GENERAL PURPOSE STANDING COMMITTEE No. 3

Tuesday 14 October 2008

Examination of proposed expenditure for the portfolio area

MENTAL HEALTH

The Committee met at 12.00 p.m.

MEMBERS

The Hon. A. R. Fazio (Chair)

The Hon. D. J. Clarke	The Hon. R. A. Smith
The Hon. M. J. Pavey	The Hon. M. S. Veitch
Ms L. Rhiannon	The Hon. L. J. Voltz

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PRESENT

The Hon. B. M. A. Perry, *Minister for Local Government, and Minister Assisting the Minister for Health (Mental Health)*

Department of Health
Dr R. Matthews, *Deputy Director General, Strategic Development*
Mr D. McGrath, *Director, Mental Health, Drug and Alcohol Programs*

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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 open to the public the inquiry into budget estimates 2008-09. I welcome Minister Perry and accompanying officials to this hearing, including Mr David McGrath, Director, Mental Health, Drugs and Alcohol, who is a late addition to our witness list. I also advise of the following Committee member substitutions for today's session: the Hon. David Clarke, for the Hon. Trevor Khan, the Hon. Melinda Pavey for the Hon. John Ajaka, and the Hon. Lynda Voltz for the Hon. Greg Donnelly. I refer witnesses, the audience and members of the media to my earlier statement about procedural matters such as broadcasting. All witnesses from departments, statutory bodies, or corporations will be sworn prior to giving evidence.

RICHARD JOHN MATTHEWS, Deputy Director General, Strategic Development, NSW Health, and

DAVID ANTHONY MCGRATH, Director, Mental Health, Drug and Alcohol Programs, NSW Health, affirmed and examined:

CHAIR: The Committee has already determined the allocation of time. We have one hour, which will be divided 20 minutes for Opposition members, 20 minutes for the Cross Bench and 20 minutes for Government members. I declare the proposed expenditure for the portfolio of Mental Health open for examination. We will begin with questions from the Opposition.

The Hon. MELINDA PAVEY: Minister, can you tell us what facilities are available in New South Wales for people with eating disorders, in particular, anorexia nervosa?

Mrs BARBARA PERRY: Eating disorders are becoming an increasing problem, in particular, in young women. There are programs in place and we have child and adolescent units in Westmead Children's Hospital and Campbelltown hospital. There are at least three or four units, one of which is located in Wollongong. I am only five weeks into the Mental Health portfolio so I have not yet seen all the facilities and I cannot list them off the top of my head.

Dr MATTHEWS: It is important to remember with eating disorders and, in particular, anorexia, that admission is a last resort. The majority of people are treated in the community. When admission is required we have child and adolescent units at The Children's Hospital, at Redbank House, Westmead, Campbelltown; a newly opened unit at Lismore; and the Nexus unit at Newcastle.

The Hon. MELINDA PAVEY: Is the Nexus unit a new facility?

Dr MATTHEWS: Yes. The Orange-Bloomfield redevelopment will contain a new child and adolescent unit. In addition, beds that are currently available in the paediatric unit in the Prince of Wales Hospital will be built as designated as child and adolescent beds in a separate unit. Sadly, when people require admission, often it is not to a mental health unit; it is to an intensive care unit. The illness has proceeded to the point where physical needs have to be met rather than mental health needs whenever patients are admitted. The longwinded answer to question is that about seven or eight child and adolescent units are available. However, when it comes to admission, it is likely that it may be to one of a large number of intensive care units.

The Hon. MELINDA PAVEY: David McGrath, are you at Royal Prince Alfred Hospital?

Mr McGRATH: No, I am from the Department of Health.

The Hon. MELINDA PAVEY: I thought you said earlier that you were with the drug and alcohol program?

Mrs BARBARA PERRY: Mr McGrath is the Director, Mental Health, Drug and Alcohol, which is co-located with mental health.

Mr McGRATH: It is a section within the department.

The Hon. MELINDA PAVEY: Is there a facility at the Missenden unit at Royal Prince Alfred Hospital?

Dr MATTHEWS: Yes, there is. Thank you for reminding me; I left that one off the list.

The Hon. MELINDA PAVEY: It is a shame.

Dr MATTHEWS: The facility there provides both an outpatient and, if necessary, an inpatient service for people with eating disorders.

The Hon. MELINDA PAVEY: Do you know whether there have been any cuts to the beds that are available in that special unit to deal with eating disorders?

Dr MATTHEWS: No, I do not. If someone with anorexia required admission for physical reasons he or she would get admission. As I said, it is not likely to be in a designated unit such as Missenden, although that is available. Often it is in an intensive care unit. I am unaware of any specific changes at Royal Prince Alfred Hospital. I am happy to take that question on notice.

The Hon. MELINDA PAVEY: The Opposition has information that the beds at the Royal Prince Alfred Hospital, which basically is an adult facility, have been reduced from 10 to four, but the Minister said that anorexia nervosa was on the increase. Are you happy with that situation, if it persists?

Mrs BARBARA PERRY: Are we talking about the child and adolescent unit?

The Hon. MELINDA PAVEY: I am talking about anorexia nervosa as a general condition, whether it involves adolescents or adults.

Dr MATTHEWS: I am not aware of any reductions at Royal Prince Alfred Hospital, but I am happy to take that question on notice, investigate the matter, and come back to you.

The Hon. MELINDA PAVEY: Minister, you said in your introduction that this disease was on the increase, so you would not be happy if the number of beds or available facilities were reduced.

Mrs BARBARA PERRY: Different sorts of treatment are available; it does not just involve admission. Admission is a last resort. Dr Matthews indicated that the best treatment for eating or other disorders is in the community. This year, 82 per cent of the new money in our budget is for community mental health, which is significant and important. This Government is allocating resources to support the community in the community.

The Hon. MELINDA PAVEY: You said earlier that the incidence of anorexia had increased. What statistics are we looking at?

Mrs BARBARA PERRY: I do not have the statistics. Anecdotally we know that young women in particular are influenced by the media and by fashion, et cetera. It is sad that those things influence women's perceptions of their body images. By virtue of the fact that we have an increase in population, there is an increasing incidence of this. The important thing is to identify it, for families to be aware of what is going on and to seek help. Help is available both in the community and within facilities. It is absolutely tragic that young girls particularly feel the need to have a body image that is portrayed somewhere and then get themselves into a situation where, unfortunately, this terrible illness is something from which it is very difficult to overcome.

The Hon. DAVID CLARKE: Do all mental health facilities have segregated areas for male and female patients?

Mrs BARBARA PERRY: I have not visited all mental health facilities, and I think you would understand that is because I have been the Minister for only five weeks. I have visited Nepean mental health facility.

The Hon. DAVID CLARKE: Perhaps Dr Matthews knows?

Dr MATTHEWS: The reason I hesitated was that I am almost certain the answer to that question is that they are segregated, but I was searching my mind to make certain that there were no special circumstances where that might not be the case. In general I cannot think of any that are together. The Bunya unit, which is a forensic unit at Cumberland, has separate wings for male and female patients, but they share common areas. When I went to New Zealand I was very interested to see that their child and adolescent units were mixed. They felt that was normal practice and that it was actually therapeutic. They have quite a different view to the one we

have taken traditionally. I have a fairly open mind on the subject because it is a subject, particularly in relation to young people, on which the mental health community is split. There are those who say they should be separate and there are those who say that there are positive benefits in having them together. It is like the schools debate, really.

The Hon. DAVID CLARKE: Without going into the policy considerations of it and so that you do not have to rely on your memory, would you like to take that question on notice?

Dr MATTHEWS: I am happy to.

The Hon. DAVID CLARKE: And advise us of what mental health facilities have segregated areas in regard to male and female patients, and which ones do not?

Dr MATTHEWS: To be specific, you are referring to the sleeping accommodation as opposed to the communal areas?

The Hon. DAVID CLARKE: As much detail as you can give us. My next question is somewhat different, but perhaps you should take it on notice too. Can you provide a list of facilities that have male and female segregated arrangements and a list of facilities that do not?

Dr MATTHEWS: I am sorry, could you—

The Hon. DAVID CLARKE: There are segregated areas and there are situations where there are segregated arrangements.

Mrs BARBARA PERRY: What is the difference?

The Hon. DAVID CLARKE: Do you not make a distinction between the two?

Mrs BARBARA PERRY: Can you please explain the difference? I cannot make a distinction between the two. Segregated areas would be a segregated arrangement. What is the difference?

The Hon. DAVID CLARKE: Not necessarily. If you give us the information to the first question, we will take it from there. We might have a supplementary question following that.

Dr MATTHEWS: Okay.

The Hon. DAVID CLARKE: Is a record kept of assaults that occur within State mental health facilities?

Mrs BARBARA PERRY: Yes.

Dr MATTHEWS: Yes.

The Hon. DAVID CLARKE: Can you provide data on the types of assaults that occur, for instance, between male and female, and so forth, the number that have occurred over the past five years and by facility?

Mrs BARBARA PERRY: Firstly, BOSCAR has recently reported on some data about assaults in hospitals generally but, secondly, it is on the website. I will defer to Dr Matthews for some information in relation to that.

Dr MATTHEWS: The Department of Health has an incident management system that records all incidents that occur in hospitals. They are aggregated into different categories. That information is published at six monthly intervals through the Clinical Excellence Commission. Certainly we keep that data.

The Hon. DAVID CLARKE: All this information is publicly available on the website?

Dr MATTHEWS: It would not be available by facility, but it would be available in aggregation.

The Hon. DAVID CLARKE: Would you be able to give us that information by facility? Could you take that on notice?

Dr MATTHEWS: I will take that on notice.

The Hon. DAVID CLARKE: When assaults occur in mental health facilities, what actions are taken by staff? Is there a process? Are they reported to police? What is procedure that is followed?

Mrs BARBARA PERRY: All assaults are treated as they should be treated, with great seriousness. Of course, the Government has a zero tolerance towards any assaults to staff—not just mental health staff, but other professional staff as well. Legislation is in place in regard to that. Assaults are generally reported to police.

Dr MATTHEWS: That is correct. We take the view that the law makes allowance for people with mental illness under the Mental Health (Criminal Procedure) Act. Whether an assault takes place in the community or in a mental health unit, the capacity to plead not guilty by reason of mental illness applies. Since that legislation is in place, these incidents should be reported.

The Hon. DAVID CLARKE: When it is suggested that they are generally reported, in what circumstances are they not reported?

Dr MATTHEWS: As is the case in the community, it may be that the individual who suffers the assault has a view that the person is mentally ill and that it should not be reported. Each case is considered on its merits. Certainly if there is any serious injury—we must remember that assault comes in different forms, levels and gradations—or actual bodily harm to an individual, we take the view that it should be reported. But an assault might take the form of a push, a shove or a slap, which does not actually cause any physical harm.

Mrs BARBARA PERRY: In the circumstances of dealing day in and day out with patients who have difficulty, I am sure that the person who may be assaulted knows that they can report these matters to the department or the authority where they are, and also to the police. I am sure that they would.

The Hon. DAVID CLARKE: You are talking about patients or the authorities?

Mrs BARBARA PERRY: You are talking about staff, are you not?

The Hon. DAVID CLARKE: Yes, I am talking about staff.

Mrs BARBARA PERRY: Staff would report it in the circumstances, if they felt they needed to.

The Hon. DAVID CLARKE: Have any guidelines been prepared for staff to assist them in what matters should be reported and what matters should not be reported?

Dr MATTHEWS: Yes. The department, as the Minister said, has a zero policy to anything of this kind in the workforce. Every acute or subacute unit and every service's normal policies and procedures manual would contain guidance as to what to do in these kinds of circumstances.

The Hon. DAVID CLARKE: These guidelines have been reduced to writing and they are in the manual?

Dr MATTHEWS: Yes, and we can provide you with some examples of those.

The Hon. DAVID CLARKE: Could you just refer us to the manual in which these guidelines are retained?

Dr MATTHEWS: Each unit has its own management guidelines, which vary according to the type of patients and the age of patients, so there is not a standard set of guidelines for the management of acute units. They are produced by the unit. We could give you some examples.

The Hon. DAVID CLARKE: Thank you. Have any sexual assaults been reported at mental health facilities in recent years?

Mrs BARBARA PERRY: Over what period are we talking about?

The Hon. DAVID CLARKE: Say, over the past four years?

Mrs BARBARA PERRY: Sexual assaults upon whom and by whom?

The Hon. DAVID CLARKE: Sexual assaults on patients or on staff.

Dr MATTHEWS: I would say the answer to that is almost certainly yes. If you ask me how many, I would have to take the question on notice, but certainly we would be able to provide that information to you.

The Hon. DAVID CLARKE: I would be obliged if you would take that on notice, as well as sexual assaults, if any, by staff of patients. Does the Government have a policy to segregate male and female patients when developing new facilities?

Dr MATTHEWS: I think the answer to that is no.

The Hon. DAVID CLARKE: When you say you think that is the answer, are you sure that the answer to that is no?

Dr MATTHEWS: Yes.

The Hon. DAVID CLARKE: Does the Government have a plan to redevelop or renovate current facilities that do not provide segregation for male and female patients?

Dr MATTHEWS: No.

The Hon. DAVID CLARKE: The Government has no plans to do that?

Dr MATTHEWS: No.

The Hon. DAVID CLARKE: Do all juvenile health and rehabilitation facilities segregate male and female patients?

Dr MATTHEWS: I will have to take that on notice. "All" is always a tricky one. I will take that one on notice and get back to you.

The Hon. MELINDA PAVEY: Minister, as part of the 2008 budget, the Premier announced a $13 million funding package for mental health, including $6.85 million for community mental health emergency care, $2.1 million for older persons' mental health services, and $3.1 million for the Community Mental Health Rehabilitation Program. I know you were not the Minister in 2006, but in that year the then Minister for Health announced a $300 million package of new initiatives over five years covering these very same areas. Is the 2008 budget announcement new money in addition to the funding announced in 2006?

Mrs BARBARA PERRY: Yes, it is, and that announcement was made in May, as I understand it.

The Hon. MELINDA PAVEY: In the area of mental health infrastructure, there is regular underspending of the financial year allocations, frequent delays in completion dates, and changes to estimated costs. We now have two projects from the 2007-08 budget underspent by over a third of the total allocation, namely, $7.927 million of the total of $19.875 million. We also have seven projects that have been extended by at least 12 months from their original completion dates. One of the more notable projects is the Illawarra Older Persons Mental Health Unit, which was announced on 6 April 2004 by the then Minister for Health as part of a four-year funding plan, but it is still waiting to be completed. Why are funding allocations so far out, considering these projects are already underway and allocation should be aligned with projected work scheduled for that financial year?

Mrs BARBARA PERRY: You referred to one specific one, and that does not relate to every specific project. That is the first point.

The Hon. MELINDA PAVEY: But you do have an underspend of $7.9 million for the 2007-08 budget.

Mrs BARBARA PERRY: I will get that in a minute. Firstly, in general, I would not call it underspending because the money is committed to these projects. Secondly, projects may, for various reasons, take time. As you know, projects are invariably staged, as is the money towards those projects. That would account for part of the matters relating to underspends on various projects—or what you call underspends. As I say, the money is committed to that particular project. Is there anything that you would wish to add to that, Dr Matthews?

Dr MATTHEWS: The forward estimates are just that. New South Wales Health manages its capital program within a $620 million cap each year. The really important questions are: Do we deliver our projects? Do we deliver them on time? The answer to the first one is yes. Sometimes we do not deliver them on time, and there are good reasons for that. I will give you a couple of examples, such as the James Fletcher subacute unit. When work began, they discovered a very old convict-built cellar that nobody was aware was under the building, and work had to stop for quite a period of time while the heritage folk recorded every aspect of it. At the Coffs Harbour subacute unit, as it turned out before work commenced it was discovered it was in the path of a koala corridor, and alternative arrangements had to be made for the koalas before work could commence. One of the Illawarra units had its roof blown off in a storm that occurred during construction.

The Hon. MELINDA PAVEY: Delay occurred at Port Macquarie as well, did it not?

CHAIR: Order!

Dr MATTHEWS: Port Macquarie was a difficult project because we were actually renovating and extending an existing unit to make it suitable for enforced treatment. We had to manage the patients around the renovation. When things are planned, the nominated amounts of money, site constraints, and things like the discovery of a cellar in James Fletcher make things difficult. Other projects are delivered ahead of time.

The Hon. MELINDA PAVEY: How many?

CHAIR: Order! There will be no more Opposition questions.

Dr MATTHEWS: The new Forensic Hospital at Long Bay will be handed over next month and it was not due until February. That is an example of one that is actually ahead. At Concord there is a very big 174-bed unit that is on time. In Lismore, there is an extension of adult beds and the addition of child and adolescent beds that are on time. It is not an exact science.

Mrs BARBARA PERRY: I add to that that the mental health program over the last few years has undergone a massive expansion in a short time frame. There have been some delays, as Dr Matthews has indicated, in the rollout of previous years' funding, and those delays of course have been attributable to many of the things that Dr Matthews has referred to, such as capital works and sometimes even recruitment issues.

Ms LEE RHIANNON: I want to ask about 24-hour mental health emergency teams. They sometimes go under different names, such as mobile treatment teams. When will the Illawarra team start operating? I understand that it was operating up until 2004 but was stopped in 2004. In May this year the former Premier, Morris Iemma, announced a $6.85 million program for different regions. I am interested in when you will be providing around-the-clock mental health response teams in the Illawarra.

Mrs BARBARA PERRY: Thank you for your question in relation to that. Of course, you are right; $6.85 million was announced in May this year for the region as a total. As you have indicated, there are different models. In the Illawarra area, for example, for the Psychiatric Emergency Care Centre [PECC] unit that has been developed there we already have the staff there and they go out and do what we call community mental health emergency responses. Am I correct in saying that that is the correct position?

Dr MATTHEWS: Yes.

Mrs BARBARA PERRY: In effect, the money is there for this year. Currently, while we are awaiting the PEC unit to be developed within the Wollongong Hospital, the staff are already there working. They are in

both the emergency department of the Wollongong Hospital and doing assessments and case managing when needed, as well as doing work in the community. That is my understanding.

Ms LEE RHIANNON: Can you clarify that? The last time I was with a number of patients and staff from the Illawarra Mental Health Action Coalition, they were saying that while there is a 24-hour hot line, mobile teams are still not going out into the community.

Dr MATTHEWS: The National Mental Health Policy called for what is known as mainstreaming, which is mental health services becoming part of the overall health service. We very strongly take the view that if someone has a mental health emergency, they should be no different from someone with a physical health emergency and that, in the main, they should be dealt with in the first instance in the emergency department. That is why we have introduced nine, soon to be 11, Psychiatric Emergency Care Centres, or PECCs as they are known. One is being introduced into the Wollongong Hospital.

The physically discrete unit is not yet in place, but the recurrent funding has been made available and the staff, such as mental health nurses, are in the emergency department 24/7. This year—in other words the 2008-09 financial year—additional money has been provided to the South East Sydney and Illawarra Area Health Service to give that emergency department's capacity an outreach capacity so that, if necessary, clinically or by reason of a need to assist the police, such as during a siege, they can go out from the emergency departments to assist in the community. But we are very strong on the idea that if you or I have a heart attack, the best place for us to be dealt with for that emergency as soon as possible is in the emergency department. We might send someone out to get you, but if there is a mental health emergency, it should come through the emergency department. In the past, too many cases of physical illness causing mental symptoms have been missed, and too many people with mental illness have had concurrent physical illness missed.

Ms LEE RHIANNON: It seems to me that you are shifting away from what I understood was the emphasis on these mobile units to saying that in the first instance they will be brought into hospital and that the mobile units going out into the community is secondary. Is that wrong?

Dr MATTHEWS: No, that is right.

Mrs BARBARA PERRY: That is what Dr Matthews is saying.

Ms LEE RHIANNON: Is that a summary of what you said?

Dr MATTHEWS: Yes. In effect, there is work to do in the emergency department all the time so you place your staff there; so they are usefully employed all the time. If there is an emergency in the community you can then send them out. That is the model of care we are looking at.

Mrs BARBARA PERRY: Do not forget that you are relating to emergency response teams as opposed to general mental health teams. Are you confusing yourself? Our response has been in relation to emergency response.

Ms LEE RHIANNON: I am trying to clarify it. You have allocated $6.85 million. You used to have teams that went into the community. We have been told that there is a big demand for them, but I am hearing, from the way you describe it, that it is like the last resort. People are sent out into the community when you cannot get them into the hospital.

Mrs BARBARA PERRY: Let us be clear: $6.8 5 million was announced in May and it is for the region.

Ms LEE RHIANNON: For the 17 regions.

Mrs BARBARA PERRY: For the whole State, that is correct. Although the funding was announced in May, the funding dollars do not come through until this financial year, which is July. We are now in October. I just want to be clear that we are talking about what we call community mental health emergency response as opposed to community mental health teams generally. I am just not clear if that is what you are talking about.

Ms LEE RHIANNON: I am getting the impression that there has been a shift in policy.

Dr MATTHEWS: No. I apologise if I gave that impression. I was talking about emergency response. There are still community mental health teams which operate and case manage patients in the community. In the last package announced by the Government, community mental health was significantly enhanced across the age bands to increase the available community staff in all areas. But for an emergency response, as opposed to general care, the emergency department is the place for assessment. That is why, as I said, we have established nine psychiatric emergency care centres. They provide the police with a place to take section 24s where the police can be certain that there will be mental health trained staff available 24/7 for an immediate handover, unless there are serious issues of dangerousness, so the police can get on with their business of policing.

Ms LEE RHIANNON: How many staff will be on each team, and how much money has been allocated for the Illawarra police?

Mrs BARBARA PERRY: The south-eastern Illawarra area health region?

Ms LEE RHIANNON: Yes, that whole region.

Dr MATTHEWS: The psychiatric emergency care centres, on average, have a staffing component of about $1.2 million. There is an additional $200,000 this year for south-eastern Illawarra, which is being committed at Wollongong. Last year there was an enhancement which was committed at St George, and next year there will be a further enhancement, which I understand will be committed at Sutherland.

Ms LEE RHIANNON: To clarify that, is the money for the emergency teams that operate as part of the psychiatric emergency centre [PEC] units, or are they mobile units that in the first instance go out into the field?

Dr MATTHEWS: No, they will be for an enhancement of the psychiatric services in the emergency department to give them an outreach capacity.

Ms LEE RHIANNON: When you first answered the question you spoke about the PEC unit at Wollongong. I understand that the mental health wards at Wollongong Hospital and Shellharbour Hospital have still not been opened.

Mrs BARBARA PERRY: Dr Matthews indicated that there is still the physical site to do in relation to Wollongong, but we already have the staff there. Whenever anyone comes into emergency care in the ordinary emergency section, the staff are assisting doctors and nurses to assess, case manage, diagnose, refer, et cetera. That is what is happening, and that is the model of care.

Dr MATTHEWS: That is correct. Ms Lee Rhiannon may also be referring to the Wollongong old person's mental health unit, which is due to open in February.

Ms LEE RHIANNON: I was going to ask about that. I realise that is a different program.

Mrs BARBARA PERRY: In relation to Shellharbour—

Dr MATTHEWS: —the subacute unit is almost complete and ready for handover.

Mrs BARBARA PERRY: The subacute unit is different to a PECC.

Ms LEE RHIANNON: With both of them, is the delay in opening because of staff shortages?

Dr MATTHEWS: No. The capital works are not quite complete but are almost, and the estimated time for the older persons unit is February. For the Shellharbour subacute unit, it is about the same.

Ms LEE RHIANNON: There has been considerable advocacy from various mental health groups in the Illawarra about restoring these mobile units. I was given an email from Angela Karooz, previously the access and service integration manager, South-east Sydney and Illawarra area mental health service. She has written to some colleagues saying, "I am looking for some quick feedback be acute crisis teams. Does anyone have information on the acute crisis teams service which do home visits on a 24-hour basis? … This question is in the context of a local lobby group trying to put pressure on the service for this type of response … We have taken the line that for safety and security reasons in the main people would be expected to contact emergency

services." Are we getting the line that these mobile mental health teams are no longer being provided for safety and security reasons? Is that concern real, or is that a line, as suggested in Ms Karooz's email?

Mrs BARBARA PERRY: I do not think either I or Dr Matthews can speak for the perception of Ms Karooz and what she has suggested there. However, over the past five years—I am proud to say this, particularly with our new directions package—we have ensured that services both in the south-east sector and everywhere else are built up for people who have emergency responses or emergency needs. That is why the PECCs are there. That is what Dr Matthews was explaining—it is just like having a heart attack. Mental health is an illness as well, and the best place to support a critical emergency of a mental health matter is in the emergency section of a hospital. We now have across our system what we call the Psychiatric Emergency Care Centre to deal with those types of emergency responses.

Ms LEE RHIANNON: From what I read that seems to be a shift away from what was previously provided. Minister, you said emergency wards are used for people with critical mental health issues. Obviously many people in community do not suffer from critical mental health but they need support. Are the mobile teams there to assist those people? It seems as though you are saying you are not providing those teams.

Dr MATTHEWS: No. I will try to be clear. Our policy is to provide mental health care and mental health support in the community. Our patients or clients have case managers to do that. Speaking as someone who has spent more than 20 years going into people's homes in emergency situations I can tell you that there is a limit to what you can actually do there. That applies to whether it is a heart attack or a mental health emergency. Where it is truly and emergency, as opposed to general care, even possibly general care where a patient is getting worse, then we believe they should come to the emergency department for a full and appropriate assessment.

The outcome of that might be that they go home again in the same way that someone with chest pain might come to the emergency department, have a cardiograph and be found not to have a heart problem and go home again. It may be that they can be recommenced on their medication but these centres allow for 24-hours, up to 72-hours care in the emergency department so an assessment can be made as to the need for admission. In many cases these days, regrettably, the situation is significantly clouded by the use of either illicit drugs or a frequently used legal drug called alcohol. It is impossible to make an assessment as to the level of mental illness until the intoxication wears of. The Psychiatric Emergency Care Centre provides an ideal place to make that assessment after the intoxicant, whatever it might be, wears off.

Ms LEE RHIANNON: I refer to the Consumer and Carer Consultative Committee [CCCC]. Are personnel or senior management obliged to attend a certain number of CCCC meetings each year?

Mrs BARBARA PERRY: Consumer carers and consumer workers within the system provide an invaluable insight into support of people who are suffering a mental illness. They make a unique contribution to improve quality of mental health service delivery because they themselves have experienced through their life some of those issues. This contribution is now universally valued. We have about 58 consumer health workers in our system at the present time. Our staff work and consult with consumer workers.

Ms LEE RHIANNON: Are they obliged to attend a certain number of CCCC meetings?

Dr MATTHEWS: It is certainly expected that managers meet with consumers on a regular basis. I do not believe there is a policy that says that they should attend X number of meetings.

Ms LEE RHIANNON: Minister, you said that CCCC meetings provide a valuable insight.

Mrs BARBARA PERRY: No, I said the consumer workers provide a valuable insight.

Ms LEE RHIANNON: Yes, I apologise. Would you agree that a valuable insight can be only be gained if a person goes to the meetings? One would have to go to a certain number of meetings to be able to benefit from that valuable insight that staff and consumers provide?

Mrs BARBARA PERRY: Do you mean the consumers themselves go to meetings or the other way around?

Ms LEE RHIANNON: You said that the committees provide a valuable insight. I assume you meant a valuable insight to workers who are delivering the services? My point is that can only be achieved if, for instance, the Director of Mental Health Services in an area actually attends the meetings?

Mrs BARBARA PERRY: I think I said that consumer workers provide a valuable insight for other people suffering a mental illness. As Dr Matthews said, I am sure that various levels of management meet with consumers usually at their workplace, I would have thought.

Ms LEE RHIANNON: Are you satisfied that since June 2007, Monica Taylor, Director of Mental Health Services in the South Eastern Sydney and Illawarra Area Health Service has attended only one of seven meetings, despite her assertion that this meeting is a peak committee to whom she reports and works with on improving service issues? Would you expect them to go to more than one in seven meetings?

Mrs BARBARA PERRY: My role as Minister is not to get down to operational matters. We do value our consumer workers in our system. I know that currently we are looking at the roles our consumer workers play and enhancement of those roles, in particular. I cannot comment on how many meetings Ms Taylor attended.

Ms LEE RHIANNON: Fair enough. I am trying to get a sense of what is required at that point of interaction. The Minister has acknowledge how important it is but feedback from the Illawarra and from other areas is a real disjunct between the staff who deliver the service and the consumers/patients and the staff in non-government organisations. What do you require?

Dr MATTHEWS: I do not know Ms Taylor, and I would not judge her by her attendance at meetings. The way we really like consumers to be engaged is to be available to talk to new admissions who are particularly distressed and to assist them by saying things like "I have been through this and it is not so bad" and the same thing with carers. We would be judging Ms Taylor on the outcomes of patients who are admitted into the units that she manages. We have a system called a Mental Health Outcome Assessment [MH-OAT] tool to judge that by, of course, capacity to meet budget. Certainly that engagement is important but to choose it as a single parameter to judge her performance would not be something that I would be doing.

Ms LEE RHIANNON: I certainly did not suggest that it was a single issue and I was not making judgment on the other aspects of work.

Mrs BARBARA PERRY: NSW Health is currently funding a New South Wales Consumer Workers Forum project to actually look at the issues of consistency in roles, conditions and support across the State for consumer workers.

Ms LEE RHIANNON: I understand that Mount Druitt, which is smack in the middle of one of the growth centres of Sydney, has the highest level of mental illness in New South Wales. I know mental health services are limited. I understand that a floor was allocated for mental health services. Would you provide an update on the commitment for the provision of that unit?

Mrs BARBARA PERRY: I am not sure what you are talking about.

Dr MATTHEWS: I am not aware of any commitment in relation to Mount Druitt.

Ms LEE RHIANNON: What do you do for mental health in Mount Druitt?

Dr MATTHEWS: We have ambulatory services at Mount Druitt. We have just commenced a HealthOne facility at Mount Druitt where there is something like more than 100 community health staff, many of whom are mental health, drug and alcohol workers at that health one working in partnership with general practice. We have some forensic services now being provided there by the forensic experts within Justice Health. In terms of admissions for those people in Mount Druitt who require admission, they would be admitted either to the unit at Blacktown Hospital or to the unit within Westmead adult hospital or the Cumberland Hospital or the Child and Adolescent Unit in Westmead kids hospital or Redbank House which is also part of that campus. There has not been a government commitment to a mental health inpatient unit at Mount Druitt in my time. There may have been one in the dim and distant past; I would have to check.

CHAIR: We now go to government members for questions.

The Hon. LYNDA VOLTZ: With regard to the emergency department teams, you said they have the ability to go outside the hospital emergency department. How does a call-out happen?

Dr MATTHEWS: Well, the enhancements giving them that capacity are new. When they were first established they were for 24/7 staffing for people who came in. We commenced with places, like St Vincent's, that had a very significant load often generated by consumption of amphetamines. Now that the capacity is being provided it will be a matter for the manager of the unit to determine priorities. This is an initiative that we particularly were interested in doing because very often the police request assistance in relation to sieges and particular issues like that which may or may not involve people who are mentally ill, but it would be the unit manager, who would generally—but not always—be a nurse, with advice from the psychiatrist potentially by telephone, and it is a matter of determining the clinical priorities at the time.

The Hon. LYNDA VOLTZ: You mentioned the police in your answer, so if the police called that would be on the advice of—

Dr MATTHEWS: Well, an example would be that the police might ring and say, "We've got a difficult situation", in a house in a particular street that is near the unit. "We believe that the person", who is holding a family member hostage, for argument's sake, "is a patient of yours. Can you provide us with some assistance?" That assistance might, in the first instance, be trying to find out who the person is, if they are known to us, and what their history might be. The police are obviously interested in past history of violence, those sorts of things, but very often it is simply a matter of providing advice to police about how to deal with people. This is, let me say, very new, so we are going to have to consider its ramifications and modify it as it evolves.

The Hon. LYNDA VOLTZ: Another point that was raised was consumer workers. I understand you are utilising the experience of mental health consumers. What support are you giving to those people?

Mrs BARBARA PERRY: As I indicated in my earlier answer, they do make an invaluable contribution to improving the quality of mental health service delivery and in turn improving the quality of life experienced by consumers. The uniqueness of the contribution stems from the varied experience they have acquired from being recipients of mental health services. They are people who have experienced the road to recovery and have recovered to a large extent. The contribution is now universally valued and actively sought as a major resource to service providers and planners in their efforts to continuously improve all aspects of mental health services, including staff and management accountability, access and quality.

Mental health consumer workers have been employed in various capacities in area health services in New South Wales for some years. They are seen as key workers in the support and advice they offer to area mental health services and to patients on a range of issues, and they are also seen as support in the sense of consumer advocacy on an individual and systemic level. There is currently estimated to be 58 consumer workers employed in New South Wales area health services across the State. These workers are both paid and voluntary and their roles may include providing peer support, individual and systems advocacy, and they also have an important role in education and research. The roles vary across area health services and they vary because they are catering for the specific needs of the local community. There is also a range of supports provided for these workers by area health services. As employees of an area health service, consumer workers are able to participate in all training courses offered by the area. They have undertaken a range of training, including advocacy, leading teams, anger management and computer skills, and supervision, peer support and counselling are also important supports that are available to consumer workers.

Since 1998 NSW Health has funded an annual statewide forum for all mental health consumer workers to provide an opportunity for them to network for peer support and development, and to provide training on specific issues. The forums are organised by the consumers themselves through an organising committee and on average about 60 people attend. One of the major benefits of the forum is the sharing of ideas and information on different models of consumer participation. Issues of particular interest to consumer workers are identified and debated, including strategies to promote and improve the consumer programs currently in place. Another important outcome of the forums is the access that less experienced consumer workers have to a concentrated wealth of knowledge from more experienced consumer workers. We know about that in any field. Funding is also being provided for a project officer to support these forums and also to support a consumer workers committee. I have talked about the fact that NSW Health has funded the consumer workers forum project looking at the issues of consistency in roles, conditions and support for them across the State, and the aim of the

project is to conduct a review of the roles, the job description of mental health consumer workers, and to make recommendations to NSW Health on defining the roles performed and the issues around reporting, support, supervision, awards and training.

A report from the project is currently being developed and I am hoping that it will be finalised some time next year. Also a detailed 12-month project plan for implementation of approved recommendations after that will be developed in consultation with consumer workers themselves. I understand that some of the initiatives being considered at this stage include development of standardised position descriptions, a consumer worker code of conduct, and also consistent training and support mechanisms for consumer workers. I am also advised that consideration is being given to moving the consumer workers project officer to the supervision and support of the New South Wales Consumer Advisory Group. That would provide good synergies and support because the advisory group is state wide; it is an incorporated NGO; it provides a mechanism for mental health consumer participation into policy and service development; and it also acts as a bridge between State and Federal Governments and mental health consumers.

An essential part of its role is to encourage and help develop consumer input concerning mental health service provision and particularly in decision making at all levels. This important initiative to improve support for consumer workers will complement the current existing structures and processes for consumer participation in mental health services in New South Wales. Included in that is the NSW Health partners in health framework, and that is about improving consistency and coordination of consumer and community participation in Health across New South Wales; and the consumers' perceptions and experiences of mental health services project, which is about adding a stronger consumer perspective to considerations of quality service delivery and to planning and developing better services for the future. The community consultative committees will facilitate meaningful participation in the planning, delivery and evaluation of mental health services in New South Wales by consumers, carers, non-government organisations and the community. The consumer-run recovery services, which are run by consumers for consumers to share the expertise gained from their lived experiences of mental illness or disorder and their recovery journeys, will be a good forum.

Consumer workers do provide a valuable support role, not only for patients but also for families generally. When someone comes into a situation like this they may not have experienced it with one of their loved ones before. I would have thought it was one of the most important aspects for a family to understand what is going on with their loved one, as well as the patients understanding what is going on with themselves as far as they can. I would like to take the opportunity in this forum to acknowledge the incredible contribution that our State's consumer workers make.

The Hon. LYNDA VOLTZ: I just want to ask a couple more questions on recovery departments. Dr Matthews, I just want to get clear in my head how a person who is in crisis and is not aware that they are in crisis presents to an emergency department?

Dr MATTHEWS: There are a number of ways. Firstly, it may simply be a self-presentation. That is common. They may be brought there by a relative, a carer or a friend. They may be brought there by police under section 24 of the Mental Health Act because the police have formed the view that they are behaving in an unusual manner and they may be mentally disordered. As the sites for the psychiatric emergency care centres become better known and it is known that at a particular hospital there are 24-hours a day seven days a week mental health staff, more people will gravitate to those sites. A national call centre is about to be introduced in New South Wales with a single number to get advice on any health matter, so the service directory for that national telephone number will of course include the site and availability of psychiatric emergency care centres. There are a number of ways in which people can get there.

One of the overwhelming pieces of evidence that showed us we needed to do this was that when we looked at admissions to a place such as Caritas the majority of them were self-presenting to the emergency department in any case. We needed a resource there to care for them. We also found that the Caritas admissions were splitting into two kinds: There were the traditional 14- to 21-day lengths of stay people who were mentally ill but there was an increasing cohort with a three-day length of stay who were suffering from amphetamine psychosis with no underlying mental illness. They may be working towards one if they keep using the amphetamines, but they tended to have three-day lengths of stay. The PECC at St Vincent's has meant that the majority of those admissions no longer go to Caritas. They are dealt with in the emergency department and referred back to practitioners near where they live. Each area health service also has a 24/7 intake line where consumers, family, carers and concerned citizens can ring and get access to care, which might be the next day if it is not urgent, or in some cases may mean their being directed to the PECC. So there are many ways.

The only other thing I am a little troubled about is I would like to make it clear that people with mental illness do not commit crime at a greater rate than the general community; in fact, at a somewhat lesser rate than the general community. I really want my remarks about the police etc to be taken in context. Mental illness is not a matter of criminality but sometimes people suffering from mental illness exhibit behaviours that are challenging.

Ms LEE RHIANNON: But Dr Matthews, considering the high percentage in our jails—

CHAIR: Order! Ms Rhiannon, it is not your time for questions. In fact we have reached the conclusion of time for this hearing. I thank the Minister for coming along today, and Dr Matthews and Mr McGrath and other staff and advisers who were here.

(The witnesses withdrew)

The Committee proceeded to deliberate.