. Things like financial distress, loneliness, homelessness, discrimination and relationship breakdown are all factors that are part of a picture which, at times, is just too overwhelming. This impacts where people might reach out for help and who they might connect with about thoughts of suicide and the supports they need. Early intervention and greater community support at times of increased life challenges may reduce the numbers of people presenting in crisis situations, benefiting both individuals and the service system. Strong connection between mental health services, primary care, and social and peer supports are another key part to the question.

To achieve this reduction in stigma, we need quality training in suicide prevention and a strong role for peer workers across health and non-health services. This is essential. New South Wales government, as a large employer in regional areas, has a key role to play. As an example, we strongly support the leadership through the adoption of the SafeSide framework by NSW Health and would like to see this continue to grow as a common framework across services beyond mental health, regardless of who funds it.

Distance in rural and regional areas has a significant impact. Travel can be difficult for people in accessing services and their carers, and also impacts what it means to provide services and outreach. For part-time workers, which many of us are, the distances involved impact on time spent with clients. We can't see the same number of people in a day. Contracts and KPIs need to take this into account. Our ability to attend training and development is constrained and we often work as part of a distributed care team, including our own supervision. Telehealth options can help but cannot always be relied upon and, therefore, cannot be the full answer. Internet outages, black spots and lack of access for some parts of the population are very real.

Funding and delivery models that take account of rural and regional locations and allow time for meaningful lived-experience engagement are needed to help address some of the challenges people face in trying to access appropriate supports and sustain our workforce. Unfortunately, because of a lack of other options, we also see high numbers of people showing up in emergency, which is not the right place for people experiencing suicidal distress. Alternatives, such as Safe Havens, are a welcoming drop-in space and suicidal outreach teams are welcome but need to be expanded.

The Suicide Prevention Collaborative formed in our region to help address these issues and support each other through the strengthening of relationships and community commitment working rather than in silos. Collaboration can be a vehicle for providing a community perspective that supports planning, integration, lived experience, engagement, co-design and implementation of supports. Some of the key issues we'd like to discuss today are equity and access. Access to services in this region can be challenging due to factors such as distance, lack of transport options in some parts of the region and cost. The collaborative strongly supports the Safe Haven initiative but the current level of funding provides access to these alternatives in Bega and surrounds, but cannot support the Eurobodalla parts, which are up to 150 kilometres away.

For example, lack of transport options, such as public transport or taxis to get home, is an unresolved issue that may prevent access to services, such as the Bega Safe Haven. Navigation of services—and we heard about a lot of that today—community feedback confirms that people find navigating the mental health service difficult, with unclear eligibility requirements, whitelisted restrictions on referral pathways, making it hard to get services. Capacity and integration of services—there have been some positive developments in the region where services across different sectors have adopted a common framework and language, using the SafeSide prevention model. SafeSide is still very much a medically based system. As a peer worker, working face to face, to me it has its limitations.

Work is currently underway with funding from the New South Wales PHN in the south-east region to develop and implement a customised SafeSide program for local alcohol and other drug-related services. In primary care, the adoption of the intake assessment and the referral systems, my general practices in community mental health should assist a lot in better ways of providing connected services for people. Digital integration and referrals with the public mental health system could further streamline this process, but are not always reliable. Issues in workforce in our area, some of the challenges identified by the Peer Work, are workforce isolation, especially for the sole number of peer workers working on their own—as I said, outside of the PHN. In my region, I'm one of only two peer workers and I work in a hub by myself. Extra time spent travelling and a significant number of roles being part time make connection and professional development difficult as well as trying to spend more time face to face.

Workforce allocation in regional areas also needs to be sufficient to cover the significant amount of travel of staff needed to undertake and support the clients into access training. A further challenge—experience in the region has been recruiting staff and trying to get staff to come down. The cost and availability of housing, to either buy or rent, since the Black Summer bushfires and COVID is a factor. Over the Black Summer fire period between the Bega Valley and the Eurobodalla, we lost 1,100 homes, so any rental availability that was there was gone immediately. It's just not there. We can't get people into the area. Digital telehealth options can add to the picture and evidence supports its safety and efficiency, including in suicide prevention. However, these services are not preferred by some parts of the community and internet access can be an issue due to where people are located. I thank the Committee for the chance to be heard today and look forward to some questions.

REBECCA GRASSO: Representing the Western Sydney Health Alliance, which is a combination of eight local government areas—so eight Western Parkland councils—are the two primary health networks within the area, the two local health districts and also Sector Connect which is a peak community organisation. The health alliance is a partnership across three levels of government and we work collaboratively to create healthy communities across the Western Parkland City. We don't seek to duplicate or to compete. We seek to capitalise on the assets that we have across each of our agencies to fill gaps and capitalise on opportunities, and be responsive where we know that there is need. We participate in research. We conduct programs. We provide education, particularly through councils, and we seek to influence planning decisions.

Access to health and wellbeing services for individuals is one of our key outcomes and we're committed to, regardless of a person's background, location or socio-economic status, being able to have a positive impact. It's no secret that the western parkland region is one of the fastest growing regions in the State, and achieving equity of access to mental health services is complex and is an ongoing challenge for our residents. So what we are advocating for the Committee to consider and address are the existing deficits in funding and access to mental health services and futureproofing for our region; fair and equitable mental health service funding allocations and provisions; evidence-based resource allocations; and locally based mental health services and facilities that are adaptable to a growing population.

Access to mental health services and health equity in New South Wales is not improving and cross-sector collaboration to address this issue is critical to make a measurable impact. The per capita spend on mental health services in the Western Parkland City has been historically less than other areas and there are significant variations in servicing ratios across health services in the region, indicating disparity in mental health and allied health services. With the unprecedented population growth occurring, it requires a beyond business-as-usual approach and to improve the limited service availability, the distances that people travel and the healthcare workforce shortages, we are seeking to engage positively in that dialogue.

The CHAIR: Thank you very much. I have a few questions and we'll go to questions from other Committee members as well. My first one is to all of you. You're all working very hard in areas where I know it can be difficult to recruit health professionals and mental health clinicians. Some of you have already spoken to some of the specific barriers to recruitment or retention in your opening statements, but I'm interested in what positive recommendations you might make in that space. What could the New South Wales Government do to support you to recruit staff in your areas?

ANNE GALLOWAY: I'm happy to speak to that. I think that one of our experiences that we would feel comfortable in sharing more information about is around a skill set based mental health team. We recognise and appreciate the requirements for AHPRA or AASW registration or membership, but it's also very much around not identifying specific positions but identifying the skill sets required to match the needs of the particular program that people are working under. I think that that's part of a workforce model within rural and regional and remote areas that in mental health allows for the development of a rural mental health clinician that provides multiple skills within the mental health services.

GLEN COTTER: From my point, as an on-the-ground peer worker, my team would normally be two peer workers and a clinician, based in the Bega Valley. We had a peer worker and a clinician move on in September last year and we have not been able to recruit anybody since then, so I am working as a one out. For me, a lot of what we need to do outside of community mental health and outside of health but in the private sector is we need to be able to offer some security in employment. We heard a little while ago about the tenders and contracts. Our program, Next Steps, is up for renewal, we believe, at the end of June this year. We still have heard nothing about whether we have a job come July. We haven't heard if the tenders have gone out. We haven't heard anything. Yes, at government level those tenders were supposed to be moved to five years. They certainly have not.

I'm funded two days a week. We can't employ people if we can't offer them a deliverable role. We can't offer them three days a week and "Maybe your contract is up in July; we don't know."

So how the hell do we get staff? We can't bring them into a regional area; there's nowhere to live. We can't offer attractive employment. Out of that, we need to be tendered better. We need to be funded better in those tenders.

I go back to that all the time, but it's the bottom line. We can't get people if we can't offer them job security, and we can't bring them into an area where they can't find housing.

REBECCA GRASSO: I think that's consistent, too, with the challenges that we face in Western Sydney. I can understand that rural and remote have some of those challenges around housing, cost-of-living pressures and also connection with family and friends, too, when it requires you to be making a decision around work. One of the challenges that we specifically have within Western Sydney—and I'm sure it's in regional areas too—is the GP shortage. This is significantly affecting people in many different ways.

We know that people with chronic health issues, and particularly chronic mental health issues, are more likely to see and more likely to need contact with a GP. The delay in people being able to connect, particularly with a bulk bill GP, is getting more difficult all the time. The availability of GPs when it's not just normal business hours—people don't always have their challenges or they're not always unwell when it's regular business hours. That is a particular challenge that needs to be addressed, not just at a State level but at a Federal level. I'm looking forward to having some of those conversations too.

One of our biggest challenges is actually the ageing profile of our GPs as well. A very significant proportion—20 per cent—of our GPs are over 65, and the median age of GPs in Fairfield alone is 68. That just goes to show that a lot of the people who are actually performing this very important I call it community service are doing it because they feel committed to it, not necessarily because—I'm sure there are other things that people could be doing at age 65 to 68 as well. But people do, and people work in the sector because of that reason. I think one of our challenges is making sure that we are bringing people through the system, as well, and making it a valued profession and community contribution that young people are enticed into for those good reasons.

The CHAIR: I have a specific question for Mr Cotter, if I may. You mentioned the SafeSide Prevention framework in your opening statement. I was hoping that you could expand on that in more detail.

GLEN COTTER: For me as a peer worker, I do a lot of my counselling or work with people in a very one-on-one, sit-down conversation. I'm personally not a fan of the SafeSide, but that's only my opinion. The SafeSide is based, to me, very much on the medical model and is very much aligned with our clinical and our social work staff, where they actually put together a formulation of working with people on their safety and their suicidality. It does require boxes to be ticked and specific people to fit into boxes. Not everybody fits into boxes in mental health, especially around suicidality risk. It's very human; it's very fluid. For me, I would never have fitted into some of those SafeSide medical models. I wouldn't have qualified for some of the help that I needed. As such, I didn't go and get help when I was suicidal. I tried to do it myself.

I think—and again it's only my opinion—that we need to get back to the community-driven, as our respected speakers previously were talking about, get back to that community model where we all sit down together. We sit down in a room together, with a clinician, with the support team that that person is working for and we talk about what we need to do and what works for that individual person, rather than have a clinician or a social worker or a psychologist tell that person what they need to do. We need to be able to sit with them and ask them, first, whether we've got it right, whether we understand what they need, and then talk about what we need to do and how that will help them. We need to go back to working hillbilly health care. We need to go back to sitting around a fire pit and talking about what the person wants, not tell them what they need, not tell them what has to happen for them.

We've got to—I'm sorry; I'm passionate about this. We've to stop looking at statistics, and we've got to stop looking at figures. We've got to stop looking at all of this stuff, and we've got to go back to looking at humans in a really fragile and distressed state. We've got remember that every one of those statistics on that piece of paper is a life, and that's what we need to look at. If we can combine the two, please. I'm passionate about the job I do. I really am. But I hate the fact that I've got it, because I'm picking them up at the broken end. We need to do the work here and get them before they fall through that gap. To me, if we can get some more understanding of that—and I will openly invite every single person in this room to come and sit in the car with me, drive up and down the coast, and sit with somebody who can't get access to a service because they don't tick a box or can't get to where I am. Come and sit and spend a day on the actual front. We've got to get back to working with people.

The CHAIR: Thank you. I can certainly hear your passion in that answer. I had another question, which feels like an uncomfortable jump from there. With apologies, my question is for Ms Grasso. I was really excited to see in the introduction to the Western Sydney Health Alliance that you work across all three levels of government. I'm a former local government councillor. I was quite passionate about the role that local government can play in health and mental health. I was hoping that you could speak to either some of the work that the alliance has done involving council or, potentially, what those opportunities are for local government to be more involved.

REBECCA GRASSO: Yes, I can. I think one of the very important pieces of the work that we did was really understanding the social determinants of health and how they related locally. It gave us insights into then how we apply that to decisions that we make. There are a number of partnerships that we have established with the local health district as well, within councils, that are particularly around looking at embedding within planning how we can achieve better health outcomes. So that's a really significant piece of work.

The relationships that we have range from undertaking research, delivering education programs. Another one that we have is around a toolkit for impact on climate, for example, and health. That toolkit approach has actually been really quite useful in modelling it for other things as well. The PHNs as well provide a real wealth of information to us that we can then consider, "Okay, so we're hearing about some of the challenges around GPs. We also understand the challenges with attracting other allied health workers to different areas. What is it that local government can do to improve the opportunities that people might see in locating"—this is really linking back to that previous question around workforce as well. We are actually doing a collaborative piece of work at the moment on a workforce strategy, and we're also including Regional Development Australia in that conversation. I think it is a really good network group that comes together, but it is about making sure we're picking the things that we can't solve ourselves.

The Hon. SUSAN CARTER: Thank you very much for all being here today and especially for travelling distances to be here today. We're very grateful. If I could go first to you, Mr Cotter, we've heard a lot about the idea of peer workers, and I note from the HealthWISE submission that you raise the issue of peer workers as well. Perhaps there's some lack of clarity around exactly what the role of a peer worker is. Mr Cotter, I wonder if you could talk about whether there is clarity or how we could better provide structure and definition. I wonder if the other thing you could address—I see that you work with suicide, and thank you very much for that work. That is very hard work, and we're very grateful that you're involved in it. That is a background that you can bring as a peer worker. Given the experience of mental health is so broad and so individual, to what extent—for example, could somebody who has lived experience of psychotic episodes be a good peer worker for somebody experiencing suicidality or the reverse? If you had some comments about that, I'd be grateful.

GLEN COTTER: That's a really good question, and I'll do my best on that. The peer work movement is really quite new. I've been really fortunate; I've been working as a peer worker for 5½ years in this role, and I've watched it transition over the years. When it first started, a lot of people really didn't understand what a peer worker did. As a lived-experience peer worker, be it from suicidality, be it from drug and alcohol, be it from trauma, the concept of lived-experience peer worker means that I don't have any pieces of paper on the wall. I know what it's like to be curled up in the fetal position on the end of the bed. As such, from that I can take a phone call at nine o'clock in the morning that just says, "Give me one good reason why I don't die today?" When you give them the answer that you're supposed to give them, they just tell you, "Wrong answer." And then you draw a breath and you sit there and you go, "Because I just don't want you to." From that the answer comes back as, "That's all I needed to hear, thank you."

My experience as a lived-experience peer worker means that I can sit and look at somebody in the eye and they don't necessarily have to explain to me what it is they're going through because we've been there ourselves. As I said, be that suicidality, be it either sexual abuse or domestic violence, a lot of it all folds together. It's a matter of just having trust with somebody. My role is to sit beside the person and help them talk about what they want. It's still understanding coming with that. We laugh sometimes: Peer workers are at the bottom of the food chain because we're not qualified. Then you go to social workers, case workers, whatever. I've recently had the pleasure of working with a social worker who became a peer worker and brought an amazing depth of knowledge with it. Personally, in my opinion, I think everybody doing their psychiatry or social studies should come down and spend time on the ground with the peer workers and actually be able to admit that they have a lived experience.

I'll be really honest: I was at Wollongong university two years ago talking to their Bachelor of Psychology students. We had about 30 people. I asked them in a safe space, "Who amongst the room has experienced some suicidality?" About 12 of them put their hand up. Then I asked them who would be prepared to admit that when they were going for their qualifications, and not one person was, because it would be detrimental to their qualification. I'd be happy to sit with a person that I'm talking to, knowing that they have a lived experience. If we're still bringing professionals in that are afraid to admit that they have a lived experience, we're running round in circles. We've got to be able to put our hand up. If we're going to change stigma, we've got to do it within the workforce. I'm a lived experience and I'm proud of it because I'm a survivor. Every day I struggle to get out of bed. I sat out here today wondering whether I had any right to walk into this room.

The Hon. SUSAN CARTER: I'm very pleased you did.

GLEN COTTER: But this is what we do. We help people to understand that they're not alone, that they can get through it, and we can still be valuable. We can bring our voice because we've been through it. We need a bit more recognition. Without getting political, our pay rate is horrendous because we're not qualified. I get paid more an hour to go down and wash dishes at the pub, and I'm not holding somebody's life in my hand.

ANNE GALLOWAY: I think that points to some variability in how lived experience is utilised across the sector. Certainly our experience of our lived-experience workforce has come from working closely with Roses in the Ocean, which is around aftercare after suicide, to develop a very specific position description before we actually embarked on our very first lived-experience worker, which was probably five, six years ago, and having that role of integration within a team, so surveying our workforce: Are they ready for lived experience? Do they understand what is happening and how this role will complement their work?

It's interesting because of some of our research we did recently. Five years later where are we now? Certainly, the acceptance of the workforce is changed quite significantly. Qualification-wise, I think as an NGO we've been able to identify what we consider is our minimum qualification. Lived experience is part of what you bring to the role but that's not what gets you the job. Our expectations are around the contribution of lived experience being equally valued because it is a very valuable experience to bring to the client and—I hate to say—the holistic care of clinician/lived experience should work interoperably. I'm sorry your experience isn't like ours, but we have had the opportunity to really explore and embrace the lived-experience workforce and really value it.

GLEN COTTER: It is getting a lot better, and I sit as part of the Roses family as well. I'm part of the lived-experience advisory panel of Suicide Prevention Australia. I also sit as a lived-experience adviser with LivingWorks Australia and part of lived-experience panels with Roses in the Ocean. So we were all working and it's pleasing to see people like SPA and that are developing lived-experience advisory panels. I recently sat, or chaired, the roundtable white paper on how we sustain the workforce for Suicide Prevention Australia. So we're learning more as we go but there's still a lot more to go. I was fortunate. I was employed as a lived-experience peer worker, but for me to go anywhere further than that I have to qualify through, you know, academic registration. I've got to get qualification. So I go nowhere until I get more medical qualifications. So we're getting there.

The Hon. SUSAN CARTER: Thank you. Ms Galloway and Ms Ingall, you raised workforce issues and I was very distressed to note in your submission one of your comments in relation to term of reference (e) that you think rural services are actually getting worse rather than better, especially face-to-face services. Could you help us understand in what ways they are getting worse? Are there fewer psychiatrists, fewer psychologists? What's the situation on the ground?

ANNE GALLOWAY: I'm certainly happy to speak to that. This is a survey of our workforce and our committees and lived-experience workforce on the ground, so I think it probably speaks to the fact that with a diminishing workforce, probably an increase in locum GPs—I'm not sure what a locum is—there's intermittent GP access. A lot of the resources that were previously available that have a relationship with your local GP perhaps are not there anymore. There's also a response to what's been, apart from the socio-economic impact across rural Australia, we're also seeing the residual impact of disasters. I think when we look at that psychological preparation, that's work that we need to address now because it's on the horizon, coming towards us at a great rate of knots. I think it's also a testament to the fact that there has been a change in the complexity of people's presentations. People, whether they're delaying or they're utilising, are not recognising the fact that their symptoms and their wellbeing are deteriorating often until they are presenting much more complex; therefore, it's a slower recovery, a more complicated recovery, and then access to the services that may be required are just not there.

The Hon. SUSAN CARTER: It's getting worse, not better.

ANNE GALLOWAY: I would believe it is.

The Hon. SUSAN CARTER: Okay.

ANNE GALLOWAY: Models of care that have been imposed in funding bodies don't necessarily match what the needs are of the community, now that we've got a sessional base model of primary health care. If you live in Glen Innes, then that NGO's got a hundred sessions and has to share it across the town as to who gets services within the primary—don't take me literally but that's what I mean.

The Hon. SUSAN CARTER: No, but as an example, yes.

ANNE GALLOWAY: That sessional target means that NGOs have to constrict, and therefore full recovery is probably jeopardised.

The Hon. SUSAN CARTER: My last question—and, again, it's quite a change of pace—is to Ms Grasso. Thank you for a very comprehensive submission. I note you were outlining the challenges facing the very rapidly growing area in Western Sydney. You're looking at factors which can compromise mental health—being single, being unemployed or underemployed increasing feelings of isolation and loneliness, and you also point to living in high-density housing. I wonder whether you've done any thinking or whether you have any concerns about the impact of the planning changes that have been flagged, and what impact that might have on increasing mental health issues for people?

REBECCA GRASSO: It's very interesting because the growing household profile for Western Sydney is actually lone households, which is something that we need to address when we are thinking about housing provision, but not just about making shelter for people, but how is it that we actually create community and connection for those people. I think that's a real consideration. I also think that, particularly for Western Sydney, with migrant households, there is an expectation of multigenerational households, and that's something that needs to be captured through planning and design, through the planning controls, but also through the way, again, that we think about building communities and building place around development. It's critically important to be considering these matters. I think the one-size-fits-all approach to high-density housing—and I'm a little bit concerned about the concept of pattern book, because it is not necessarily taking into consideration all of those other environmental factors that relate.

Proximity to transport is probably the main thing that is being considered, but that isn't the only factor. There needs to be truly local considerations given, particularly for health impacts when it comes to planning. The partnerships that we do have with the local health district through Population Health to be doing some of that more localised research and sharing those insights across other councils has been very useful. I hope that that is something that we can continue considering very deeply—those social determinants of health. The same social determinants of health are also the same things that impact on mental health. Certainly, the exacerbation of pressure on family households is extremely important, and the way that that actually then impacts on people's ability to manage their social interaction and what they choose to spend their money on. It's on the essentials, rather than on the things that actually give them joy, and the things that enable them to connect with other people is of consideration too.

The Hon. GREG DONNELLY: Thank you all for coming along and, first of all, for your submissions, which are all very good and helpful, but also for coming along today and providing us with the opportunity to ask you some questions and probe a bit further. The three organisations are represented at the table, but Ms Galloway and Ms Ingall, I will consider you as one organisation, but you can both obviously contribute, and Mr Cotter and Ms Grasso also. If I asked you the question that, with respect to your respective bailiwicks—so we are talking about New England North West, the beautiful Bega Valley in Eurobodalla and Western Sydney, and specifically the arc of the LGAs you cover, Ms Grasso—is there anywhere that a person can go to find out what are the "mental health" services available in this neck of the woods? That's my first question. Secondly, how would that person know that what they are looking at is comprehensive and could have faith, in fact, to the point where they would be prepared to know that this has a reputation of being a place where I could go to, to see that what I was looking at was accurate and up to date?

ANNE GALLOWAY: I'm happy to start from the New England North West. I think that there are a couple of directions there. One of them is the HealthPathways model, which has been rolled out within NSW Health for a number of years. HealthPathways for our organisation has been problematic because of the changes in programs and the ability to say, "We don't do that program anymore; this NGO now does it."

So keeping it up to date is problematic, but we, with our comms team, have come to a solution. We keep our website up to date and then link it through to HealthPathways. That's community access as well as health professional access.

There's also a program that we were previously running, called PRIMA—which is going to take on the role of intake and assessment, like Head to Health—whereby we have access to who are the resources around that are funded by the primary health care network, so undertake a mental health assessment and redirect that referral through to the most appropriate service available for that person, funded by the primary health network. That's a partial directory because we need a working knowledge within our footprint: Who's where? What have they got? It might be, "Yes, okay, we've got headspace in Inverell but, hello, we don't have it in Wee Waa," that kind of thing.

That is within our ability, but a referral has got to hit us before we can distribute that information. I think promotion of the Head to Health website is really what's coming through, and Healthdirect. If I want to find a mental health service in Boggabri, where do I go to look? If you type it into Healthdirect, they'll say there's none there. But we know from Narrabri to there, there's a visiting service. I guess a short answer from us is: We innovate to be able to deliver the information.

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

LOUISE INGALL: From the point of view of a government who might be making changes and who commissions services, do you provide a comprehensive communications component in your contract to support people who work in mental health to do that? Because, if you expect the providers to be educating their communities—not an unreasonable expectation—who's paying for that? If your contract is ending, I don't think the communications person is staying in place to fully advise what's happening in the community. So there are investments to be made at all levels of government into information. I think a previous contributor today also mentioned that we need to be aware that, when we're seeking this information, we're not sitting in a place of peace and quiet; we're in stress. We've got a family member in distress. It needs to be simple.

The Hon. GREG DONNELLY: Thank you. Mr Cotter?

GLEN COTTER: As part of the collaborative's idea—and we were formed in May last year, we launched. As we say, we have over 30 organisations in the collaborative and working with us. One of the main things we did—and it's simple, old-fashioned—was we actually put together a wall chart or something that could go on the wall that showed all of the services in the area. Somebody could pick it up and look at it and see what services were available in that area, so they could go to help when they needed it and the contact numbers were there.

Unfortunately, again, contracts run out; people don't get services renewed. That is literally a full-time job to keep that up to date. We've got over 30 services at 30 organisations. A lot of those services look great on paper, but a lot of those services might have one staff member, who may only work three days a week. While it looks really good on paper and government can pick it up and go, "Wow, that area's got all of these services, staffing and accessibility to it," we can't always explain referral programs. We can't always explain how people can get to us. The only way somebody can get to me in my program is to come from ED or from community mental health. We don't have soft referral pathways to get them to us.

It's still something we're trying to do. A lot of people don't know how to get help until they need it. You're not in a position to be able to sit down and take the time to read something. A family member is in distress or you're in distress. You continually tell people to ring the 1300 number. That takes time and that's not always a situation that people can sit and do. I've had the really hard experience of having to ring the 1300 number and try to do an escalation on my own son. As somebody in the field, what I had to go through to do the escalation on him, anybody else would turn around, put the phone down and walk away. It's not a friendly service; it's not. We're trying to get Safe Havens open. We hear Safe Haven is the big way to go. They are. For Christ's sake, let's get it open. I sat on a co-design panel for our local one in 2021; it's still not open. Hopefully it's open at the end of this one.

The Hon. GREG DONNELLY: Can you elaborate on that? Which one are you referring to there?

GLEN COTTER: The Bega Valley Safe Haven, which is part of community mental health and part of the Towards Zero program. Safe Haven is where somebody in distress can go and sit—

The Hon. GREG DONNELLY: Yes. I just wanted the location. Thank you.

GLEN COTTER: Yes, Bega Valley. When we did the co-design, we were working on one for Queanbeyan and one for Bega. For some reason, the money was cut for Queanbeyan; they only decided to go to Bega. It's still not open.

The Hon. GREG DONNELLY: That's good to know.

GLEN COTTER: We don't know what the delay is—been multiple delays through Health, through council, through whatever. We've now got a SPOT team open, which is great. They do amazing work.

The Hon. GREG DONNELLY: Sorry, who was that again?

GLEN COTTER: SPOT. The regional SPOT team, which is Suicide Prevention Outreach Team. They opened in 2022, and they've been doing amazing work filling the gaps. But they're still not staffed adequately. There's not the funding there to staff them adequately through NSW Health. We're plugging gaps; we're not doing it properly. We're reactive, is the problem. We're not proactive, we're reactive. When a problem comes up, we try to fill the gap. We don't look ahead. I don't know where that comes from. We laugh at times and, as I said, we call it hillbilly healthcare. We do what we do.

The Hon. GREG DONNELLY: It sounds friendly.

GLEN COTTER: It doesn't always fit our NGO funding model, and we consequently are slapped in the back of the head sometimes for doing things. But how we advise people of where they could go, I don't know, because in that level of distress, we can't get it out to them properly. We could sit down and tell somebody that there's a service that they could go to; I find out that they're losing their contract in six months and it's a three-month wait period to get into it. I don't know the answers. I really don't. I wish I did and hopefully some of it will come out of some of these.

The Hon. GREG DONNELLY: Your evidence is very helpful. It's laying it on the table, which is very helpful.

GLEN COTTER: I'm afraid I'm very much like that. If you ask a question, you're going to get an answer.

The Hon. GREG DONNELLY: They've been quite fine answers, so I appreciate your evidence. Moving across now to western and south-west Sydney, to understand the availability of services that are there, is there a source or a point or a domain or a hub that someone can go to find out information?

REBECCA GRASSO: It's probably outside the scope of my knowledge. It's something I can take on notice, if you'd like.

The Hon. GREG DONNELLY: Thank you. There's been evidence to this Committee on more than one occasion that there's much out there but this connectivity between the person in need at the point in time when they need it and making their way, ideally, by a straight line because it's the shortest distance between two points, is not readily available and often people do struggle.

REBECCA GRASSO: Without knowing what that information might be or those services or the networks to those services, certainly one of the biggest challenges is the digital equity issue in Western Sydney. The first place that people would most likely go to, if it wasn't from a referral or from advice from someone directly, would be the internet. Digital equity is certainly a significant issue—digital literacy as well as digital access.

The Hon. GREG DONNELLY: That's important evidence. Would you, if you can, elaborate on that if you've got some broad detail and then take the difference on notice—if you want to give us some specific details? It's a matter of some significance.

REBECCA GRASSO: Yes, it is. It particularly became apparent during COVID, for a range of different reasons. I think you mentioned earlier, Glen, about telehealth and some of the challenges around reliable access through telehealth.

The Hon. GREG DONNELLY: Connectivity, yes.

REBECCA GRASSO: Connectivity. It's more than that. It's actually people having access to devices. It is people being able to have access to wi-fi or broadband connections. It's the challenge of lower socio-economic households not having devices for all members within the household and some of them either being taken to work or taken to school every day and then just access not being available. Certainly with an ageing population as well, confidence with being able to navigate is a particular challenge. Similarly with people with English as a second language—challenge with whether, if the navigation exists, there's actually language-appropriate advice as well. So from a digital equity perspective, for Western Sydney it is a real issue. I can provide with you some data on notice.

The Hon. GREG DONNELLY: I will just finish on what you call a Dorothy Dixer, so you can go for your life. We are going to produce a report at the end of the inquiry and we're grateful for your evidence and to all those who participated either through submissions or coming along and giving evidence at a hearing. If there was just one matter or one real issue that you would like the Government to focus on—let's be generous and say two. If you've got a priority of two, for each group—through all your work and experience and thinking and engagement with others, amongst all matters you've identified that need to be dealt with, what are the ones that stick out as the number one and number two priority for this whole matter of what we are covering in this inquiry? What would you identify and say?

LOUISE INGALL: I could give a non-clinical answer and Anne could give a clinical answer, probably reflecting our backgrounds.

The Hon. GREG DONNELLY: That would be nice.

LOUISE INGALL: Anne can talk about the way services might be delivered, but it comes back to funding and the five-year contract. If you can be brave, listen to the advice from the Productivity Commission. The five-year contract provides continuity of care for all our communities. It erases this need to update everything—some of these issues we have touched on. If people have a job for five years, people can get a mortgage and buy a house. They're there for five years and they're part of our community. From that point of view and within that— looking at where we were five years ago is different from where we are today—have the capacity within the contracts to deliver the service that the community needs. If that includes social prescribing, have a contract that allows that to be included. With that certainty from a non-clinical perspective, delivering services to a community for better mental health outcomes, access and continuity of care will be achieved with longer contract periods.

ANNE GALLOWAY: Certainly one of the take-home messages that I'd like you to hear is about the rural primary mental health care workforce. I think that the ability for workforce development—futureproofing our rural health workforce—is a priority. In mental health we have demonstrated the value of an interdisciplinary skills-based workforce. I think there's opportunity to reconsider the models of education that we have for our health professionals. I feel there's probably an opportunity to challenge whether or not a university-based small onsite prac is the model that's going to work across the rural health workforce.

I also think consideration for NGOs who take on student placement from goodwill needs to be considered and what does that student placement look like—we're not just fitting students in to make up hours and sit in the corner—in order to have a really genuine career pathway. The other thing is around primary healthcare nursing and that nursing workforce that is vulnerable. When you're looking at workforce career pathways for nursing, you automatically think GP practice nurse but there is a role in primary health care, certainly where we are looking at the integration of physical and mental health needs. I think that in all of the mental health disciplines, including lived experience, we can't underestimate the value of that social connection, that clinical connection and also that medical connection. I don't know what you call that. It is a biopsychosocial model, but it's kind of taking it back to the grassroots.

The Hon. GREG DONNELLY: Holistic, yes.

GLEN COTTER: Two points: First one, I just want to work out Louise's point. The fact that if we want to sustain our workforce, we have to keep them. We need to keep them. We need to fund the programs better. We need to make sure that we know we have work. As I said, the last couple of years every year I find out whether I've got a job at the end of June or not. I'm lucky. I've got a mortgage; I'm settled. But we can't get people in. We can't offer people attractive jobs. When we put tenders out, five-year contracts, please.

Also, two, for me—and this is a personal one—if we're going to offer tenders, especially in regional areas, I want to see that whoever applies for that tender can pick that tender up and run it from the first day they get it. I've watched local services lose programs to a national body that has won a tender because they just don't have anybody in that area, and it has taken them 15 months to put somebody on the ground there. That service disappears overnight and isn't replaced. Then it's replaced by somebody 600 kay away on a phone.

If someone's going to tender for something, give it to the organisations that can run it, that are on the ground, and not to an organisation that can pay a better tender writer. Sorry, it's passionate for me because I've watched it happen. I've watched it happen with a service that provided direct bereavement support. That company lost the contract. It took them 15 months to put somebody on the ground since then. In the meantime, there was nobody there for those people.

The Hon. GREG DONNELLY: It's just a vacuum.

GLEN COTTER: We picked it up privately because there were no organisations there, so we did it on our own time. Support the workforce. Make it an attractive workforce. Offer them job security. Look at the tenders better; look at the contract better. Look at how they can provide it. Telehealth—in our region, a lot of us are on ADSL. On 27 December due to problems in the exchange, our ADSL services went down. They were up and running on 16 January. That was three weeks where people in regional areas that are still on landline and ADSL had no access to internet, had no access to health. Telstra's response to that was, "The exchange broke down; we had to get parts because it's old." All they wanted to do was push us all onto NBN and mobile coverage. People don't have it. After the 2020 bushfires, people are still living in tents in areas where there's no access and no telehealth. It's not the way. It is in some areas and it's great. A lot of people just want to sit down face to face with people and talk. We have to make that part of the tender processes. We have to make it part of the service delivery because you can't beat sitting down with somebody face to face.

The Hon. GREG DONNELLY: I'm just conscious of the time. Thank you very much, Mr Cotter. Ms Grasso?

REBECCA GRASSO: At this level, I would say: fair and equitable service funding allocations and provisions that are evidence-based. When we say evidence-based, it's more than just statistics and data; it's actually considering all of those social determinants of health and how they apply in a very local context—and locally based services and facilities that are adaptable to a growing population, including making sure that we have culturally sensitive services.

The CHAIR: Thank you so much again for your time preparing submissions and travelling to come in today. The secretariat will be in touch with you if there are any questions on notice.

(The witnesses withdrew.)

Ms DEB WILLCOX, AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health, on former affirmation

Dr BRENDAN FLYNN, Executive Director, Mental Health Branch, NSW Ministry of Health, on former affirmation

Dr MURRAY WRIGHT, Chief Psychiatrist, NSW Ministry of Health, sworn and examined

The CHAIR: We appreciate you reappearing at this stage of the inquiry. I am sure you have been following it closely. Did you want to make an opening statement today?

DEB WILLCOX: No, thank you, Chair.

The CHAIR: I have a couple of questions for today. The first relates to the HASI and HASI Plus programs. You are probably aware that the Committee undertook a site visit to a HASI Plus in Carlingford earlier this week.

BRENDAN FLYNN: Yes.

The CHAIR: I was really interested in the process by which people are allocated to those kinds of services. I was trying to get an understanding of the scale of demand, or potential waitlists. I got quite a complicated answer that the individual service doesn't actually keep a waitlist because if there isn't a place available they are essentially bumped to another one that might have a place available. I'm hoping you might be able to give us a sense of what the demand is statewide for that type of service and whether it's being met.

BRENDAN FLYNN: Yes, I was aware of the visit. I think it's fair to say the facility are very grateful for the Committee's interest in the facility and the consumers there. HASI Plus—just to go to HASI Plus—is a statewide service. That means that intake can be discussed centrally but, even though the baseline demand for these services is high, at times there can be gaps. Often that's, for example, if a consumer is identified in Sydney as appropriate, but the bed that's available is in Tamworth. There's, understandably, a family or a personal discussion that that may not be optimal.

To come to the first part of your question around how people are assessed for community supportive services, it's a spectrum, from people who may have less formal supports in the community, there are NDIS participants in SIL, there are HASI and CLS, which are essentially the same program with different names—they're from different eras. Then there's HASI Plus. As you know, that is clinical plus wraparound NGO psychosocial support. We want to add to that, as a part of our ambition, the PCLI supported living services, which in a sense is a more intense support than HASI Plus. That program hasn't yet commenced.

The way that clinical teams work out who's appropriate is often related to an assessment of someone's functional skills, their abilities and hopefully their capacity to demonstrate to the team—and to their carers and their family—where they're at on a spectrum around things like self-care, cooking, ability to work, all the way through to medication, shopping, that sort of thing. It's actually a fairly sophisticated assessment. It's done by different members of the team. Originally you'd be familiar with the model of—at least, when I started working in the system around 25 years ago, often that might have been a single social worker on a team who had a lot of expertise.

But because the programs have developed, we've now got NDIS support officers in some LHDs. We've got PCLI staff who are not part of the build of the PCLI program but go into hospitals and work out who is a person who would be appropriate for NDIS or HASI or HASI Plus. It's an advanced skill to make sure that you've got that assessment right, because I think it's profoundly disappointing—mostly to the consumer but to those around them—if, for some reason, that assessment is wrong. It's often tried out. We don't tend to put someone in a supported living position and say, "End of story; you can't come back to hospital." It's done in a graded way to make sure it's the right facility. I can understand why the local answer to that question is a little bit unclear. It's a statewide service.

The CHAIR: That was really helpful information but didn't quite answer my question, so I'll try to be really specific. Are there people in New South Wales who are assessed as would benefit from being in a service like HASI Plus but who can't get a place?

BRENDAN FLYNN: Over different periods of time the answer to that question would be yes. I'm not sure about HASI Plus. I think HASI itself may have some vacancies. But I'd have to come back to you with whether or not there is a numerical number of people who are waiting for a HASI Plus position.

The CHAIR: I am happy for it to be taken on notice. I'm really just trying to get a sense of supply versus demand for these kinds of really wonderful intensive programs.

BRENDAN FLYNN: Yes, that's fine.

The CHAIR: I want to ask about a recommendation we heard this morning from the Australasian College for Emergency Medicine. They were talking about the need to extend operational hours of psychiatry and mental health specialists that are able to do assessments in emergency departments. I understand that we're talking about hospitals. It's slightly adjacent to the scope of this inquiry, but it's relevant because it has to do with the wait times in EDs. What barriers would need to be addressed to be able to implement that recommendation?

BRENDAN FLYNN: I'm happy to have a first pass at that, Chair. I just want to be specific on exactly what the recommendation was. Was it about increased specialist clinical psychiatric supports in EDs?

The CHAIR: Yes. They were talking about the significant wait time when the emergency department staff have recommended specialist assessments. Whether that is either the psych reg, the psychiatrist or the clinical nurse specialist coming to ED to do the assessment, there are scenarios where that wait is extended because of those staff members not being available overnight or on weekends or being over capacity.

BRENDAN FLYNN: I'm very happy to answer that. The first thing I would say, and it's a really important point, is that we agree that emergency departments, ideally, should be avoided. That's not a minor point to make. I do want to say that's a commitment. I also think, however, that it is not necessarily a failure of care if an individual finds himself in an emergency department, because if someone is really unwell that's a health emergency and that's what an emergency department is for. Different people may wait for different lengths for services, but I am aware, as I'm sure you are as well, every graduate of a health profession in Australia who finds himself working in an emergency department does have skills around talking to people, de-escalation, listening.

Every junior medical officer in Australia has been assessed on their ability to take a mental state examination. I'm just concerned the assumption might be that this person is not really, in a sense, in the care of the emergency department but is simply waiting there for a mental health team to come along and assist the emergency department with their own patient. I very strongly feel that people with a mental health condition have equal right to the expertise of people in an emergency department and that that can start as soon as that person comes in the door, as it would if they had pneumonia or a broken leg.

The CHAIR: I don't disagree with what you're saying, but this is in a context where we've heard from emergency physician specialists, who have extraordinary skills in mental health as part of their generalist qualification. If they've assessed someone, for example, as likely needing an in-patient admission, who then does need to be seen by the admitting psychiatrist or the registrar—ACEM has identified this as an issue. I'm interested in understanding practically what we need to do.

BRENDAN FLYNN: I would briefly answer that and might pass over to Murray. My view is that it depends on demand, but we have tried very hard to supply in-person psychiatric staff in terms of clinical nurse specialists; psychiatry registrars; telehealth support across large patches of regional New South Wales, where a consumer can have an assessment via videoconference; and 24-hour on-call specialist psychiatric cover across the State in every facility. I do accept that at times there are extended waits. I just want to make the case that, similar for every other consumer in the ED, it's not simply a matter of waiting for another service. It's really important to see the two services as working together. I'm very sensitive to any narrative that says we're waiting for something. It's actually—it's an emergency department to assist. But there's no standardised time data that is kept around, statewide. I think emergency departments definitely would have access, but it would vary depending on who's available and how busy the department is.

MURRAY WRIGHT: I might make a couple of additional comments. I think that Dr Flynn's overall point, which is that mental health care in an emergency department is collaborative between all the parties, including the emergency staff—I think that what I've seen over a couple of decades is that, as particularly our larger hospitals and emergency departments have become busier, we have initially gone from an on-call after-hours registrar presence to an extended-hours registrar presence and in some places a 24-hour registrar presence. That's on the basis of the sorts of issues that ACEM is raising.

I think that there is a conversation within psychiatry about whether that should be followed by finding a way to create an extended-hours presence of the more senior psychiatrists. It's enormously challenging because there are constraints, the biggest one of which is workforce. It's all very well to say we would like this, and even if we say we can afford it, but to find the workforce who are suitably qualified and willing to do that is a challenge. But I think it's a legitimate question to be raising, and I think that—again, endorsing Dr Flynn's comments—we are working very closely with our emergency department colleagues and have done for quite a long time to try to find collaborative solutions. In the very old days, it used to be quite an adversarial relationship between mental health and emergency. That's not the case anymore, and we welcome their ideas and want to work constructively with them.

The CHAIR: This is the last question from me; I'm conscious of time. You are probably aware that the Committee has demonstrated some interest in interstate responses to mental health emergencies, and, particularly, we had as a witness the representative of the South Australian Ambulance Service. I know they are not identical programs, but it bears a lot of similarity to the MHAAT program that was trialled in a particular LHD—if I recall correctly, it was Western Sydney. Were there any particular reasons that that wasn't continued or rolled out more broadly? As I understand it, there has been really positive feedback from people who access that service and also from the staff who worked in it.

DEB WILLCOX: I don't know the evaluation of the impact.

BRENDAN FLYNN: I don't know about the evaluation of that either. I am aware of that; I think it's Western Sydney. It does get very good feedback from consumers and staff. I think it's also accurate to say that the PACER program has a lot of very committed staff and has had some very good feedback from consumers. I think our challenge is to work out what the right combination of responses may be. PACER will be right for some places. MHAAT, I think, is really well received in its community. But the challenges may be supporting first responders with mental health expertise—be that clinicians, be that peer workers—in a way to do that that is safe and that is meeting needs, particularly where there are geographic and workforce challenges in regional New South Wales. I am aware of MHAAT as one particular program, but I would emphasise there are other similar programs—in particular, PACER—that are also well received.

The Hon. SUSAN CARTER: Dr Flynn, if I could just pick up on something you said in response to a question from my colleague when you were talking about provision of psychiatric services. You made a comment really directed at regional New South Wales, where you were talking about availability of consultation via videoconference. What is NSW Health's attitude? Are there areas in regional New South Wales where consultation with specialists like psychiatrists is only available over video and face to face is not available on a regular basis to health consumers?

BRENDAN FLYNN: Thank you for the question. The question I answered was about after-hours support in emergency departments.

The Hon. SUSAN CARTER: The question remains. Is face to face only available in limited hours? What is the mix for regional and rural hospitals and people presenting?

BRENDAN FLYNN: I would say that it varies. Maybe if we took an in-hours picture first. If we were to lock across regional New South Wales and, for example, if we took community mental health clinics, it varies, but there are many services that have a face-to-face clinician. It doesn't necessarily need to be a psychiatrist, but often is. I think we're all aware that sometimes that's on the basis of a non-resident coming in—

The Hon. SUSAN CARTER: I don't want to cut you off, Dr Flynn.

BRENDAN FLYNN: No, that's okay.

The Hon. SUSAN CARTER: I'm just wondering, in the interests of time, is that something you could take on notice and perhaps provide details of to us later?

BRENDAN FLYNN: Yes.

The Hon. SUSAN CARTER: Given it varies, as you said.

BRENDAN FLYNN: It varies. To be honest, I'm not sure I'm necessarily—I'm very happy to take that on notice, but I guess it very much depends on the locality. There are places where it is delivered via telehealth. I would need to get—

The Hon. SUSAN CARTER: So there are localities where it is only telehealth that's offered?

BRENDAN FLYNN: There would be.

The Hon. SUSAN CARTER: Why is that? Why are no face-to-face services offered for regional New South Wales?

BRENDAN FLYNN: I did not say that there were no face-to-face services offered for New South Wales.

The Hon. SUSAN CARTER: If it's only telehealth, by definition there is nothing face to face.

BRENDAN FLYNN: But I'm not talking about regional New South Wales. I think the question was about particular areas in New South Wales.

The Hon. SUSAN CARTER: Which areas is it only telehealth then?

BRENDAN FLYNN: I would take that on notice and I can certainly get back to you around that.

The Hon. SUSAN CARTER: I would be very grateful. Thank you. I have another quick question, if I may. I notice on page 15 of your submission you point to the NSW Family Focused Recovery Framework 2020-2025. Do you have any preliminary data on how well that's working and what change it's making in terms of the inclusion of families in health care?

BRENDAN FLYNN: I would have to take the data question on notice. Certainly, if it assists the Committee, I would mention that the feedback we've had from consumers and staff—and, in particular, families—has been very good, but I would need to come back to you around the nature of the evaluation and the details of what was in that.

The Hon. SUSAN CARTER: Is a review of that planned at the end of 2025?

BRENDAN FLYNN: I would need to come back to you about that on notice.

The Hon. SUSAN CARTER: Thank you very much. I have one last question. If it's possible for a quick answer, and I accept it may not be. I note the discussion on page 9 of your submission, where you talk about presentations being triaged according to clinical acuity. It states:

> NSW Health mental health services focus on consumers with higher clinical acuity and complex clinical needs.

Who focuses on people with lower clinical acuity to stop escalation to higher clinical acuity?

BRENDAN FLYNN: It's an excellent question. I'm happy to pass to my colleagues, but I'm happy to answer it. It is a joint responsibility of NGOs, primary care and some of the bilateral-funded services that are colloquially—and you would be familiar with the language now—called the "missing middle". Sometimes specialist services who happen to be available and have that person referred and have capacity say, "We might not be the right service but we can certainly help you with the lower acuity work." It is one of the themes, I think, of evidence that you've heard, and an accurate comment is that it can be very confusing for community members, with so many seemingly different options, trying to work out perhaps who to call or which service is appropriate. It's actually very difficult for an individual to know where their distress lies, because for them it's significant, whatever a clinical view around that might be. I hope I've answered that question, but I would say it's a joint responsibility between those services.

The Hon. SUSAN CARTER: Actually, the question was who focuses on it? What I heard is, "Nobody but everybody. Good luck."

BRENDAN FLYNN: I don't think that's quite fair.

MURRAY WRIGHT: Can I just make an additional comment? I don't think that's accurate. In an ideal world, it's initially an appropriately qualified primary health response. We've got primary health networks, who are responsible across the State and the country for delivering that range of services. It is a shared responsibility. As Dr Flynn said, if someone finds themselves with a low-acuity condition in a specialist mental health service, they will get an initial assessment and, perhaps, initial treatment. But it is about matching the person to the skill and the resource that's available. What we have in Australia is a matrix of Commonwealth- and State-funded private, public and NGO services. I accept that they are sometimes difficult to navigate, but the low-acuity area of responsibility is largely with the primary health and NGO sector.

DEB WILLCOX: Chair, through you, if I could just add to that in relation to our primary health network colleagues, the geographical remit of the PHNs, as we call them, in the main overlay directly with the local health districts. And there are joint regional plans done in mental health so that we connect the lower acuity and the pathway for care into the higher acuity, complex care that you'd expect a local health district to provide. Literally just this morning, we met with Beyond Blue, talking about them strongly defining their role to be in that area of low-acuity prevention in a partnership with Lifeline because, to both Dr Wright and Dr Flynn's point, it is a matrix.

It is about a collection of all of us working in a particular area and who is best placed to do which part so that it's clear and defined for consumers and not a confusing thing to navigate, which I acknowledge is sometimes the case. If I could make a comment on the framework too, while I've got the mic, if that's okay—I will be quick. It is a document that has a life span to 2025. As Dr Flynn rightly pointed out, we've had good feedback anecdotally. We will start a review process later this year or in early 2025, collect the evaluation and the data and refresh the framework, because its natural life span is to 2025.

The Hon. EMILY SUVAAL: I just wondered if you would be able to update the Committee on anything else that is happening in this space. We visited some great initiatives locally, like a Safe Haven, as part of our regional trip. I wonder if there are any updates to provide around Safe Havens more generally—if we've got any opening soon or anything like that.

BRENDAN FLYNN: We've got 19 operational Safe Havens. I think the issue might've come up today around the opening of Bega. I've had advice that that is actually scheduled for Monday the 19th and for Wyong to open in April. I think that's an important update. The other thing I'd offer about Safe Havens—and I honestly can't remember if it came up at this inquiry or at estimates, but there was a question around evaluation of that initiative—there is an evaluation drafted, and it's due in the second quarter of this year. We hope to be able to report back around that. Certainly there's feedback that people find the service very helpful, but there's certainly also ways to make what at this stage is a developing model of care even better.

The CHAIR: Thank you very much for making the time to come back and take our questions twice. I am sure there will be some questions on notice, so the secretariat will be in touch with those. Thank you to those in the gallery and anyone who is still watching online for your interest in our inquiry. That brings us to the end of the day.

(The witnesses withdrew.)

The Committee adjourned at 17:00.