# GENERAL PURPOSE STANDING COMMITTEE NO. 2

**Wednesday 26 October 2011**

**Examination of proposed expenditure for the portfolio area**

# MENTAL HEALTH, HEALTHY LIFESTYLES, WESTERN NEW SOUTH WALES

**The Committee met at 8.30 a.m.**

## MEMBERS

The Hon. M. A. Ficarra (Chair)

The Hon. C. M. Faehrmann
The Hon. P. Green
The Hon. T. Khan
The Hon. S. Mitchell
The Hon. A. Searle
The Hon. M. Veitch

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## PRESENT

**The Hon. Kevin Humphries**, *Minister for Mental Health, Minister for Healthy Lifestyles, and Minister for Western New South Wales*

**New South Wales Health**
**Dr Kerry Chant**, *Chief Health Officer and Deputy Director General, Population Health, Ministry of Health*
**Mr David McGrath**, *Director, Mental Health and Drug and Alcohol Programs*

**Department of Premier and Cabinet**
**Mr Simon Smith**, *Deputy Director General, Delivery and Implementation*

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## CORRECTIONS TO TRANSCRIPT OF COMMITTEE PROCEEDINGS

**Corrections should be marked on a photocopy of the proof and forwarded to:**

**Budget Estimates secretariat**
**Room 812**
**Parliament House**
**Macquarie Street**
**SYDNEY NSW 2000**

**CHAIR:** I declare this hearing for the inquiry into the budget estimates 2011-2012 open to the public. I welcome Minister Kevin Humphries and accompanying officials to the hearing. Today the Committee will examine the proposed expenditure for the portfolios of Mental Health, Healthy Lifestyles and Western New South Wales.

In accordance with the guidelines of the Legislative Council for the broadcast of proceedings, only Committee members and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. In reporting the proceedings of the Committee, the media must take responsibility for what they publish or what interpretation they place on anything that is said before the Committee. The guidelines for the broadcast of proceedings are available on the table by the door. I remind everyone that any messages from attendees in the public gallery for Committee members or witnesses must be delivered through the Chamber and support staff or the Committee clerks. I remind the Minister and his officers accompanying him that they are free to pass notes and refer directly to his advisers while at the table.

The Committee has agreed that the Mental Health, Healthy Lifestyles and Western New South Wales portfolios be examined concurrently. Transcripts of this hearing will be available on the web from tomorrow morning. The House has resolved that answers to questions on notice must be provided within 21 days. I remind everyone that mobile phones should be turned off or put on silent, and kept away from the microphones. All witnesses from departments, statutory bodies or corporations will be sworn prior to giving evidence. The Minister does not need to be sworn as he has already sworn an oath to his office as a member of Parliament. Dr Kerry Chant also does not need to be sworn as she has already been sworn during an earlier budget estimates hearing.

**DAVID McGRATH**, Director, Mental Health and Drug and Alcohol Programs, Ministry of Health, sworn and examined

**SIMON SMITH**, Deputy Director General, Department of Premier and Cabinet, affirmed and examined, and

**KERRY CHANT**, Chief Health Officer and Deputy Director General, Population Health, Ministry of Health, on former oath:

**CHAIR:** I declare the proposed expenditure for the portfolios of Mental Health, Healthy Lifestyles and Western New South Wales open for examination. As there is no provision for the Minister to make an opening statement before the Committee commences questioning, we will begin with questions from the Opposition.

**The Hon. ADAM SEARLE:** Minister, the Government proposes to spend, without taking account of inflation, nearly $25 million less in mental health services in the 2011-12 financial year compared to the previous year. Are you able to tell the Committee what program areas will have their spending reduced?

**Mr KEVIN HUMPHRIES:** I am not sure I agree with that question, or statement. We have articulated that we have invested or are investing $1.34 billion this financial year for mental health—the largest mental health budget this State has ever seen. There is some confusion around a couple of points. That figure does not include capital costs. There is a capital program in addition to that $1.34 billion. The $1.34 billion is largely to fund recurrent costs, mainly staffing obviously. The capital costs which we have outlined and made some significant announcements about in the coming 12 months, where there will upgrades to certain facilities in regional areas or in the city, is over and on top. To subtract the potential capital injection into that from the $1.34 billion is not correct.

I am comfortable that the $1.34 billion will be spent on that. Issues around budgeting were highlighted under the previous Government through the Auditor-General's report and which we are addressing in government. One of those key strategies which David McGrath might want to talk about is making sure that we have a clearer line of sight on funding that we do allocate to the area health services and into mental health services. The Auditor-General highlighted that it was very difficult to track that funding. With the new specific, measurable, attainable, realistic, timely [SMART] system that is being trialled across the health system and, certainly in mental health, we believe that will be a significant advantage. We should be able to address the issue of following through funds that are allocated into the system, making sure where and how they are spent. The ultimate aim is to assess whether people are living better. I am certainly comfortable that is the case but Mr McGrath might comment on that.

**Mr McGRATH:** Recently the department instigated a single Oracle-based general ledger system. It allows for a standard set of cost centre structures across the local health district entities. Similarly with the implementation of a statewide management reporting tool, the chief financial officer advises that at various levels within the ministry, along with various levels of management within the local health districts, there will be the capacity to interrogate those cost centres at the level of expenditure for each of those individual programs. Currently when the mental health budget is rolled out in the local health districts there is a specific program code that allows those cost centres that are mental health cost centres to be identified. This new reporting tool will allow a much greater line of sight at all levels of the organisation for the expenditure against those cost centres.

**The Hon. ADAM SEARLE:** Having regard to what the Minister said about the total spending of $1.34 billion, when you compare that proposed expenditure for the next year to the actual expenditure for the last financial year, the increase is less than inflation. Do you agree with that?

**Mr KEVIN HUMPHRIES:** My understanding is it is on par with inflation. Most of that increase would be addressing wage increases. I might quickly outline the capital injection if you have a minute. If we followed on from what was committed in the 2010-11 budget, where we had upgrades to the Hornsby Hospital Adult and Child Adolescent Unit, Sydney Children's Hospital and additional staged projects, $45 million was allocated. The one going forward—some of which were election commitments, and this is where we are looking at new money—we have $48 million for the Wagga Wagga Hospital redevelopment, which included 30 bed acute mental health units and 20 subacute mental health units. Some of that funding is conditional, and we have an agreement in principle with the Federal Government, with the subacute roll-out of additional beds which you

might want to ask me about later, given that that is a pretty contentious and serious gap in mental health service delivery, those step-down type facilities.

Stage three of the Nepean Hospital redevelopment includes a 64-bed mental health inpatient unit and community mental health works worth $22.6 million. An amount of $60.9 million is allocated for the Liverpool Hospital redevelopment, stage two, and that is a reconfiguration of its clinical services block and it will also include a six-bed psychiatric emergency care centre unit. Also, there is a $21 million injection to the Children's Hospital to include a child and adolescent inpatient unit and also community mental health facilities. There is an amount of $8.8 million to the Royal North Shore stage two upgrade to incorporate a 34-bed acute inpatient facility and an upgrade of the current unit. In addition, I suppose the budget is holding its own but there are some reasonably serious injections in capital works.

**The Hon. MICK VEITCH:** That is all well and good but will the Minister table for the Committee all of the brand new projects under your Government that do not involve carry-over funding from the previous Government and are not Commonwealth funded?

**Mr KEVIN HUMPHRIES:** We have committed to entering into those agreements. To say that they were on the books or on the table did not necessarily mean that they would be delivered.

**The Hon. MICK VEITCH:** Not under your Government.

**The Hon. TREVOR KHAN:** Point of order: The Hon. Mick Veitch is carrying on like he was yesterday. He is clearly grandstanding and harassing the Minister. He should allow the Minister to answer his questions and behave himself for a change.

**CHAIR:** Order! The Minister and witnesses will be heard with respect and courtesy. Hopefully, we can continue in that manner.

**Mr KEVIN HUMPHRIES:** Before I ask Mr McGrath to comment, I might say that the honourable member would be aware that where projects were listed in budget estimates or in future estimates there was indeed a carry-over of at least two, and in some cases three, terms of government. We have tried to pick up in a priority order. We know that the biggest issue facing the community, particularly in mental health and health, is infrastructure. There is no doubt about that; it is about ability to access the services. We know that we cannot realise all those infrastructure additions without Commonwealth support.

We have to have a positive relationship with the Commonwealth. We also have to have an inter-portfolio, cooperative working network, which I believe we had, and that is why I think, under the current regime and with the project management ability and degree of discipline that we have, we will commit to and deliver what we have outlined. That has not been the case in the past. It is certainly something we are committed to, and it is something that the community expects. But in relation to new funding and the question asked by the honourable member, I might ask Mr McGrath to comment a little further on that, if that is all right.

**Mr McGRATH:** There are a few new funding initiatives in the budget this year, totalling $11.3 million for the Mental Health program. There are a few exemplars. There is half a million this year for a new rural mental health emergency transport service, which steps up to $2.1 million in future years. There is $500,000 for the schizophrenia research chair at the University of New South Wales; $800,000 for a clinical academic research program; $2 million for a family care and mental health program; $3.4 million for an assertive community response and mental health services program; and $800,000 for older persons beds in the Hunter-New England service at the Mater Hospital, the public version of Newcastle Hospital.

**The Hon. ADAM SEARLE:** You can subsequently provide details of those?

**Mr McGRATH:** I am happy to.

**The Hon. ADAM SEARLE:** The $500,000 for the schizophrenia research chair, is that brand new under this Government? It was not planned already?

**Mr McGRATH:** The schizophrenia research chair previously was $500,000 funded by the government and $500,000 funded by contributions from fundraising by the institution. This $500,000 is in addition to the original $500,000 provided by government.

**The Hon. ADAM SEARLE:** So it is correct to say it is an extension of an existing program?

**Mr McGRATH:** No, it is an expansion. Previously, the government commitment was $500,000; it will now be $1 million.

**The Hon. ADAM SEARLE:** So it is an expansion of a pre-existing commitment?

**Mr McGRATH:** That is right.

**The Hon. ADAM SEARLE:** Those other specific items of new expenditure that you have mentioned, are they also expansions? Which of those are completely brand new since, say, April?

**Mr KEVIN HUMPHRIES:** I might comment on that. The honourable member, who is a country member, would understand that the transfer of people from community settings into a health facility or gazetted inpatient unit has been a serious issue. It has not been addressed fully to date across the State; it is more so a regional issue because we have far fewer gazetted health facilities. The agreement on the relationship between police, for instance, and the Ambulance Service has not been resolved to the point that you could comfortably say we have a statewide strategy that works. As Mr McGrath alluded to—and it is a matter I have raised with the Police Association and its members and the Mental Health Intervention Team—you will see quite serious resourcing to move that whole project forward.

In some cases we do not have people presenting to the appropriate health facility because the agreements between police and ambulance have not been tight enough. That will improve under us. It involves resourcing and the training of ambulance staff, for instance, and potentially gazetting more of our health facilities so there is a clearer line of the role of who transports patients, where to, and who has responsibility. That is not an extension of the existing commitment; it is cleaning up a mess that has been going on for far too long between, say, police, ambulance and health. We need to get it right. So you will see particularly in the north-west of the State an injection of new resources to help make that happen.

**The Hon. ADAM SEARLE:** Thank you, Minister. Going back to what the departmental official indicated, I think out of the total budget of $1.34 billion you indicated that $11.3 million was new funding.

**Mr McGRATH:** Yes.

**The Hon. ADAM SEARLE:** But is not half a million of that $11.3 million for the expansion of pre-existing programs? Which of those $11.3 million worth are completely new? I think the Minister has identified one of them.

**Mr KEVIN HUMPHRIES:** I can tell you one sensational one—I was there the other day, and so were some of my staff—that is, the relationship we are promoting between, say, St Vincents Hospital, the MediCottage facility, and groups like Neami, which has an assertive outreach team that targets homelessness. We are allocating just under $1 million, but certainly over the term of this Government about $3.2 million, to look at relationships that clinically support people with mental health illness who are homeless, so that basically they are not discharged from a facility without having proper accommodation or wraparound services. Members will hear a lot more of the term "wraparound services" integrated between, say, mental health and housing. When you have a hothouse in which an assertive outreach team, your local mental health and drug and alcohol team and the clinicians are all housed, we will support St Vincents and that new program, because a lot of those who end up homeless in the city do not come from these areas.

We are looking to develop relationships to clinically support people who drift into the city to return to places whence they came. That will be an extensive trial of helping support people back into, say, western Sydney in particular, and more particularly the outer part of western Sydney, where probably 40 per cent of the homeless in the inner city—about 350 rough sleepers, most of whom will have some form of mental illness or drug and alcohol issue—can be supported back into their community. We believe, based on the data given us to date, if they are clinically supported, and that is matched with the assertive outreach for homelessness, and the services are supplied, those people will stay a lot more stably in their community and will be far less likely to drift back into homelessness or back into a mental health facility. That is just one new program.

What we are trying to say with the new mental health services—not that anyone should accept blame or guilt—is that there are a lot of gaps between acute facilities, and you have to be seriously unwell to get proper, consistent treatment, and how people are supported back in the community. What members will see is a re-investment in existing services. You can give people a certain amount of money, but what they do with it will vary. We are saying that we want a much tighter plan; we want to plug those gaps between the acute facility and supports back in the community for people who do not necessarily need transition into an acute facility, or who are less likely to present to an acute facility if they are supported much more stably back in the community.

So there is an issue about new money. But, for us, the important issue is: What do we do with the resources we currently have? That $1.34 billion is a serious amount of money. You could have put double that into the existing system without any change but, as the Auditor-General highlighted, under the previous regime that would not guarantee any better wellness outcomes for people with mental health issues. The system was not tight enough, it was not robust enough, and it certainly did not have enough options—and to an extent still does not—because it will take some time for those mental health consumers to be back out in the community.

**The Hon. ADAM SEARLE:** Minister, recently you indicated that you are considering giving persons with mental illness who are denied access to treatment a right of appeal against those decisions, and for families to have the right of appeal against hospital releases or refusal to admit to hospitals.

**Mr KEVIN HUMPHRIES:** Yes.

**The Hon. ADAM SEARLE:** What are the costings around those policy proposals?

**Mr KEVIN HUMPHRIES:** There are no costings around those proposals at the moment. That is an issue that will be taken on board on two fronts. You might want to ask me about the Mental Health Commission. But certainly one of the three pillars is the role of the mental health tribunal, in conjunction with a review of the Mental Health Act that needs to be undertaken next year. Part of the commission's remit, which will kick into gear on 1 July next year, is to look at the role of the tribunal. How do we support people who end up in voluntary care?

How we support the wider community in knowing their rights and about the services available is fundamentally important, given that most people who reach a crisis point and enter the mental health system find it very difficult to navigate. I think most people would agree with that. An article in the *Sydney Morning Herald* today deals with this issue. There is genuine concern on the part of people who are denied care and that is the issue we want to address. If someone is feeling seriously unwell and is denied care because of the number of people presenting to acute facilities or for some other reason, there should be an appeal process. I can probably explain that if you want in more detail.

Concern has also been expressed by consumers, carers and advocates that communication between those groups, which in most cases do a fantastic job in providing care, is not optimal and that they should be included in this process. There must be a collective approach to dealing with people who require care, whether it be voluntary or involuntary. Part of the commission's role—with the budget that has been provided—is to look at how best that might be achieved. We have looked at other interesting models, but we will not pre-empt the commission's findings. The New Zealand model—

**The Hon. ADAM SEARLE:** Is that being done by the task force?

**Mr KEVIN HUMPHRIES:** Technically the task force has finished its work. The legislation for the commission will be tabled shortly; it is in its final stages now. That will allow the commission to act as an independent entity. The three tasks are, first, targeting best care models; secondly, providing incarceration diversion; and, thirdly, supporting those people who might need or, in some cases, be relieved of that type of care. The costings have not been undertaken and we do not want to pre-empt anything. We have looked at the Canadian model and at what the Western Australians are doing. We know that the commission's remit will result in a better standard of advocacy of rights when we get to the pointy end of involuntary care.

**The Hon. ADAM SEARLE:** My question related to appeal rights costings.

**Mr KEVIN HUMPHRIES:** The commission's budget has been increased by $30 million. Obviously much of that will be used to test and trial the best methods of care. However, part of it will be used to enhance

the tribunal's role. Given that we are not in that financial year, putting a dollar figure on that is probably something for the future.

**The Hon. ADAM SEARLE:** I will suspend any questions I have about the commission until we see the draft legislation.

**Mr KEVIN HUMPHRIES:** I will be interested in your comments on that.

**The Hon. MICK VEITCH:** Your department funds a number of non-government organisations.

**Mr KEVIN HUMPHRIES:** Correct.

**The Hon. MICK VEITCH:** What was the indexation for grants under this budget?

**Mr KEVIN HUMPHRIES:** I will take that question on notice.

**The Hon. MICK VEITCH:** Was it 2.5 per cent?

**Mr McGRATH:** We will take that question on notice. There would be a standard non-government organisation escalation process across the entire health program; it would not be specific to mental health.

**The Hon. MICK VEITCH:** We heard earlier in the week that the index for disability groups is 2.5 per cent. Can you take that question on notice and provide the figure for indexation?

**Mr KEVIN HUMPHRIES:** Yes.

**The Hon. MICK VEITCH:** Prior to becoming Minister you made a number of statements in western New South Wales about the importance of the Government subsidising air services into that area. Is that still your view?

**Mr KEVIN HUMPHRIES:** We were looking at creative ways to re-establish air services to western New South Wales. The Accessibility/Remoteness Index of Australia identified Berkshire as the only isolated local government area in the State. Concerns were raised when the commercial operator pulled out two years ago, given the number of government services that were provided by air into western New South Wales. The main affected communities, which are in my electorate, are Bourke and Walgett, and additional services were provided into Lightning Ridge and Coonamble. The main user of those services was the Ministry of Health, followed by the Department of Community Services, the NSW Police Force, the Local Court and the Department of Education and Training, and then it peters off.

The difficulty we had, which was put to your Government, was that the alternatives—that is, fly-drive through Dubbo or not service the area at all—were untenable. We needed to come up with a better option. Since then two things have happened. The Royal Flying Doctor Service of Australia has done a fantastic job and we work in close collaboration. We nearly lost that service under the previous Government. It was only because of the efforts of your upper House colleague the Hon. John Della Bosca and a few others that your Government was convinced to retain it.

**The Hon. MICK VEITCH:** My outstanding upper House colleagues.

**Mr KEVIN HUMPHRIES:** Yes, outstanding. The Royal Flying Doctor Service provides much more than aerial retrievals to western New South Wales. It has also expanded its provision of clinics into the area and it has picked up a large part of the shortfall. The other group that has stepped up is the Aboriginal Medical Service. The service at Walgett was chartering aircraft, and still does on occasion, to get midwives into that area. It is not a designated birth centre, but it obviously still needs to be serviced.

**The Hon. MICK VEITCH:** Can you take that question on notice and provide the rest of the information I requested?

**Mr KEVIN HUMPHRIES:** Yes.

**The Hon. MICK VEITCH:** As you can see, I am an athlete and I want to ask a question about healthy lifestyles.

**Mr KEVIN HUMPHRIES:** I point out also that two other proposals are coming up for review.

**The Hon. MICK VEITCH:** I am running out of time and I would like to ask a question about healthy lifestyles. Will your Government commit to continued fluoridation of public drinking water in New South Wales?

**Mr KEVIN HUMPHRIES:** This Government supports the fluoridation program, and I am not sure whether it differs from the previous Government in that regard. Fluoridation does have health benefits and 95 per cent of our drinking water is now fluoridated. We have said that there will be no mandatory fluoridation of water schemes. In fact, the vast majority were probably taken up under the previous Government largely because of education campaigns and a positive attitude towards its benefits. Of course, in some small places there is no town water supply and that requires another push. Aboriginal medical services and the western health services have supported alternatives, but we will not make it mandatory.

**Dr CHANT:** The State target is to achieve 98 per cent fluoridation. As the Minister said, in the smaller communities—that is, those with fewer than 1,000 people—it is not appropriate to have the same fluoridation water plans. We look at other strategies to increase access to fluoridation. We are currently at 95 per cent and we have a number of capital works programs progressing. The surveys have demonstrated that the community supports fluoridation.

**The Hon. CATE FAEHRMANN:** Minister, you will be aware of the growing body of evidence from overseas jurisdictions, such as the United Kingdom, Switzerland and Germany, to support the use of heroin-assisted treatment as an alternative to oral methadone programs in more extreme cases. These programs have proven to be extremely effective in reducing associated crime or improving access to health services and treatment for addicts. Is the department currently undertaking any research into heroin-assisted programs? Is the Government actively considering any such programs?

**Mr KEVIN HUMPHRIES:** Good question. As you would be aware, the 1999 Drug Summit concluded in 2009. That 10-year approach had not really been developed until recently. There were several commitments on that front. One was to recognise the number of people on the methadone program in the allocated funding. Part of the budget we have allocated is to recognise that there are 19,000-odd people on the methadone program in New South Wales. Previously there were only about 16,000 funded positions. The issues around certain parts of the State were that the Government or other departments were topping up funding and there were people who had been too long on the waiting lists. The lower Hunter still is a problem area in that regard and we have topped up that funding. We have also provided $10 million in new funding, which we flagged pre-election.

The Opioid Treatment Program was driven by Bureau of Crime Statistics and Research [BOCSAR] figures; it was about a reduction in crime as much as a reduction in addiction. The Opioid Treatment Program has been successful in achieving that outcome. We know that it stabilises people. The current treatment is available and I have met with a number of organisations and the Network of Alcohol and Drug Agencies [NADA] to look at some alternatives. You either have opioid replacement programs or other providers that pretty much articulate total abstinence. There is virtually nothing in between that supports people from, say, the Opioid Treatment Program to abstinence. We have asked them to come up with a number of programs that would include a number of step-down type programs. We have told them that we are prepared to put up $10 million and we are waiting on a response. There will be a targeted approach over the next couple of years, which is quite exciting. The difficulty is that when people who want to reduce their use or get off heroin are being stepped down, they need to be clinically supported. Obviously, that step-down process is difficult and people often fall over.

**The Hon. CATE FAEHRMANN:** Perhaps I can ask Mr McGrath whether research has been done or whether any of those programs the Minister is suggesting are heroin-assisted programs which, of course, are different to stepping down programs and which are designed more for those 5 per cent of extreme addicts. As I stated originally, some countries provide great evidence that this program really keeps these people out of criminal behaviour. Is the department investigating the worth of those programs?

**Mr McGRATH:** We are not currently working up any policy parameters around a heroin trial of any sort, if that is your question. Obviously, research has been done overseas with regard to the benefits of heroin programs, as you have alluded to.

**The Hon. CATE FAEHRMANN:** It is more than research; some countries have it in place.

**Mr McGRATH:** Indeed, a number of jurisdictions have in place working prescription heroin programs, and those programs have shown some benefits. Those benefits would not be dissimilar in many ways to some of the benefits provided by other opioid substitution programs. It is important to point out that heroin is an opioid in the same class of drugs as methadone, drip morphine and similar drugs. The fundamental neurophysiological mechanisms are the same. The differences in the route of administration are an important consideration of the practicalities of running a trial of that type. The overall neuropharmacology benefits are not substantially different. Therefore, given the importance of establishing the right frameworks for administering a program of this size—at this stage we are not doing any policy work in that regard—it is conceivable that there may be thoughts at the Commonwealth Government level around running research programs in this domain, given that it has fundamental constitutional responsibility for research. We are not organising anything at this stage.

**The Hon. CATE FAEHRMANN:** Minister, is the Government 100 per cent behind the medically supervised injecting centre [MSIC] in Kings Cross? Can the Government guarantee that the centre will remain open and funded throughout its term of office?

**Mr KEVIN HUMPHRIES:** Were you at Customs House when I made a speech?

**The Hon. CATE FAEHRMANN:** I was not at Customs House.

**Dr JOHN KAYE:** I was.

**Mr KEVIN HUMPHRIES:** People would be well aware—and I have explained this not just to MSIC staff but also to those at other facilities located in the area around the needle exchange—that the MSIC is a mainstream health issue. Criminality issues should not be discussed as it is a mainstream service. We support that service. Having visited it a number of times, I believe it also is a service that could be a front door into rehabilitation for those who want to go down that track.

**The Hon. CATE FAEHRMANN:** Would you consider any additional medically supervised injecting centres after conducting research and assessing the need in the State perhaps somewhere in western Sydney if, as we all know, it has such good outcomes?

**Mr KEVIN HUMPHRIES:** The Government has no plans at this stage to go down that track.

**Dr JOHN KAYE:** I refer the Minister to the Mental Health Review Tribunal. What proportion of patients involuntarily detained in a mental health facility is never seen by the Mental Health Review Tribunal?

**Mr KEVIN HUMPHRIES:** Never seen by or made contact with?

**Dr JOHN KAYE:** Never made contact, never seen—same thing.

**Mr KEVIN HUMPHRIES:** I am referring to videoconferencing.

**Dr JOHN KAYE:** I beg your pardon, yes, including videoconferencing.

**Mr KEVIN HUMPHRIES:** My understanding is that under the previous magistrate system the vast majority of people in involuntary care were seen within the first week, of which you would be aware as you have a considerable interest in this issue. That was largely around personal contact. The number of deferrals was significant because many people who were seen were not well enough for a judgement or determination to be made. I accept that when the system was referred to the Mental Health Review Tribunal just over 12 months ago a lot of the contact did not occur within that week. But those who were seen or who made contact through videoconferencing did so within that period of two to three weeks. In some cases it was more and in some cases it was less. I would have to defer to David on that issue but my understanding is that a determination was made for the vast majority of people seen within the three-week period. On my advice the difference between the two

systems is that it has not led to people spending more time in involuntary care. There are two schools of thought on that and I am waiting to receive the evaluation report, which should be out by the end of November.

**Dr JOHN KAYE:** You will receive it by the end of November or it will be out by the end of November?

**Mr KEVIN HUMPHRIES:** My understanding is that it is to be delivered by the end of November.

**Dr JOHN KAYE:** Delivered to you?

**Mr KEVIN HUMPHRIES:** Yes. But we have no problems in making that available. That is part of the remit where we want to go to the next level—we might have discussed this before—to look at the role of the tribunal. It is a bit difficult to be critical or to jump to conclusions without having that evaluation. I certainly welcome debate on the issue, but David might be able to be more specific in relation to the matter.

**Dr JOHN KAYE:** If you do not mind—and I mean no disrespect to you, Mr McGrath—I want to refer now to community mental health services. Do you track the time between a person being discharged from an acute residential care facility and making contact with a community health care team?

**Mr KEVIN HUMPHRIES:** In theory or in practice?

**Dr JOHN KAYE:** Firstly, in practice, are they tracked and do you hold statistics on what that time is?

**Mr KEVIN HUMPHRIES:** Yes, there is a policy, but the policy is being updated because people like me, when I was in your position 12 months ago, had concerns about that. I had concerns largely because the previous Government was propping up its wages policy by not filling front-line positions in community mental health teams. It was a disgrace. Discharge planning, which we are currently beefing up, in some cases worked well. People had to be contacted within a week, or up to 28 days, where you had enough front-line community mental health workers. You could say that that really was variable at best.

Part of the initial push from day one of government, being the new Minister, was to meet all the clinical service directors and say that, really, if we are going to keep people well and track them back into the community, or prevent them from transition or trajectory into acute facilities, the relationship between community mental health teams and inpatient units had to be improved. We cannot improve that if we do not have the people there in the first place. In some cases our community mental health teams were 40 per cent understaffed. We are watching that very closely and I can say that many of those positions have been filled. We have a target of making contact within seven days, of follow-up, and I think you will see a much more targeted approach to discharge planning.

**Dr JOHN KAYE:** So your target is seven days from discharge to contact?

**Mr KEVIN HUMPHRIES:** Yes.

**Dr JOHN KAYE:** And from contact to treatment?

**Mr KEVIN HUMPHRIES:** Again, that is where we need a tightening up, but there are some other resources coming on line. One of the issues that we really want to push is e-health and telehealth. There are ways that we can target people other than face-to-face follow-up, which indeed does happen, having talked with case managers only this week, and companies like Medibank that have a devolution of responsibility to support caseworkers, so it will get better—

**Dr JOHN KAYE:** Sorry if I am interrupting, but are you increasing the number of caseworkers?

**Mr KEVIN HUMPHRIES:** What we are doing is getting the identified positions filled first. In some cases there are workforce issues in some parts of the State. Where there are difficulties in filling some of those positions, for whatever reason, there are other providers in the non-government organisations sector that we are encouraging clinical directors and leaders of community mental health teams to partner up with. What we are saying is that mental health is everybody's business, it is not just a health issue. That is off the back of awareness campaigns as well. But the initial target is to make sure that those designated positions are filled.

**Dr JOHN KAYE:** Will you then look at adequacy? Do you have a target number of caseworkers per 100,000 population in each local health district [LHD]?

**Mr KEVIN HUMPHRIES:** It is on need; it is not necessarily on numbers. Where we have people who are managing acutely unwell people, many of whose issues are around medication compliance post-release or on discharge from a facility. That is an area where we need to make sure that we are solid, and I suspect that has been the case previously. But we do have a target.

**Dr JOHN KAYE:** You do have a target number. How is that determined? Is that determined on population health?

**Mr McGRATH:** We have a population-based planning tool based on population prevalence, which is called the mental health clinical care and prevention [MHCCP] model.

**Dr JOHN KAYE:** Is the basic driver of that the number of acute psychosis episodes per 100,000 people?

**Mr McGRATH:** No, there are a number of diagnostic categories that fit within the mental health program. Psychosis is not the only one. It works on the premise of a population of 100,000. It looks at the diagnostics that would be expected reasonably within that population. It looks at what the expected flow of those diagnostics into treatment services might be, whether that might be primary care or the specialist sector and could be the private sector, depending upon the Commonwealth responsibilities or State's responsibilities. Then, working with clinicians, we develop care packages for each of those diagnostic categories, and those care packages determine what level of functional resource is required for each patient flowing through that particular care package. We are then able to aggregate that with the 100,000 population and come up with an estimate of the required resource to deliver that functionality.

When we get into the community sector—and this is one of the major complications we have had—there are obviously responsibilities at the Commonwealth level and responsibilities at the State level with regard to the delivery of primary care services, which may or may not overlap with the funding of non-government organisations, services provided by general practitioners, the new Medicare items for private psychology, et cetera. We have been negotiating with the Commonwealth Government over a period for the creation of a national model—not just a New South Wales model, but a model that enables the State and Commonwealth responsibilities to be integrated for that same population of 100,000 people. That then allows us to discount or adjust on the basis of investment by appropriate investment regimes for community-based mental health. The contract for that was let by the Commonwealth Government and the New South Wales Government was successful in tendering for that contract. That project will be running over the next two years to create a national model for both community and inpatient services, again for that nominal population of 100,000 people.

**Mr KEVIN HUMPHRIES:** Yesterday I was in Terrigal and we announced 100 Aboriginal Housing and Accommodation Support Initiative [HASI] packages. You are going to see more options coming in. The idea is to alleviate and give those community mental health teams more options. Those 100 packages were an extension on what existed, so the concept is not new. What we want to do over time is expand the 1,100 packages that we currently have in New South Wales to probably nearly double that. That is the estimated need. As David McGrath alluded to, we are currently having discussions with the Federal Government to broaden the remit of the Housing and Accommodation Support Initiative.

There are people with mental health issues who are not supported, principally in boarding houses, because they do not fit anywhere. We are talking about several thousand people there. There are people who are not supported with accommodation or housing or care post-release from prison, and recidivism rates are too high because of the accommodation issue, the case management issue, so we are looking to partner with other organisations on that front. The third group that we really want to target in terms of better care is young mothers or mothers with children. We do not want to see the trauma, particularly with regard to post-natal depression, where women are separated from their children.

Whilst the case management numbers are sitting where they are, we do not necessarily want more of the same. That is what the experts are saying to us and it is what the community is saying to us. They want more options and more joint services, and I think if we achieve anything in the first term of government it is that people will see that that is what we are doing. We are joining up services and working on that wraparound care type model. Case managers really are there to oversee that and help to direct traffic. Many of them—and I

caught up with quite a few yesterday from part of the State—are pretty frustrated because they do not have those options in the community. Traditionally, the default option has been acute mental health facilities, which are not always appropriate. Statistics show that about half the people who present to an inpatient unit do not need to be there but they are there because options do not exist in the wider community. If you really want to get to the pointy end, they end up in a forensic hospital because they have gone too far and not necessarily made a good decision, which is not their fault—and that will grow.

**The Hon. PAUL GREEN:** Carrying on with mental health, I will only talk from my experience in the Shoalhaven, where we are definitely short of mental health beds—

**Mr KEVIN HUMPHRIES:** The people I spoke to yesterday were from the Shoalhaven.

**The Hon. PAUL GREEN:** Many would be aware that, sadly, people in acute psychotic situations are put in the back of a police wagon and taken to Shellharbour, which in my view, in the twenty-first century, is pretty inhumane. What are you doing in regional and rural areas regarding management of people with acute psychoses? Surely we should not just put them in a police van and drive them to the closest facility. What plans do you have, given that in other areas of health such as cancer care networks throughout New South Wales they are trying to get linear accelerators in strategic places to ensure that people do not have to travel umpteen miles to get decent treatment?

**Mr KEVIN HUMPHRIES:** You are spot on, which is why some of those cancer treatment facilities are going to places like Dubbo and Tamworth. I will digress very quickly. The issue of patient transfer also covers people detained in custody. The transfer of people in the criminal justice system is just as big an issue. To have that undertaken by police is not appropriate, and the system recognises that. The Government has put some serious funding into this budget to address that issue for regional areas where we do not have gazetted facilities that can take involuntary patients. The Ambulance Service will step-up with more services. In most places across the State I am happy to say those agreements have been reached, but there are still pockets of the State where those agreements are not good enough. On two fronts that will make it difficult, because either the existing services are not transporting those patients, which means they are not getting the care they need, or in some cases they are being transported inappropriately. You will see an improvement on that service over the next 12 months.

There will be an enhanced push for mental health intervention teams and police. Every one of the 80 local area commands in the State has senior police trained in mental health intervention: as to what is appropriate and what is not. We want to accelerate that training through the whole of the Police Force with the support of the Minister for Police. The Police Force is very much on side. It will become part of their basic training. For 80 per cent of people that have a psychotic episode the first people they run into are the police. That is an issue if we potentially have staff that are not trained appropriately or they do not have access to the facilities. For example, if there is a person in Lightning Ridge who has a psychotic episode—which happens on occasions—the transport for the 10-hour trip to Orange needs to be pretty good.

I did meet up with a number of community mental health people yesterday from the Shoalhaven. It is not publicly announced yet but two things are going to happen in that part of the world. First, you will receive a headspace centre. There will be more services in place down there inside of two years. Secondly, the South Coast has been identified in negotiations with the Federal Government as a recipient of subacute beds. The South Coast will have infrastructure built in the Shoalhaven that will target step-down facilities. So people that are starting to feel unwell but may not need to be in the Nowra base or to be moved up to Shellharbour or Wollongong, or wherever they may end up, have somewhere to go. We are trying to push that strategy with the Federal Government. If the Federal Government comes up with capital funding the State Government will support it on the recurrent front. There are 120 beds earmarked over the next few years and the Shoalhaven was one of the top priorities. You will see better facilities for adolescents and you will hopefully see the rebuilding of the community mental health teams to an acceptable level. There will be infrastructure in place to accommodate those people who get to the next level and have not been that well.

**The Hon. PAUL GREEN:** Training for the Police Force is a good thing. Once again relying on my regional experience, we do not want our police taking acutely psychotic people 100 kilometres away from the city for two reasons. First, it is an inappropriate use of a resource. Are you going to implement a system where volunteers, who are trained to handle the situation, instead of police will escort the mentally ill? Secondly, in our situation every time one mentally ill person is taken to Shellharbour two police are away from the local area in a situation where we are already under staffed in terms of authorised numbers and actual numbers. Will you look

at that? There are a lot of volunteers out there who are qualified to take such patients to Shellharbour in far better comfort than in the back of the paddy wagon. The Government should be mindful of making an initiative down that track. My next question is: Given the levels of depression in rural farming communities, what structures or policies are currently in place to improve farmers' access to mental health services in rural communities statewide?

**Mr KEVIN HUMPHRIES:** Good question. I will come back to you on the rural retrieval model because there is a plan there for that and it is involved with the ambulance services, which I alluded to before. One of the things the drought did, if it did do anything good, was that it actually lifted the lid on mental health issues. The evidence is there that there were pockets of the State that experienced more presentations. Having said that, part of the awareness campaign also encouraged people to present. Once the issues surrounding depression and anxiety went through the roof I wrote an article saying that men drink and women worry. As the drought bit into rural areas people were masking that distress, anxiety and depression in other ways. Did that lead to higher suicide rates as we were discussing? Yes, it did.

The Government previously did a good thing in supporting the Centre for Rural and Remote Mental Health, where a level of expertise was developed, particularly out of Orange, in partnership with the NSW Farmers Association, the Government and the community. The drought support workers, the mental health first aid workshops, and the rural adversity group are funded out of Orange to continue that support and awareness. I have to say the awareness was one of the bigger issues: the point being that the first three years of my first term as a member was spent on drought relief and mental health support. There were farmers who walked off the land because they were not busy and had nothing to do, their bank accounts were diminishing, and there was reasonable pressure put on by the finance companies. The finance companies eventually came to the party and there were no buttons pressed for a long time, which was a good outcome.

We have sitting in place at the moment the funded rural and remote mental health team and the administration that works out of Orange. The rural adversity teams are out there doing their job and they are also a referral point. I come into constant contact with them about awareness. Orange is a hothouse for information technology support and mental health telephone support. I have sat in on a number of telephone support demonstrations where they have outreach virtually to all our facilities across the west. I believe it is the future for mental health in terms of support. There is a lot happening out there and I think it is pretty good. One of the issues with the mental health teams was to make sure that they were fully staffed.

You will see an announcement in the not too distant future saying transport is our biggest issue. We can get the philanthropic and we can get the specialists but the issue is getting them in and out over a period where they are able to undertake some good. The arrangements that we have with the Royal Flying Doctor Service are going to ramp up and there will be an extension of the dental health and mental health programs into remote areas. The NSW Farmers Association does a good job. As the Hon. Mick Veitch would know, men's sheds have gone ballistic. I do not know of any community now that does not have that facility and most of the participants are ex-tradesmen or farmers that do not want to gather at clubs.

**The Hon. PAUL GREEN:** Are there grants for that?

**Mr KEVIN HUMPHRIES:** There is the Federal $17 million commitment that was made and there is strong bipartisan support Federally for that roll-out; the Department of Veterans' Affairs provides grants; there are community partnerships; and a lot of the funding from my ministry goes into men's sheds as well. The Government has never funded a start-up; the men's sheds have to get up and going themselves. It is one of the fastest-growing movements in regional areas and cities.

**The Hon. PAUL GREEN:** I believe there are now 600 of them.

**Mr KEVIN HUMPHRIES:** There are nearly 700 across the country. The Federal member and I have more men's sheds in our electorate than anyone. I think we have 35 at the moment. It is a good intervention point for health services as we are trying to grow that awareness campaign in terms of mental health and the fact that it is okay to gather and talk about these issues. Centrelink has done a pretty good job. It is providing back-up support for those people that are living with mental illness or other disabilities, because a lot of these guys do not know what they have access to.

**CHAIR:** Minister, you have touched on a lot of the programs you are introducing but the mentally ill are heavily represented in our State's prisons. As the Minister for Mental Health, what are you doing to ensure that fewer mentally ill people are put behind bars, which is the wrong place for some of them?

**Mr KEVIN HUMPHRIES:** That is a very good question. It is by no accident that the Government is in the process of closing two prisons. This is to do not only with mental illness but also with the Bail Act, remand and a few other things. The number of people entering our incarceration system is way too high. As I alluded to earlier, mental health robs someone of the ability to make good decisions for himself or herself, and often for other people. If those with mental illness are not treated appropriately or fall through the cracks we will have difficulties. The behaviour and the illness of such people then gets on a trajectory that heads in one direction that usually results in them coming before the justice system at some stage and a lot of them end up in jail or in our forensic hospitals.

The Government's target is to reduce that rate—I would like to say exponentially but obviously it has to be stepped in. It is one of the key reforms that the Mental Health Commission will take up in its resourcing and review of best care and incarceration diversion—a reform that not only I believe we should be taking. The statistics on who is representing to prison or to the forensic system are way too high. It costs give or take $100,000 each year to keep a prisoner incarcerated. It costs much more than that at the high level forensic hospital at Long Bay. We talk about justice reinvestment but it is not appropriate to get into a Dutch auction on who can apply the greatest sentence and who can incarcerate a person for the longest time. We have tried to have that discussion in the community. It is not the best result for the community or for those people. Those with mental health issues can live a restorative model of life if supported appropriately with the best clinical supervision.

The community will soon see a push to target incarceration. Some of the strategies that will be put in place over time, which are being discussed at the moment, include court liaison officers and mental health support workers being present at local courts—an area that the Government wants to target—to give the magistrates more information on people who potentially will come before them. This will give magistrates more second chance or diversionary strategies up their sleeves. One of the best examples of a program that previously existed but that was never really used was the Magistrates Early Referral Into Treatment, or MERIT, program. That program could be significantly expanded if the appropriate resources existed in the community. But that is not the only program. There are also drug courts, second chance options and even the Young Offenders Act, which the Government is currently looking at, given that some of those people would fall into that remit.

The Government considers having more referral points as a good starting point. This will divert people away from the incarceration system and into a model of care that is more appropriate and mental-health based. I refer to a few other issues relating to drug and alcohol treatment centres, in particular, in the Aboriginal community, that are funded largely by the Federal Government and that have little or no oversight. The Government must get into that space over time. We have a strong intellectual base in the forensic mental health system, which really is associated with justice health. People in the community on that trajectory should be supported.

We should use the forensic health team in a more robust way to support those in the community who have mental health issues in the same way as we support post-release patients. Earlier we were talking about the housing and accommodation support initiative. Over time the Government will use the forensic mental health team to mentor and support people who return to the community. We know we can cut back on recidivism rates and presentations to acute facilities if those people are properly supported. It is a big issue for the Government. To physically detain people is a big call. It should not be the default option if better methods of care are available in the community. The Attorney General and the Minister for Community Services also feel strongly about this issue and there is a good across-government push to make it happen.

**The Hon. SARAH MITCHELL:** Minister, I ask a question relating to your portfolio as Minister for Western New South Wales. Will you tell the Committee a little more about what the Government has been doing to improve services in regional New South Wales since it was elected to office?

**Mr KEVIN HUMPHRIES:** I would love to do so. The push by the Liberal-Nationals Coalition was not only to broaden our access to service but also to broaden service delivery and to have a fair share of resources across the State, which resonated with voters at the recent election. Whilst I could not say at that time that I was shadow Minister for western New South Wales, as we did not have a Minister for western New South Wales, I wanted to flag the population base west of the Great Dividing Range and across the State. Regional

people are highly productive. Those from what we call the "inside country" do not necessarily have the same needs as those who are living in metropolitan or other regional areas. It was a way to corral many of those issues and to have a position in Cabinet where those opportunities could be addressed. Western New South Wales is not the only area that was affected; areas such as the North Coast, western Sydney and other areas required a regional ministry. This is something in which this Government strongly believes.

I am conscious of the time so I will stick to my notes in advocating for the region, otherwise I might go on for hours. This ministry does not have a funded allocation; we are working through the Department of Premier and Cabinet to ensure that those interests are addressed. One of the problems faced in the west has been the demographic shift in population. That has led to some interesting impacts on, for example, local government where the rural ratepayer base has shrunk because the farms are getting bigger. However, productivity has not fallen; productivity is growing despite the fact that there are fewer people in the region and the ratepayer base is smaller. In isolated and remote communities that largely have fewer employment opportunities and, in some cases, a growing Aboriginal population, particularly across the far west, an opportunity exists for new ways of doing business. For example, we are looking at new ways for local government to do business in Wilcannia, which is based in the Central Darling area.

Earlier we talked about joining up services. People do not care who delivers a service or who provides support. Too many groups are located in those areas, which is akin to having too many chiefs and not enough Indians. Something more formal will be done about this in the near future, but at the moment we are discussing how to better corporately govern those parts of the State that need new ways of doing business. For instance, it is hard for smaller communities to target infrastructure because of the huge costs. The further west one goes, roads are probably the number one issue. At the moment we are putting together a joint submission. A group of 14 councils joined together to look at their regional roads. Regional roads were hived off to local government largely because the State did not have the will or the wherewithal to fund and maintain those roads. Those councils individually cannot take on that infrastructure issue. That is just one way that we are looking at doing business in a new way.

If you look at the Coalition's policy on rebuilding the State, the whole area over the next 10 years is to promote economic growth. People like me—and I know members on both sides of the Committee hearing—recognise that we have enormous opportunities in rural areas. I suppose the drought highlighted the difficulties we have at times. Part of my role is to help balance in some areas—not in all areas—the competing land use issue. That will not go away. Historically, that has always been there, but we need to ensure that any entrants into that field do not disadvantage our existing industry. This year my valley alone, the Gwydir Valley, will turn over $1 billion. That is not bad for 13,000 people. Our difficulty is, for instance, that a third of the cost of getting that product to market goes out in transport costs. So at the end of the day farmers and people who want to be based in rural areas become logistic companies. They are not just growers or producers. The push for infrastructure upgrade will continue; it will not go away.

One interesting opportunity we have in some areas in the west is the whole issue around the strategic land use policy. No-one has ever had a plan for areas west of the divide. That engagement will be fundamentally important not only to addressing our productivity and efficiency issues but also to making sure that we do it in an environmentally responsible way so that we are planning for intergenerational change. Things are changing in farming and agricultural communities, in mining communities and in Aboriginal communities. Communication and technology are driving that. How we get to the next level is an opportunity. I do not see it as a negative. It is causing debate in some areas, and that debate should be happening.

The main issue for us is to keep the people who are there viable and sustainable and to help them access markets in a more timely and cost-effective way. As a Government we can do that, which is why you will probably see this Government commit to more infrastructure in the first term than has been previously undertaken for some time. To attract people there and to keep our folk there, obviously we need service delivery, and the biggest issue for us is twofold. One is health services and the other is education. If we do not have good health service delivery and if we do not have schools that will attract young families to come and stay there, it will be difficult to grow our communities. In communities like Broken Hill, for instance, that have a couple of new mines, either to re-open and expand or new expansion, you will not necessarily see a population increase because the technology and the efficiencies are better.

Part of the mix for us is ensuring that we are encouraging a more diverse industry base in some of those towns. I think you will see places such as Broken Hill grow as a health hub, for instance. There are opportunities out there in the arts, with theatre, film and production. It will differ in a whole lot of areas but I think one push

the Coalition Government will make is that those areas, and certainly the west, are now on the map. It has a front door into Cabinet through the ministry. As members would know, the local councils in the west have been constantly crying out for support for a long time, which is why we are starting to see them work together a bit better with their planning.

I think it is all good. Tourism is a big one for us as well. The funding that was announced by the Minister for Tourism, Major Events, Hospitality and Racing, and Minister for the Arts has created a good dynamic where a lot of the previous tourism operators are now amalgamating. They are taking a bigger picture of marketing inland or in the outback. There is an opportunity to do that in resources. The Government is committed to doing that. So that is a little bit about what we are doing in the west. It is encouraging people to take more responsibility for their decision making. It is also highlighting what does not work and we have had a fair bit of that. If the message is that there is a new way of doing business, that is the take-home message.

**(The witnesses withdrew.)**

**The Committee proceeded to deliberate.**