LEGISLATIVE COUNCIL

PORTFOLIO COMMITTEE NO. 2

Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

Report 64

2

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Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

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Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

"June 2024"

Chair: Dr Amanda Cohn MLC

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Terms of reference

That Portfolio Committee No. 2 – Health inquire into and report on the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales, and in particular:

(a) equity of access to outpatient mental health services

(b) navigation of outpatient and community mental health services from the perspectives of patients and carers

(c) capacity of State and other community mental health services, including in rural, regional and remote New South Wales

(d) integration between physical and mental health services, and between mental health services and providers

(e) appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, counsellors, social workers, allied health professionals and peer workers

(f) the use of Community Treatment Orders under the *Mental Health Act 2007*

(g) benefits and risks of online and telehealth services

(h) accessibility and cultural safety of mental health services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability

(i) alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER)

(j) any other related matter.

The terms of reference for the inquiry were self-referred by the committee on 12 July 2023.[1]

[1] *Minutes*, NSW Legislative Council, 1 August 2023, p 294.

Committee details

Committee members		
Dr Amanda Cohn MLC	The Greens	*Chair*
Hon Susan Carter MLC	Liberal Party	*Deputy Chair*
Hon Mark Buttigieg MLC	Australian Labor Party	
Hon Greg Donnelly MLC	Australian Labor Party	
Ms Cate Faehrmann MLC	The Greens	
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Hon Bronnie Taylor MLC	The Nationals	

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Chair's foreword

'If someone has cancer, we don't wait for it to get to Stage 4 before admitting them to hospital for one course of treatment and then discharging them as soon as possible with no follow-up support. We wouldn't accept this for any other illness - but it's what's happening in mental health.'

This is one of many compelling arguments made during this inquiry for significant reform in the way mental health care is delivered.

On behalf of the committee, I extend our deepest gratitude to all who contributed to this inquiry. Thank you for sharing your experiences of the mental health system – especially to those who have lived with mental ill-health, as well as families and carers. We recognise that in retelling their stories, many have relived painful memories and trauma in order to advocate for change. The insights have been invaluable to inform this report and its findings and recommendations.

We also acknowledge the dedication of those working on the front line of the mental health crisis. This includes health workers, the community and NGO sector, and those working in the justice system and emergency services who spoke about the difficult choices they are forced to make every day. Thank you for sharing your time, experience and expertise with the committee, and for your hard work delivering mental health care every day in extraordinary circumstances. We recognise and appreciate the investment of time and energy into advocating for your colleagues and the people you care for, on top of already unacceptable workloads.

It is clear that mental health care in NSW has become reactive and crisis-driven, and is letting down people seeking help, carers, as well as those working within the mental health sector. This report confirms what advocates have been saying for a long time – mental health care is chronically and severely underfunded and fragmented. Immediate action is needed to make sure people can access the care they deserve.

The committee therefore made 39 recommendations to improve community and outpatient mental health care in NSW.

These include a key recommendation for an immediate increase in funding to mental health care, with particular investment in community-based mental health services. Focusing on early and effective mental health care within the community, as well as improved integration and navigation, will provide better outcomes for the people of NSW, and reduce the burden on emergency and crisis care. Sustainable staffing will require better remuneration and support for mental health clinicians.

There are many interconnected factors that contribute to a person's mental health. Improving mental health requires a holistic approach that considers all aspects of a person's life and the society, community and environment in which they live.

We heard about the specific unmet needs of priority populations including young people, older people, First Nations people, LGBTQIA+ people, people in rural and remote areas, culturally and linguistically diverse people, and people with a disability.

We heard clearly that the attendance of police in mental health emergencies can escalate emotional and psychological distress, and has been harmful in a significant number of cases. A broad range of stakeholders including police representatives support a health-led approach to mental health emergencies.

There is much work to be done across many areas of the NSW mental health system, but it is clear that there isn't a moment to waste before significant reform is implemented. Moving forward, the question shouldn't be whether or not the NSW government can afford to implement the transformative change that is needed – but what will the cost be to us all if they don't, and how can revenue be raised to fund what is required?

I would like to thank committee members for their considered engagement throughout the inquiry, and the committee secretariat for their hard work and capable assistance, in particular in the context of the sensitive content of this inquiry.

Dr Amanda Cohn BA BMed MD MPH MIPH FRACGP MLC
Committee Chair

The below resources are available to those who may feel distressed as a result of this report's sensitive content and themes:

Seeking support
If you require further support, please contact one of the organisations listed below:

Lifeline 13 11 14 (24/7) or text 0477 131 114. Lifeline is a free 24/7 telephone crisis support service.
Mental Health Line 1800 011 511. Mental Health Line is a NSW 24/7 statewide phone services which links people with NSW mental health services.
Kids Helpline 1800 55 1800. Kids Helpline provides free confidential counselling by phone or webchat for 12-25 year olds.
13Yarn 13 92 76. 13Yarn is a free 24/7 Aboriginal & Torres Strait Islanders crisis support line.
QLife 1800 184 527. QLife provides phone or webchat peer support from 3pm-midnight for LGBTQIA+ people.

To speak to the 24/7 NSW **Mental Health Line** in a language other than English, call the Translating and Interpreting Service on 131 450, state your preferred language, and ask for the service to be phoned on 1800 011 511. The Transcultural Mental Health Line can also assist with information, referral and connection to services on 1800 648 911.

Findings

Recommendations

Conduct of inquiry

The terms of reference for the inquiry were self-referred by the committee on 12 July 2023.

The committee received 165 submissions and six supplementary submissions.

The committee held six public hearings: five at Parliament House in Sydney and one in Lismore.

The committee also conducted site visits to Lismore Safe Haven on 13 February 2024, and to Uniting Housing and Accommodation Support Initiative Plus (HASI+) Western Sydney on 14 February 2024.

Inquiry related documents are available on the committee's website, including submissions, hearing transcripts, tabled documents and answers to questions on notice.

Chapter 1 Background

This chapter provides an overview of the mental health care system in New South Wales and care options for those experiencing mental ill health seeking support. It commences by outlining the different roles and responsibilities of the Australian Government, the New South Wales Government and the private and community sector. It then briefly explores mental health services available to a person in New South Wales including general practitioners, community mental health services, specialist mental health services, community managed organisations, telephone and online support, and emergency and inpatient hospital care.

The provision of mental health care in New South Wales

1.1 The operation of Australia's mental health system is a shared responsibility with services being both delivered and funded by the Australian Government, state and territory governments and the private and non-government sectors.[2] The multiple care options available across these domains are outlined in detail below.

The Australian Government

1.2 The Australian Government funds a range of mental health-related services including:

- consultations with psychiatrists, general practitioners (GPs), psychologists, mental health accredited social workers and other allied health practitioners through the Medicare Benefits Schedule (MBS) and Better Access initiative[3],
- support for some psychosocial disabilities through the National Disability Insurance Scheme, (NDIS)[4]
- providing access to subsidised mental health-related medications under the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS)[5]
- other primary mental health services through the Primary Health Networks.[6]

2 Australian Institute of Health and Welfare – Australia's Mental Health System (October 2023), https://www.aihw.gov.au/mental-health/overview/australias-mental-health-services

3 Australian Institute of Health and Welfare – Australia's Mental Health System (October 2023), https://www.aihw.gov.au/mental-health/overview/australias-mental-health-services

4 Australian Institute of Health and Welfare – Australia's Mental Health System (October 2023), https://www.aihw.gov.au/mental-health/overview/australias-mental-health-services

5 Australian Institute of Health and Welfare – Mental Health Services (February 2024) https://www.aihw.gov.au/mental-health/overview/mental-health-services

6 Australian Institute of Health and Welfare – Australia's Mental Health System (October 2023), https://www.aihw.gov.au/mental-health/overview/australias-mental-health-services

1.3 The Australian Government also funds a variety of programs and services which provide essential support for people with mental illness, such as income support, social and community support, disability services, workforce participation programs, and housing.[7]

The NSW Government

1.4 State and territory governments provide specialist mental health services through public hospitals, including emergency departments (EDs) and mental health inpatient care, as well as through community mental health care services.[8]

1.5 Core specialist clinical services provided in NSW include:

- acute assessment and treatment services, and continuing care and rehabilitation services, which are provided in both hospital and community settings,
- specialist clinical services in inpatient and community settings for children and young people, older people, and forensic patients.[9]

1.6 Public-funded specialised community mental health care services in New South Wales are delivered through a network of 15 Local Health Districts (LHDs), three Specialty Health Networks (SHNs), and through NSW Health funded grants to non-government affiliated health organisations.[10]

1.7 Local governments also contribute significantly to the health system, providing a range of environmental and public health services, community-based health, and home care services.[11]

1.8 Under the National Mental Health and Suicide Prevention Agreement, Australian and state and territory governments also have a shared responsibility to reduce the rate of suicide toward zero, as well as to ensure the sustainability and enhance the services of the Australian mental health and suicide prevention system.

1.9 In addition to specialised services, both the Australian Government and NSW Government support crisis and information services, such as Lifeline, Kids Helpline, and Beyond Blue.[12]

Private and community sectors

1.10 The private and community sectors also play an important role in the mental health system by providing care and delivering services.

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7 Australian Institute of Health and Welfare – Australia's Mental Health System (October 2023), https://www.aihw.gov.au/mental-health/overview/australias-mental-health-services

8 Submission 148, NSW Health, p 7.

9 Submission 148, NSW Health, p 7.

10 Submission 148, NSW Health, p 4.

11 Submission 148, NSW Health, p 7.

12 Submission 148, NSW Health, p 7.

1.11 Private sector services include admitted patient care in private psychiatric hospitals and private services provided by psychiatrists, psychologists and other allied health professionals, and other mental health professionals including counsellors.[13]

1.12 Community and non-government organisations (both not-for-profit and for-profit) receive a combination of government and private funding to deliver services. In general, these services focus on 'providing wellbeing programs, support and assistance to people who live with a mental illness rather than the assessment, diagnostic and treatment tasks undertaken by clinically-focused services'.[14]

Pathways to mental health care in New South Wales

1.13 A variety of terms are used across the mental health and psychosocial disability sectors to refer to a person living with a mental health condition,[15] or experiencing 'mental ill health'.[16] In many service environments 'person', 'client' or 'service user' is used, while others prefer 'consumer', 'person with lived experience' or 'people who access mental health services' or 'participant'.[17] This report uses a combination of these terms, based on the stakeholder evidence.

1.14 NSW Health defines a mental illness as 'a clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional, or social abilities'[18]. This definition covers a range of conditions including anxiety disorders, mood disorders, psychotic disorders, and substance use disorders.[19] It is noted that a person 'does not need to meet the criteria for a mental illness or mental disorder to be negatively affected by their mental health.'[20]

1.15 It is estimated that 1 in 5 Australians experience a mental illness in any given year, most of which will be mild (15 per cent) or moderate (7 per cent).[21] In New South Wales, it is estimated that 5 per cent, or 403,606 people have a severe mental illness, of which 302,706 people have episodic mental illness and 100,902 have persistent mental illness.[22]

13 Australian Institute of Health and Welfare – Australia's Mental Health System (October 2023), https://www.aihw.gov.au/mental-health/overview/australias-mental-health-services

14 Australian Institute of Health and Welfare – Australia's Mental Health System (October 2023), https://www.aihw.gov.au/mental-health/overview/australias-mental-health-services

15 Mental Health Coordinating Council, *Recovery Oriented Language Guide – Words Matter*, (2022), https://mhcc.org.au/wp-content/uploads/2022/10/Recovery-Oriented-Language-Guide-3rd-edition.pdf

16 Submission 148, NSW Health, p 4.

17 Mental Health Coordinating Council, *Recovery Oriented Language Guide – Words Matter*, (2022), https://mhcc.org.au/wp-content/uploads/2022/10/Recovery-Oriented-Language-Guide-3rd-edition.pdf

18 Submission 148, NSW Health, p 4.

19 Submission 148, NSW Health, p 4.

20 Submission 148, NSW Health, p 4.

21 Submission 148, NSW Health, p 4.

22 Submission 148, NSW Health, p 4.

1.16 Mental ill health is also linked to physical illness, with individuals who have a serious mental illness having significantly shorter life expectancies than the general population.[23]

1.17 Mental health impacts and is impacted by multiple biological and socioeconomic factors, including a person's access to services, living conditions, and employment status.[24] A person's mental health can impact all aspects of their life and affects not only the individual but also their families and carers.[25]

1.18 People seeking mental health care may need to access different support services at different times. There are various pathways a person can take to access services and receive mental health care and may depend on the severity and acuity of their illness. These pathways are explored in turn below.

General practitioners

1.19 In most cases, people seeking mental health care first see a general practitioner (GP).[26] A GP can diagnose and treat some mental health conditions themselves, as well as refer people to relevant services or other mental health professionals if needed.[27] Whilst a referral from a doctor is not always required in order for a person to see a mental health professional such as a psychiatrist, psychologist, mental health accredited social worker, or occupational therapist, a referral may enable a partial Medicare rebate for services in addition to communicating clinically relevant information.[28]

1.20 Some general practices also work with mental health teams to provide care within the community.[29]

1.21 For people living in regional, rural or remote New South Wales, a general practice may be one of the few places to offer a mental health service.[30]

Community mental health services

1.22 People experiencing mental ill health can also be treated in community and hospital-based outpatient care services. Community mental health care refers to 'government-funded and

23 Submission 148, NSW Health, p 9.

24 Submission 148, NSW Health, p 4.

25 Submission 148, NSW Health, p 4.

26 Submission 148, NSW Health, p 7.

27 Healthdirect, *Australian mental health services* (August 2022) https://www.healthdirect.gov.au/australian-mental-health-services

28 Healthdirect, *Australian mental health services* (August 2022) https://www.healthdirect.gov.au/australian-mental-health-services

29 Healthdirect, *Australian mental health services* (August 2022) https://www.healthdirect.gov.au/australian-mental-health-services

30 Healthdirect, *Australian mental health services* (August 2022) https://www.healthdirect.gov.au/australian-mental-health-services

operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services'.[31]

1.23 Community mental health services can assess people experiencing mental health problems and give them support via the following:

- Hospital outpatient psychiatric services,
- Non-hospital community mental health care services such as crisis or mobile assessment and treatment services,
- Day programs,
- Outreach services,
- Consultation/liaison services.[32]

1.24 In New South Wales, NSW Health Community Mental Health Services are delivered by LHDs and SHNs, often separated from a hospital campus, in the commercial or community hub of the locality they serve.[33] Generally these services are organised around serving one or more local government areas (depending on the catchment population).[34] Community mental health services can be provided in several settings including, hospital outpatient clinics, community mental health centres or clinics, in a person's home and online or by telephone.[35]

1.25 Community Mental Health Services are declared facilities under the *Mental Health Act* 2007, which means that individuals on a Community Treatment Order (CTO) can be treated there.[36] The use of CTOs in NSW is discussed in more detail in Chapter 5.

1.26 The providers of these services, Local Community Mental Health Teams (CMHT) are multidisciplinary and include a range of mental health professionals, including:

- psychiatrists
- psychologists
- mental health nurses
- occupational therapists
- social workers
- peer workers.[37]

31 Submission 148, NSW Health, p 6

32 Submission 148, NSW Health, p 6.

33 Submission 148, NSW Health, p 8.

34 Submission 148, NSW Health, p 8.

35 Healthdirect, *Australian mental health services* (August 2022) https://www.healthdirect.gov.au/australian-mental-health-services

36 Submission 148, NSW Health, p 8.

37 Healthdirect, *Australian mental health services* (August 2022) https://www.healthdirect.gov.au/australian-mental-health-services

1.27 Generally, CHMTs operate in smaller groups of clinicians who manage intake, perform initial assessments, care coordination for individuals with complex needs and work with long-term consumers.[38]

1.28 Community mental health services can also have specialised teams who deliver services specifically for young people, children and families, adults and older people, as well as people:

- experiencing acute episodes
- needing recovery orientated care
- with complex needs, for example homelessness
- experiencing early psychosis.[39]

1.29 There are many ways a person may come to access community mental health services. A person may be referred to a CMHT for assessment by a GP, emergency department, or private practitioners. They could also be referred to services once discharged from a mental health inpatient unit or can self-refer.[40]

Services provided by community managed organisations

1.30 Services may also be delivered by community-managed organisations (non-government, not-for-profit) to assist people living with mental health conditions to live well in the community and face everyday challenges, including support with:

- Accommodation support and outreach
- Employment and education
- Leisure and recreation
- Family and carer support
- Self-help and peer support
- Helpline and counselling services
- Promotion, information and advocacy.[41]

1.31 Many community-managed organisations focus on providing psychosocial support and rehabilitation services to maximise recovery for those living with a mental health condition. These services are delivered in community settings to support people to live well in the community, avoid crises and stay out of hospital.[42]

38 Submission 148, NSW Health, p 8.

39 Healthdirect, *Australian mental health services* (August 2022) https://www.healthdirect.gov.au/australian-mental-health-services

40 Submission 148, NSW Health, p 8.

41 Healthdirect, *Australian mental health services* (August 2022) https://www.healthdirect.gov.au/australian-mental-health-services

42 Mental Health Coordinating Council, *About the sector,* https://mhcc.org.au/who-we-are/about-the-sector.

Specialist mental health services

1.32 There are some mental health services that specialise in certain mental health conditions or are aimed at specific groups of people.

1.33 Examples include services for eating disorders, substance use disorders, personality disorders and postnatal disorders. Some support priority populations such as Aboriginal and Torres Strait Islander peoples, young people, LGBTQIA+ people, war veterans, refugees, older people and families.[43]

Telephone and online mental health support services

1.34 For people experiencing mental ill-health who are unable to access face-to-face services or who prefer to remain anonymous, as well as people seeking initial information for themselves or others, there are many non-government organisations that offer free or low-cost mental health advice, counselling and online programs.[44] These include Lifeline, Kids Helpline, Beyond Blue and ReachOut.

1.35 In New South Wales, the NSW Mental Health Line is NSW Health's Statewide telephone service that provides 24/7 access to trained mental health professionals who offer mental health advice and can make referrals to NSW Health mental health services.[45]

1.36 Many healthcare professionals now also offer video and telephone consultations.[46]

Emergency mental health care

1.37 In more severe instances of mental illness or psychological distress, a person may seek crisis and emergency care via the following pathways:

- Helplines
- Mental health clinical triage services
- Attendance in the community by a Crisis Assessment and Treatment Team
- Presentation to a hospital emergency department
- Police and Ambulance Services.[47]

Responses to mental health crises, including presentations to hospital emergency departments and the involvement of first responders such as police or ambulance services are discussed in further detail in Chapter 4.

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43 Healthdirect, *Australian mental health services* (August 2022), https://www.healthdirect.gov.au/australian-mental-health-services.

44 Healthdirect, *Australian mental health services* (August 2022), https://www.healthdirect.gov.au/australian-mental-health-services.

45 Submission 148, NSW Health, p 7.

46 Healthdirect, *Australian mental health services* (August 2022), https://www.healthdirect.gov.au/australian-mental-health-services.

47 Submission 148, NSW Health, p 7.

Inpatient hospital care

1.38 Should a person need to stay in hospital for mental health care and treatment, they may stay in a psychiatric unit, which are available in most major public hospitals.[48] There are also specialist psychiatric hospitals (both public and private) where a person can stay for long periods and receive care from a range of specialist mental health professionals. Often a person is admitted to a public psychiatric facility through the emergency department, admissions unit or through a community mental health team.

1.39 In some cases, a person may need to stay at a mental health unit by law if it has been determined that they are a risk of serious harm to themselves or others.[49] After the person's admission to a mental health unit, a doctor must make the case to the Mental Health Review Tribunal to extend their stay and the person can legally object.[50]

48 Healthdirect, *Australian mental health services* (August 2022), https://www.healthdirect.gov.au/australian-mental-health-services.

49 *Mental Health Act 2007,* s 14.

50 Healthdirect, *Australian mental health services* (August 2022), https://www.healthdirect.gov.au/australian-mental-health-services.

Chapter 2 Challenges facing consumers and carers

This chapter provides an overview of the challenges facing individuals with lived experience and carers in the mental health care system in New South Wales. The main challenges explored include equity of access to, and navigation of, outpatient and community health services. This chapter also examines the key risks and benefits of online and telehealth mental health services.

Equity of access

2.1 People experiencing mental ill health often cannot access the mental health services that are right for them. This can be for a variety of reasons including that services are not available to them, they do not know about them, or their location or cost means they are inaccessible. Cultural safety is an important component of accessibility for a number of communities including First Nations people, people who are culturally and linguistically diverse, LGBTQIA+ people, and young people. A person's family, friends or carer may also experience similar challenges when supporting someone through their mental health journey.

2.2 These challenges can be further compounded by other factors such the acuity of the condition and whether a person has any comorbidities, and the impact of social determinants as well as financial barriers related to mental health care. These issues are further explored in the section below.

Social determinants of mental ill health

2.3 The committee recognises, as highlighted by a number of submissions, the social and environmental factors which can influence and impact a person's health and health equity. Social factors, collectively termed 'social determinants of health', include but are not limited to housing,[51] disability, cultural or linguistic background, literacy and health literacy, gender,[52] sexuality,[53] socio-economic status,[54] and living in a regional or remote area.[55]

2.4 The COVID-19 pandemic combined with concerns about climate change and the increasing cost of living, were also recognised as having negative impacts on mental health.[56]

51 Submission 138, Black Dog Institute, p 21.

52 Submission 38, ReachOut, p 14.

53 Submission 55, Sydney Bi+ Network, p 4.

54 Submission 77, Western Sydney Health Alliance, pp 4-5.

55 Submission 138, Black Dog Institute, p 15; Submission 44, RACGP Rural, p 2.

56 See for example; Evidence, Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute, 17 November, p 4; Submission 104, Australasian College of Paramedicine, pp 1, 4; Evidence, Mr Simon Dodd, Head of Workforce Planning and Development, Headspace, 17 November 2023, p 19; Evidence, Ms Jennifer Parke, Head of Operations, Human Nature, 13 February 2024, p 11; Evidence, Mx Amber Loomis, President, Sydney Bi+ Network, 22 September 2023, p 22.

2.5 The committee heard in depth about the increasing impact of natural disasters, particularly the recent bushfires and floods, on mental health.[57] During its regional hearing in Lismore on 13 February 2024, Mr Andy Hamilton, Therapeutic Lead and Founder, Human Nature, a youth mental health organisation in the Far North Coast, said that the aftermath of the 2017 and 2022 floods in the Northern Rivers had a significant impact on young people's development and that there will likely be a great need for services and support for these young people in the future.[58] At a hearing in Sydney, Dr Kylie Coventry, cited a studied that showed that natural disasters, such as the recent floods in New South Wales, can also have a significant effect on the mental health of clinicians and support staff who live and work in an affected area:

> [The study] focused on the impact of natural disasters on psychologists, particularly those who live and work in the communities that have been affected by the recent fires and floods in New South Wales, and the impact that that has on them in terms of their own personal lives but also in terms of their professional lives in trying to support the community they live in.[59]

2.6 Ms Sonja Habernicht, Trauma Counsellor/Psychologist, Women's Outreach Trauma Health Service, Northern Rivers Women and Children's Service, made similar observations about the compounding effects of the recent floods on the mental health of the clinical workforce, noting that 'a huge chunk of the workforce in Lismore and Northern Rivers has been flood affected privately and they are going through these stressors for two years now alongside their work'.[60]

2.7 Several stakeholders argued that addressing equity and accessibility to outpatient and community mental health care requires an approach which recognises and considers these social determinants of health.[61] For example, the Western Sydney Health Alliance said that 'it is essential to acknowledge and address existing deficiencies and equity of access in mental health.'[62] Ms Kate O'Brien, Member, Australian Association of Social Workers observed that the 'unique' lens social workers have often allowed them to see all of the factors contributing to their mental ill health, something she saw as very important to tailoring the support provided:

> [S]eeing someone as a whole person and seeing them within the context that they exist is extremely important. I think that's something unique to the social worker lens and

57 See for example; Evidence, Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute, 17 November 2023, p 14; Evidence, Mr Simon Dodd, Head of Workforce Planning and Development, headspace, 17 November 2023, p 20; Evidence, Ms Catherine Lourey, Commissioner, Mental Health Commission of New South Wales, 17 November 2023, p 30.

58 Evidence, Mr Andy Hamilton, Therapeutic Lead and Founder, Human Nature, 13 February 2024, pp 10-11.

59 Evidence, Dr Kylie Coventry, Head of Policy, Australian Psychological Society, 16 October 2023, pp 33-4.

60 Evidence, Ms Sonja Habernicht, Trauma Counsellor/Psychologist, Women's Outreach Trauma Health Service, Northern Rivers Women and Children's Service, 13 February 2024, p 4.

61 See for example; Submission 39, Mental Health Coordinating Council, p 18; Submission 40, Marathon Health, p 3; Evidence, Ms Rebecca Grasso, Chair, Western Sydney Health Alliance, 15 February 2023, p 57; Evidence, Ms Katie Thorburn, Policy Manager, Mental Health Carers NSW, 22 September 2023, p 2; Evidence, Ms Rachel Laidler, Policy Officer, Mental Health Carers NSW, 22 September 2023, p 6; Submission 77, Western Sydney Health Alliance, p 1, 10 and 16; Evidence, Mr Ben Bartlett, Director of Government Relations and Communications, ReachOut, 22 September 2023, p 40.

62 Submission 77, Western Sydney Health Alliance, p 4.

> approach to mental health—not simply pathologising or seeing someone within a diagnoses, but also seeing them in their context…I think in terms of understanding actually what's happening for a person, their culture, their lived experiences, their gender, their ability, their socio-economic status—all of these things are extremely important and inform and shape those social determinants of health.[63]

2.8 Similarly, Lifeline endorsed the position that a person experiencing mental ill health should have access to the services they need, regardless of a person's social, economic or environmental conditions.[64] That is, they argued that it is important to ensure equity of access to services for those whose experiences may have predisposed them to an increased risk of mental ill health.

Missing middle

2.9 Stakeholders also stressed the importance of addressing the gap in the mental health care system for people with moderate to severe mental health concerns, colloquially referred to in the sector as the 'missing middle'.[65]

2.10 Stakeholders referred to consumers in the 'missing middle' as those that are moderately unwell, who require more intensive or specialised care than that provided in primary care or self-directed online services but who are not severe enough to meet the criteria for more specialised support including public community mental health services.[66]

2.11 The Black Dog Institute attributed the 'missing middle' to the gap in funding between federal and state services. In their written submission, the Black Dog Institute remarked that state-funded and federal-funded services exist to theoretically, meet the needs of all people across the mental health spectrum. Generally, the Australian Government funds a range of mental health services, which are largely catered to more mild-to-moderate cases, while State-funded services, such as community mental health service teams, acute units and emergency departments, often cater to the more moderate-to-severe and complex cases.[67]

2.12 While the coverage of mental health care services may appear comprehensive, there remain significant gaps in practice for those with moderate to severe mental health issues.[68] For

63 Evidence, Ms Kate O'Brien, Member, Australian Association of Social Workers, 15 February 2024, p 43.

64 Submission 25, Lifeline, p 5.

65 Evidence, Dr Angelo Virgona, Chair, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists, 16 October 2023, p 12.

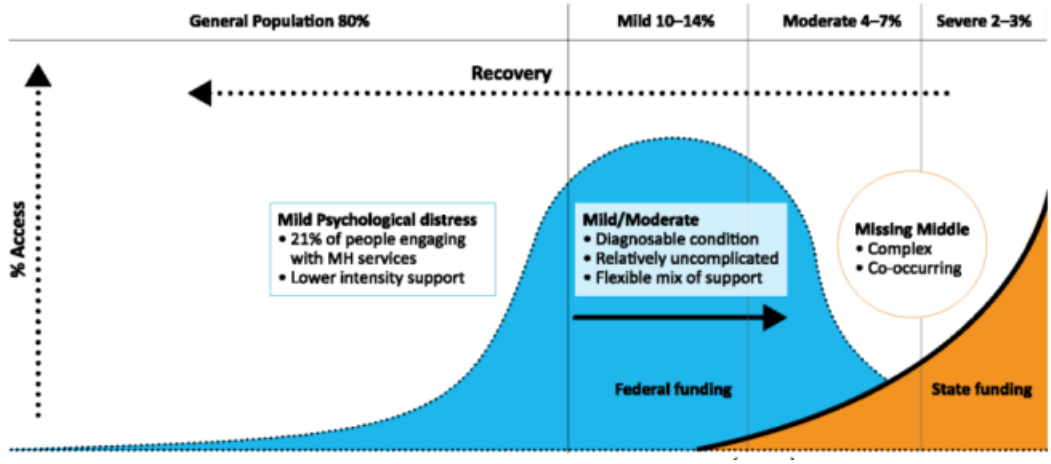
66 See for example; Evidence, Ms Catherine Lourey, Commissioner, Mental Health Commission of NSW, 17 November 2023, p 31; Evidence, Ms Rachel Laidler, Policy Officer, Mental Health Carers NSW, 22 September, p 7; Submission 146, New South Wales Nurses and Midwives' Association, p 5; Submission 40, Marathon health, p 3; Evidence, Dr Vicki Mattiazzo, Deputy Chair, RACGP Rural Faculty, Royal Australian College of General Practitioners Rural, 16 October 2023, p 21; Submission 38, ReachOut Australia, p 5.

67 Submission 138, Black Dog Institute, p 6.

68 Submission 138, Black Dog Institute, p 6.

example, there may be services which exist, but they have become inaccessible due to cost or long wait times.[69] This is highlighted in Figure 1 below.

Figure 1 The Missing middle



Submission 138, Black Dog Institute, p 6.

2.13

2.14 In the context of young people, Barnardos reported that while many young people benefit from receiving services from headspace, referrals are frequently declined because the young person is self-harming, experiencing suicidal ideation, are victims of sexual assault or are experiencing eating disorders, and are therefore no longer considered eligible for early intervention.[70] Barnados explained that while these clients would be considered too complex for headspace, they are often considered *not-complex-enough* for services like the NSW Government's Child and Adolescent Mental Health Services. When referrals are declined from both these services there are few other options for young people, leaving many young people in a cycle where they are repeatedly entering hospital emergency services for crisis treatment.[71]

Other barriers to accessing mental health care

2.15 Throughout the inquiry, the committee heard that too many people in NSW are missing out on mental health care because it is too expensive, too far away, or the right type of care for a particular condition is not available.[72]

69 See for example; Evidence, Ms Tara Hunter, Director, Clinical and Client Services, Full Stop Australia, 15 February 2024, p 4; Submission 85, Sharon Grocott, p 1; Submission 134, Health Services Union – NSW ACT QLD, p 6; Submission 136, BrainStorm Mid North Coast, p 6.

70 Submission 43, Barnados Australia, p 3.

71 Submission 43, Barnados Australia, p 3.

72 See for example, Submission 58, NSW ACT PHN Mental Health Network, p 7. Submission 64, The Royal Australian College of General Practitioners, p 2, Submission 67, BEING Mental Health Consumers, p 5, Submission 35, Australian Association of Psychologists Inc, p 2.

2.16 In this regard, stakeholders noted that these issues are of particular concern for people who have experienced trauma as the combination of cost barriers, lengthy wait lists, and a shortage of care coordinators can exacerbate complex mental health issues.[73]

2.17 Stakeholders highlighted that people from priority populations, including culturally and linguistically diverse people, First Nations people, LQBTQIA+, children, young people, and those in regional and remote areas, confront additional barriers such as cultural insensitivity, language barriers, and geographical limitations that further restrict their access to vital mental health support.[74]

Long waiting periods

2.18 In locations where mental health services are available, it can also be difficult, or in some cases impossible, for people in need to access appropriate services due to long waiting periods, excessively stringent eligibility requirements, or high out of pocket costs.[75]

2.19 As a result, some people do not seek care, or are not able to access care for mental health issues, leaving them to wait until their condition deteriorates to the point that need to seek assistance in emergency departments (EDs), an environment that may amplify distress rather than reduce it. The impacts on consumers presenting to emergency departments is discussed further in Chapter 4.

2.20 A number of the stories provided to the committee by members of the community on these issues are included below. Many stakeholders detailed their challenges with accessing mental health care, particularly with the cost and availability of care:

- 'There are less psychiatrists in rural areas compared to Metro areas. Waiting lists can be up to one year – this is unacceptable. There are fewer psychologists and the gap fee after the GP MH Care Plan is prohibitive for many (up to $100 gap). Most GPs in rural areas do not bulk bill, so even getting a referral costs $38. If you are on a Centrelink payment these fees act as a deterrent to seeking help. It is not surprising that people on low earnings have poorer mental health.'[76]
- 'I have been diagnosed as anxious and depressed for years. I have been unable to have a care plan or team as it has always been far too costly and I'm too old for free youth services.'[77]

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73 See for example, Submission 155, Full Stop Australia, p 7; Submission 58, NSW ACT PHN Mental Health Network, p 7; Submission 106, Dietitians Australia, p 3; Submission 80, Australian Medical Association (NSW) Ltd, p 7; Submission 92, Ms Lynne Jennings, p 2; Submission 74, Youth Action, p 22; Submission 114, Name Suppressed, p 8; Evidence, Mr Craig Parsons, General Manager, Partnerships & Innovation, Sydney North PHN and Chair, NSW/ ACT Mental Health Network, 17 November 2023, p 37; Submission 165, Queer Family, p 3.

74 Submission 155, Full Stop Australia, pp 6-7.

75 See for example, Submission 16, Name Suppressed, p 1; Submission 41, ACON, p 6; Submission 43, Barnados Australia, p 5; Submission 68, HealthWISE, p 5.

76 Submission 3, Name Suppressed, p 1.

77 Submission 16, Name Suppressed, p 1.

- '[Equity of access is] woefully inadequate. I'm on a waitlist and it's been more than two years!'[78]
- 'People getting discharged from hospital are seen first, and those with GP referrals less so. Depending on the capacity of the local mental health service, some services won't see people without a diagnosed mental illness or won't see people with a borderline personality disorder diagnosis. Too many people are falling through the gaps.'[79]

2.21 These challenges can lead to delayed access to mental health care, which in turn may result in the following:

- prolonged distress,
- deterioration of symptoms,
- missed opportunities to mitigate against harm and reduce suicide risk,
- prolonged impact on quality of life and economic participation,
- a requirement for more intensive or specialist services in the long run.[80]

2.22 Further, while the 'burden of unmet mental health treatment' is most significant for the person experiencing mental ill health, [81] the impact it can have on carers, family, kin and the broader community is substantial.[82]

Cost

2.23 The committee also heard that the cost of mental health care prevents many people from accessing services, particularly young people.[83] Youth Action stated that many young people felt that psychologists were unaffordable and that they often faced difficulty when looking for a free or bulk billing service, with out-of-pocket expenses preventing young people from accessing care.[84]

2.24 Youth Action argued that this lack of bulk billing increased demand for free mental health services, yet many of these had long waitlists for clinical mental health support and other services were no longer accepting referrals. These challenges are further exacerbated in regional areas.[85]

78 Submission 39, Mental Health Coordinating Council, p 5.

79 Submission 39, Mental Health Coordinating Council, p 5.

80 Submission 58, NSW ACT PHN Mental Health Network, p 7.

81 Submission 58, NSW ACT PHN Mental Health Network, p 7.

82 Submission 58, NSW ACT PHN Mental Health Network, p 7.

83 See for example, Submission 74, Youth Action, p 16; Submission 58, NSW ACT PHN Mental Health Network, p 7; Submission 64, The Royal Australian College of General Practitioners, p 2; Submission 67, BEING Mental Health Consumers, p 5; Evidence, Mr Craig Parsons, General Manager, Partnerships & Innovation, Sydney North PHN and Chair, NSW/ ACT Mental Health Network, 17 November 2023, p 37.

84 Submission 74, Youth Action, p 16.

85 See for example, Evidence, Ms Annie Hong, Youth National Reference Group Member, headspace, 17 November 2023, p 18; Submission 74, Youth Action, p 16; Submission 58, NSW ACT PHN Mental Health Network, p 7; Submission 64, The Royal Australian College of General Practitioners,

2.25 Some stories outlining the challenges young people experience when trying to access mental health care are outlined below:

- 'There are GPs in most suburbs but they are expensive.'[86]
- 'You may not have the financial means to pay for the service or the transportation to get there.'[87]
- 'I believe young people find it difficult to access high quality, low-cost or free health care services, particularly mental health services. Often access to these mental health care services in NSW is limited to those who can afford it either through private health insurance, or out of pocket payments. Without access to these services, the mental health of young people is suffering.'[88]

2.26 The Australian Association of Psychologists put forward the view that the current demand on the public mental health system is significantly impacted by the lack of affordable and accessible services in the private sector.[89]

2.27 In addition, the committee heard that the current rebate structure of the Medicare Benefits Schedule (MBS) including the Better Access Scheme, which provides specific rebates for psychological treatments, does not adequately cater to the increased demand for and diversification of mental health care.[90]

2.28 Unbound Minds expressed concern that the current Medicare rebate for psychological services is 'not reflective of the true cost of providing high-quality mental health care'[91] and that the resulting out-of-pocket expenses for consumers can deter people seeking and continuing treatment.[92]

2.29 Some stakeholders were frustrated that the number of GP Mental Health Treatment Plans, which were increased from ten to twenty during Covid, reverted back to ten in 2022.[93] The Australian Medical Association (NSW) called for an urgent review of GP Mental Health Care Plans as well as the number of sessions eligible within a calendar year to be increased.[94]

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p 2; Submission 67, BEING Mental Health Consumers, p 5; Evidence, Mr Craig Parsons, General Manager, Partnerships & Innovation, Sydney North PHN and Chair, NSW/ ACT Mental Health Network, 17 November 2023, p 37; Evidence, Ms Nicola Rabbitte, Wellness Health In-reach Nurse Coordinator Program, 17 November 2023, p 26; Submission 74, Youth Action, p 16; Evidence, Mr Rob Curry, Executive Officer, North Coast Allied Health Association, 15 February 2024, p 19.

86 Submission 74, Youth Action, p 17.

87 Submission 74, Youth Action, p 17.

88 Submission 74, Youth Action, p 17.

89 Submission 35, Australian Association of Psychologists, p 1.

90 Submission 69, Unbound Minds, p 1.

91 Submission 69, Unbound Minds, p 1.

92 Submission 69, Unbound Minds, p 1.

93 See for example, Submission 80, Australian Medical Association (NSW) Ltd, p 5; Submission 41, ACON, p 4; Submission 69, Unbound Minds, p 1.

94 Submission 80, Australian Medical Association (NSW) Ltd, p 5.

2.30 The Black Dog Institute referred to a recent MBS Better Access evaluation which showed that that co-payments and long wait times made MBS-subsidised sessions inaccessible for many consumers, particularly those in rural, regional and remote areas, and those of low socio-economic backgrounds.[95] The Black Dog Institute argued that this meant that people needing help would go untreated, with symptoms worsening, until they reached crisis-point and presented at either emergency or at an acute unit. This is further explored in Chapter 4.

2.31 In addition, the current Medicare Benefits Schedule disincentivizes GPs from providing mental health care, with rebates for mental health appointments worth less than rebates for appointments of the same length for physical health concerns.[96]

Navigation of outpatient and community mental health services

2.32 A key theme throughout the inquiry was the difficulty of understanding and navigating the mental health system, which many stakeholders – both consumers and workers within the system – referred to as confusing and complex.[97] General Practitioner Dr Tim Senior described navigating community mental health services as challenging, particularly if you are already experiencing distress:

> The health system, particularly the mental health system, is really complex. I think it's difficult enough for practitioners to navigate that. For patients, it's really difficult. I think it's worth acknowledging that mental health conditions aren't just a condition that exists independent of that. It actually takes away people's ability to navigate the system, either through anxiety or through the sheer effort that that requires. People are anxious about the attitudes that they will meet when they come into contact. It's a really complex system to navigate even for those who know the system.[98]

2.33 One Door Mental Health reported that its reference group felt they needed to become 'experts' themselves to navigate the changing environment of the mental health system,[99] while the NSW Nurses and Midwives Association said that patients and carers find the process of finding mental health treatment 'frustrating and confusing'.[100] Independent Community Living Australia noted that the terminology to describe mental health and related services is often confusing, complex and lacks standardisation.[101]

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95 Submission 138, Black Dog Institute, p 6.

96 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 6.

97 See for example, Evidence, Ms Catherine Lourey, Commissioner, Mental Health Commission of NSW, 17 November 2023, p 30; Evidence, Ms Ashley de Silva, Chief Executive Officer, ReachOut, 22 September 2023, p 37; Evidence, Ms Marjorie Anderson, National Manager, 13YARN, 16 October 2023, p 51; Evidence, Ms Nicole Cockayne, Director, Policy and Research Operations, Black Dog Institute, 17 November 2023, p 17; Submission 60, One Door Mental Health, p 2; Submission 133, Advocate for Children and Young People, p 13; Submission 146, New South Wales Nurses and Midwives Association, p 8.

98 Evidence, Dr Tim Senior, General Practitioner, 16 October 2023, p 5.

99 Submission 60, One Door Mental Health, p 2.

100 Submission 146, New South Wales Nurses and Midwives Association, p 8.

101 Submission 98, Independent Community Living Australia, p 4.

2.34 A lack of available information on mental health services, that is also easy to find and accessible for various audiences, was highlighted as one of the factors that led people to find the system complex and confusing. For example, Mental Health Carers NSW described the lack of information as the 'first hurdle' that consumers and carers must overcome to access the system.[102] Mx Georgie Fischer, Board Member, Sydney Bi+ Network, suggested that there was a particular lack of information for bi+ people, stating that 'there is not a single place where I can go and find information around anything—literally anything'. [103]

2.35 Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council acknowledged the challenges for consumers in information gathering, telling the committee that there is no 'one stop shop' that covers the many mental health and services available to consumers and their carers more generally. [104] One Door added that all too often emergency departments are used as a mental health navigation tool with poor outcomes.[105]

2.36 Some stakeholder asserted that the issues caused by a lack of information were compounded by the ever-changing nature of the mental health sector presents. In his evidence, Mr William Campos, Chief Executive Officer, Independent Community Living Australia, described the sector as 'always changing' given that there are government funding cycles for services, and every two to three years there is a change in the available of services in communities depending on the allocations for funding.[106]

2.37 The challenges with tracking what services are available was articulated by Dr Vicki Mattiazzo, Deputy Chair, RACGP Rural Faculty, Royal Australian College of General Practitioners Rural:

> I think it's really difficult because the services do come and go. It's hard to stay current and up to date with what's out there. It would be really helpful to have some more centralised information that's kept live so that we can tap our patients into the services that they're coming to seek.[107]

2.38 Of the information that is available on mental health services, participants discussed that this information is often not accessible, particularly to young people and people with intellectual disability. To remedy this, the Office for the Advocate for Children and Young People reported that young people expressed a strong demand for more information of mental health support, particularly young women and young people with a disability.[108]

2.39 Mr Ashley de Silva, Chief Executive Officer, ReachOut, stated that information also needs to be accessible for young people, using language that is appropriate for them:

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102 Submission 132, Mental Health Carers NSW, p 6.

103 Evidence, Mx Georgie Fischer, Board Member, Sydney Bi+ Network, 22 September, p 23.

104 Evidence, Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council, 16 October 2023, p 37.

105 Submission 160, One Door, p 3.

106 Evidence, Mr William Campos, Chief Executive Officer, Independent Community Living Australia, 15 February 2024, p 15.

107 Evidence, Dr Vicki Mattiazzo, Deputy Chair, RACGP Rural Faculty, Royal Australian College of General Practitioners Rural, 16 October 2023, p 26.

108 Submission 133, Office of the Advocate for Children and Young People, p 13.

> 'Access for young people includes the appropriate language… The thing that's got the lowest barriers is just high-quality information, written in language that resonates; it's not medical. It really does frame the experience in the way that a lot of young people experience it. Sometimes it might not be through an anxiety lens. It could be through the stress of study or it could be through feeling like "I'm lonely," or "I'm finding it hard to find friends." Very often, the starting point for young people is not that medical lens.'[109]

2.40 Dr Janelle Weise, Senior Researcher, Department of Developmental Disability Neuropsychiatry, University of New South Wales (UNSW), reported the findings of an audit of the accessibility of the information in the mental health sector across NSW.[110] The researchers found that information was largely inaccessible, even to the general population. Dr Weise remarked that Easy Read was one solution, but noted that people have varying communication needs and that further research is needed.[111]

Peer navigation

2.41 Given the challenges in navigating a complex and often ill-explained system, Flourish Australia stated that families and carers often look to organisations like theirs to educate and support them on the care that might be required for their loved one, as well as for themselves.[112]

2.42 Several witnesses emphasised the importance and benefit of 'peer navigation', where an experienced peer worker assists consumers and carers to navigate the system.[113]

2.43 The Mental Health Commission of NSW praised the role played by peer navigators in a project it had recently commissioned, stating that their use resulted in an 'improvement in referral pathways and a reduction in waiting lists, [as well as] improved personal recovery outcomes'.[114] Ms Nicole Cockayne also spoke positively of this project and suggested it be used as a template for further support services:

> What we think could occur … is having a support service where you have that warm and friendly concierge type of approach where somebody is there to support you, to understand where you're at, and to understand and guide you toward the services that are appropriate to your own local area, whether that be a bricks-and-mortar kind of service or a digital service that you can access—whatever it might be. …We'd actually suggest that the peer navigation project from the New South Wales Mental Health

109 Evidence, Mr Ashley de Silva, Chief Executive Officer, ReachOut, 22 September, p 37.

110 Evidence, Dr Janelle Weise, Senior Researcher, Department of Developmental Disability Neuropsychiatry, University of New South Wales, 22 September 2023, p 16.

111 Evidence, Dr Janelle Weise, Senior Researcher, Department of Developmental Disability Neuropsychiatry, University of New South Wales, 22 September 2023, p 16.

112 Submission 49, Flourish Australia, p 5.

113 See for example; Evidence, Ms Nicole Cockayne, Director, Policy and Research Operations, Black Dog Institute, 17 November 2023, p 17; Evidence, Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council, 16 October 2024, p 36; Evidence, Ms Fay Jackson, Former Deputy Commissioner, Mental Health Commission of NSW and General Manager, Inclusion, Flourish Australia, 13 February 2023, p 14.

114 Submission 147, Mental Health Commission of New South Wales, p 6.

> Commission should be the grounding for which we could look at how this could operate.[115]

2.44 When asked whether a navigator for Indigenous people should be Indigenous or could be any person who was sensitive to cultural safety, Mrs Marjorie Anderson, National Manager, 13YARN, stated that it needs to be an Aboriginal person – 'service delivery to Aboriginal people should be Aboriginal-led'.[116]

2.45 In their submissions, NSW Health and the Mental Health Commission of NSW drew attention to existing supports for navigation of mental health services, including the 'Physical Health Care Guide: how to make sure your physical and mental health are in check' and the WayAhead directory. [117] Ms Sharon Grocott, Chief Executive Officer, WayAhead stated they provide a current and up-to-date information directory of mental health care services in NSW.[118]

Mental health literacy

2.46 In navigating the system, the inquiry heard that consumers seeking services often do not know where to go for help, citing low mental health literacy and a lack of information that is accessible and easy to find, as contributing factors.[119]

2.47 Several submissions stated that the current mental health system appears to favour well-informed, health literate consumers who can advocate for their own needs and drive their own care.[120] One stakeholder who has worked in the mental health, alcohol and other drugs (AOD) sector for over 40 years also made the point that those navigating the system are often not functioning well enough to navigate its complexity.[121]

2.48 The committee heard that a consumers' individual health literacy may be affected by age, disability, education, culture and language, and Aboriginal and Torres Strait Islander status. Core components of mental health literacy include people having the knowledge, ability, attitude, confidence and comfort to access and understand mental health and mental health care.

2.49 A number of submissions observed lower levels of mental health literacy in NSW's culturally and linguistically diverse (CALD) communities, including diversity in recognition and understandings of mental health.[122] Stakeholders noted that young people with a CALD

115 Evidence, Ms Nicole Cockayne, Director, Policy and Research Operations, Black Dog Institute, 17 November 2023, p 17.

116 Evidence, Ms Marjorie Anderson, National Manager, 13YARN, 16 October 2023, p 54.

117 Submission 147, Mental Health Commission, p 6; Submission 148, NSW Health, p 24.

118 Evidence, Ms Sharon Grocott, Chief Executive Officer, WayAhead, 15 February 2024, p 9.

119 Submission 60, One Door Mental Health, p 2.

120 Submission 78, Gidget Foundation Australia, p 5.

121 Submission 3, Name suppressed, p 2.

122 See for example, Submission 43, Barnardos Australia, p 3; Submission 133, Office of the Advocate for Children and Young People, p 16; Submission 77, Western Sydney Health Alliance, p 3; Submission 78, Gidget Foundation Australia, p 9.

background have indicated that discussions of mental health are not common and not encouraged in their families and communities.[123]

2.50 Limited proficiency in language skills may also lead to considerable delays in mental health treatment as well as the increased risk of misdiagnosis, as clinical assessments are dependent on an individual's ability to articulate their concerns and convey their needs.[124] The Y NSW Youth Parliament also highlighted that prior to the stage of consultation with medical professionals, language barriers can inhibit the retrieval of information on available mental health services, appointment scheduling as well as affordability.[125]

2.51 On the impact of age, Mental Health Committee Members of The Y NSW Youth Parliament 2023 advocated for introducing mental health education in early schooling and primary schools, so that young people can understand their emotions and be equipped with the skills needed to recognise and self-manage mild psychological and emotional distress.[126] Similarly, Youth Action also supported education and awareness programs for young people.[127]

2.52 Mr Ashley de Silva, Chief Executive Officer, ReachOut, stated that mental health literacy is also important for young people in helping them to understand their experience and potentially validate what they are going through.[128]

2.53 In their submission, NSW Health highlighted the importance of health literacy at the state and national level:

> Health literacy is fundamental to improving a person's health outcomes and health equity across population groups. Health literacy also has an economic impact through direct and indirect health care costs, rates and number of years living with disability and chronic conditions, and quality of life…Improving health literacy is a national and state government priority. [129]

Stigma and negative attitudes towards seeking support

2.54 Attitudes towards mental health support, including the perceived and apparent stigma of seeking help, were also identified as a major barrier to seeking support.[130]

2.55 In their submission, Gidget Foundation Australia stated that for many new parents, stereotypes and stigma around who gets perinatal depression and anxiety and why, can create barriers to

123 See for example, Submission 133, Office of the Advocate for Children and Young People, p 16; Submission 26, Name suppressed, p 3.

124 Submission 131, Mental Health Committee Members of The Y NSW Youth Parliament 2023, p 8 citing Ohtani, A., Suzuki, T., Takeuchi, H., & Uchida, H, (2015, May 1), *Language Barriers and Access to Psychiatric Care: A Systematic Review*.

125 Submission 131, Mental Health Committee Members, The Y NSW Youth Parliament 2023, p 8.

126 Submission 131, Mental Health Committee Members of The Y NSW Youth Parliament 2023, p 8.

127 Submission 74, Youth Action, p 8.

128 Evidence, Mr Ashely de Silva, Chief Executive Officer, ReachOut, 22 September 2023, p 37.

129 Submission 148, NSW Health, p 27.

130 See for example; Submission 38, Reach Out, p 6; Submission 39, Mental Health Coordinating Council, p 18; Submission 44, RACGP Rural, p 2.

accessing timely and appropriate care.[131] The Office of the Advocate for Children and Young People also identified stigma as barrier to entry into the mental health system for young people.[132] For those in regional areas, young people have reported that stigma can be compounded by fewer available services and gossip in small communities.[133]

2.56 The Black Dog Institute said that the prospect of feeling 'shame' regarding a diagnosis combined with a fear of discrimination from others as a significant and ongoing barrier for First Nations people.[134] This is often exacerbated by cultural beliefs regarding what mental health issues may mean for individuals and their families.[135]

Challenges for parents and guardians of children

2.57 Parents, carers and guardians of children experiencing mental ill health also described particular challenges, noting that the burden of navigating the mental health system often falls on parents, guardians, caregivers, families and kin and that they encounter specific challenges when attempting to access care on behalf of children in their care.[136]

2.58 These challenges include service eligibility partitioning by age and tight eligibility criteria,[137] as well as a difficulty in getting referrals to psychiatrists for children, particularly for those with a history of suicidality[138] and complex development and neurological conditions such as OCD and ADHD.[139] This leaves parents and carers feeling frustrated to the 'point of burnout and breakdown'.[140]

2.59 Challenges in access were particularly concerning for parents and caregivers, given that earlier onset of illness is associated with poorer outcomes, an increased likelihood of mental ill health persisting into adulthood, and a significant risk to a child's developmental trajectory.[141] It is estimated 50 per cent of adult mental illness begins before 14 years of age.[142] Many stakeholders were therefore adamant that finding support for their child while young was crucial to ensuring they were best supported into adulthood.

131 Submission 78, Gidget Foundation Australia, p 4.

132 Submission 133, Office of the Advocate for Children and Young People, p 16.

133 Submission 133, Office of the Advocate for Children and Young People, p 16.

134 Submission 138, Black Dog Institute, p 20.

135 Submission 138, Black Dog Institute, p 20.

136 See for example; Submission 154, Name Supressed, pp 1-4; Submission 94, Ms Tabitha Merrell, pp 1-8; Submission 18, Name Suppressed, pp 1-6; Submission 27, Name Supressed, pp 1-2; Submission 17, Name Suppressed, p 1; Submission 27, Name Suppressed, pp 1-3; Submission 93, Ms Gail Mensinga, pp 1-4; Submission 81, Patsy Fokes and Rosemary Brown, pp 1-7; Submission 85, Rachael Morris, pp 1-3.

137 Submission 58, NSW ACT PHN Mental Health Network, p 8.

138 Submission 154, Name Suppressed, p 2.

139 See for example, Submission 154, Name Suppressed, p 1; Submission 129, Name Suppressed, p 1; Submission 85, Rachael Morris, pp 1-3.

140 Submission 81, Patsy Fokes and Rosemary Brown, p 1.

141 Submission 58, NSW ACT PHN Mental Health Network, p 8.

142 Submission 58, NSW ACT PHN Mental Health Network, p 8.

2.60 Despite this, the NSW ACT PHN Mental Health Network stated that there is a gap in mental health services for young children – for example, headspace services are designed for youth aged from 12 to 25 years old.[143]

2.61 There were also marked differences in the level of support provided to children across local health districts. The Child and Adolescent Mental Health Services (CAMHS) operates in all LHDS except Sydney LHD, which operates the Community Adolescent Outreach Service (CAOS).[144] In evidence to the inquiry, a parent outlined the stark differences in resourcing between these two programs, with the recommendation that CAMHS be implemented in Sydney LHD.[145] They advised that the CAMHS team includes child psychiatrists, clinical and counselling psychologists, specialised social workers, occupational therapists, dieticians, psychotherapists, family therapists and specialist nurses.[146] However, the CAOS team consists of four FTE (nurse/psychologists) and a one day a week registrar, which makes it difficult to access consistent care, as illustrated by this parent's experience trying to access care for their 15 year old child experiencing acute OCD:

> They can only provide light touch support for acute cases. If the psychiatrist is unwell (as happened to us) there is no cover, another week goes by with no guarantee of availability the following week. Had we been able to access a CAMHS team, we would had quicker access to tertiary specialist for acute mental health issues. We would have benefited greatly from early intervention family therapy. I had to continually call and follow up the CAOS team for even the basics. The aim seemed to be to move us on as quickly as possible. The stress this placed on our family whilst navigating discharge from an inpatient mental health ward was unnecessary and distressing for all.[147]

2.62 NSW ACT PHN Mental Health Network acknowledged that the capacity of CAMHS is significantly reduced with tight eligibility criteria, making referrals to such services difficult.[148]

2.63 Overall, there was a strong call for an increase to child mental health services.[149] In particular, NSW ACT PHN Mental Health Network recommended that the following should be prioritised to improve child mental health model of care and support parents:

- Information, resources, and evidence-based child mental health services,
- Parenting programs for families and carers,
- Assessment and treatment planning,
- Evidence-based therapeutic intervention,
- Urgent community assessment pathways and multidisciplinary team care for children experiencing severe symptoms, severe functional impairment, or other complexities,

143 Submission 58, NSW ACT PHN Mental Health Network, p 8.

144 Submission 129, Name Suppressed, p 1.

145 Submission 129, Name Suppressed, p 1.

146 Submission 129, Name Suppressed, p 1.

147 Submission 129, Name Suppressed, p 1.

148 NSW ACT PHN Mental Health Network, p 8.

149 See for example, Submission 58, NSW ACT PHN Mental Health Network, p 8; Submission 129, Name Suppressed, p 1; Submission 85, Rachael Morris, p 1-3.

- Specialist paediatric psychiatry consultation and liaison options for GPs and mental health clinicians.[150]

A fragmented system

2.64 Submissions to the committee conveyed that in New South Wales, systems and services are not integrated. Rather, they are siloed, fragmented, and as discussed above, hard for consumers and carers to navigate. This can lead to re-traumatisation and a reluctance to continue seeking help.

2.65 Submissions called for increased holistic, multi-disciplinary, wrap-around support that responds to individuals' needs and circumstances across ages and stages of life – ensuring people can access the right support, when they need it and how they want it.

2.66 A number of submissions highlighted that physical and mental health are inextricably linked and that holistic patient-centred care must integrate primary care with mental health care.[151]

Re-traumatisation

2.67 Throughout the inquiry, the committee heard that the lack of integration of services across the mental health sector negatively impacts consumers' recovery as they repeatedly have to tell their story (give their history) as they travel through the system.[152]

2.68 The Mental Health Coordinating Council told the committee that consumers have reported appointments with different clinicians and the need to tell and retell their traumatic experiences and medical history multiple times.[153] Mr Joel Orchard, Executive Director, Wardell CORE, explained that people who have experienced trauma engaging with a mental health care service may also be less likely to seek help the next time they experience distress.

> What we know clearly is that anyone who has to repeat their story and re-walk their trauma history time and time again entrenches that challenge and it disenfranchises them from accessing those formal and traditional support services.[154]

2.69 Barnardos also reported a similar experience for young people, stating that when young people are forced to retell their story to new services, this often results in them discontinuing their mental health treatment journey.[155]

150 Submission 58, NSW ACT PHN Mental Health Network, p 8.

151 See for example, Submission 25, Lifeline, p 7; Submission 35, Australian Association of Psychologists Inc (AAPi), p 5; Submission 39, Mental Health Coordinating Council (MHCC), p 9.

152 Submission 160, One Door, p 3.

153 Submission 39, Mental Health Coordinating Council, p 4.

154 Evidence, Mr Joel Orchard, Executive Director, Wardell CORE, 13 February 2024, p 26.

155 Submission 43, Barnardos, p 5.

No wrong door policy

2.70 In addition to retraumatisation, several stakeholders shared personal experiences or accounts of consumers who were 'turned away' from mental health care services.[156] Consumers were told 'sorry we cannot help', 'there is nothing we can do'[157], 'you are not suicidal enough'[158], or 'you've got someone else,'[159]without being referred to a service that was right for them.

2.71 The Mental Health Coordinating Council highlighted feedback they had received from rural and remote consumers and the difficulty they encounter when attempting to access care:

> State/public mental health say: 'we have no staff, go private;, and private mental health say: 'you're too complex, you will need to go back to public', then public direct to ED, ED direct to GP, GP calls Mental Health line who say you need to call your local mental health service – it never ends.[160]

2.72 In her evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, shared that one of her clients was turned away from a community mental health team on the basis that she already had a private appointment with a psychologist or psychiatrist appointment scheduled. The client was referred to another organisation but was subsequently turned away as she was considered 'too suicidal' for the organisation to be involved'.[161] Dr Williams told the committee that her client could have died in the time waiting for her scheduled appointment.

2.73 One repeated suggestion to combat this issue is to establish a 'no wrong door policy'.[162] The NSW ACT PHN Mental Health articulated that such a policy would ensure that:

> '…no person should be turned away from treatment; when a person presents at a service that cannot provide a particular type of service or is at capacity, they should be guided to the appropriate service using warm referral and follow-up advocating that people seeking people seeking help should not be turned away without a referral to an appropriate service.'[163]

2.74 Mrs Marjorie Anderson agreed with this suggestion, emphasising its importance to First Nations consumers:

> I believe there should be no wrong door. If an Aboriginal person walks in your door and you don't deliver that service, find out who does and refer them on. Don't just say,

156 See for example; Mr Ashely de Silva, 22 September 2023, p 37; Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 3; Submission 155, Full Stop Australia, p 8.

157 Submission 81, Patsy Fokes and Rosemary Brown, p 1.

158 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 4.

159 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 4.

160 Submission 39, Mental Health Coordinating Council, p 8.

161 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 4.

162 See for example, Submission 58, NSW ACT PHN Mental Health Network, p 10; Submission 43, Barnardos Australia, p 5; Submission 64, The Royal Australian College of General Practitioners, p 2.

163 Submission 58, NSW ACT PHN Mental Health Network, p 10.

> "We don't deliver that service." I see 13YARN as a bit of a front door to the industry—but it's still really hard. I'm a grandmother of a transgender young person who is 11. Most of that counselling doesn't start until 12. She has been going through this for a number of years, telling us since she was three that she was a girl. Trying to find the help for—I work in the system and I had trouble finding the help needed for my transgender granddaughter. If I'm having trouble, imagine somebody in Wilcannia trying to find services, or in Bourke or Brewarrina. If I'm having trouble in Sydney; imagine what they would go through.[164]

Need for specialised services

2.75 In addition to the need to improve mainstream health and mental health services, the committee received a large volume of evidence that there is a need for targeted, specialised services to support people experiencing particular mental health conditions as well as priority populations with specific requirements to enable safety and accessibility.[165]

2.76 Specific mental health conditions raised as requiring particular attention included eating disorders, dual diagnosis of substance use disorder with another mental illness, and rarer conditions including functional neurological disorder, obsessive-compulsive disorder, and rarer sub-types of depression.[166]

2.77 In addition, the committee heard that people seeking mental health support may also be experiencing comorbidities related to substance use and that the siloed service delivery of services is problematic for people living with co-existing conditions.[167] The Royal Australian College of General Practitioners (RACGP) Rural noted that often due to the narrow scope of practice in community mental health services, these consumers are unable to access support through mental health specific services due to their substance related comorbidities. Further, the committee was told that specific services for alcohol and other drug use have extensive wait times, averaging three to four months in regional and rural areas.[168]

2.78 During the inquiry, stakeholders also emphasised the intersectional experiences of priority populations when accessing mental health care and the need for holistic care.[169]

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164 Evidence, Mrs Marjorie Anderson, National Manager, 13YARN, 16 October 2023, p 54.

165 See for example; Submission 44, RACGP Rural, p 2; Submission 57, Local Government NSW, pp 9 and 11; Submission 60, One Door Mental Health, pp 2 and 3; Submission 80, Australian Medical Association NSW, p 4; Submission 96, Department of Developmental Disability Neuropsychiatry, UNSW, p 6; Submission 102, Name Supressed, p 2.

166 See for example; Submission 64, The Royal Australian College of General Practitioners (RACGP), p 1; Submission 39, Mental Health Coordinating Council (MHCC), p 17; Submission 58, NSW ACT PHN Mental Health Network, p 8; Submission 154, Name Suppressed, p 1.

167 See for example; Submission 44, The Royal Australian College of General Practitioners (RACGP) Rural, p 3; Submission 39, Mental Health Coordination Council, p 17.

168 Submission 44, The Royal Australian College of General Practitioners (RACGP) Rural, p 3.

169 See for example, Submission 58, NSW ACT PHN Mental Health Network, p 12; Submission 25, Lifeline, p 10; Submission 35, Australian Association of Psychologists Inc (AAPi), p 5; Submission 41, ACON, p 14; Evidence, Ms Catherine Lourey, Commissioner, Mental Health Commission of NSW, 17 November 2023, p 30.

2.79 A number of stakeholders explained the benefits that an assertive outreach approach from mental health services can have for both for people with chronic and complex mental health conditions as well as for priority population groups.[170] Such an approach includes being able to provide care outside of traditional clinical settings, with appropriate protocols in place for safety for staff.[171]

2.80 Ms Jennifer Parke, Head of Operations, Human Nature, described the critical importance of being able to develop a therapeutic alliance with a young person, particularly for young people with backgrounds of complex trauma. She also spoke of the success of their assertive outreach model that is evidence-based and provided by qualified clinicians in the spaces where young people feel safe and motivated to engage, including at home or at school, in public spaces or outdoors.[172] Similarly, Mr Rob Curry, Executive Officer, North Coast Allied Health Association described the benefits of outreach to young people in school settings.[173]

2.81 The committee also heard of the Wellbeing and Health In-reach Nurse Coordinator program (WHIN) where nurses are co-located in public schools to support students and their families on a range of health and wellbeing issues, including mental health. Ms Nicola Rabbittee, Wellbeing Nurse, Wellbeing and Health In-reach Nurse Coordinator Program, told the committee that WHIN nurses develop trusted relationships with children and young people, with a key part of their role being advocacy. She noted that the majority of her work is mental health related and that WHIN nurses can make necessary referrals for students including connecting them to relevant networks and support groups:

> Our engagement with community also assists vulnerable groups of students to access culturally safe care, including our First Nations, CALD, LGBTQIA+ and students with disability, often connecting them to lifelong support networks and groups. For the quarter of young Australians now experiencing psychological distress, support for mental as well as physical health in school is paramount. As a WHIN, I was initially surprised that mental health issues make up more than 70 per cent of my work.[174]

2.82 As outlined in section 2.57, which discusses the challenges faced by parents and guardians of children, there is clearly a need for specialized services for children and their families, and in particular improved accessibility to these services for people living in rural, regional and remote NSW.

2.83 Throughout the inquiry, the committee also received evidence about the benefits of Aboriginal Community Controlled Health Organisations (ACCHO) in providing culturally safe mental health care to Aboriginal and Torres Strait people.[175] However, the UNSW Indigenous Health

170 Submission 39, Mental Health Coordinating Council (MHCC), p 9.

171 Submission 135, Community Restorative Centre, p 14.

172 Evidence, Ms Jennifer Parke, Head of Operations, Human Nature, 13 February 2024, p 10.

173 Evidence, Mr Rob Curry, Executive Officer, North Coast Allied Health Association, 13 February 2024, p 20.

174 Evidence, Ms Nicola Rabbittee, Wellbeing Nurse, Wellbeing and Health In-reach Nurse Coordinator Program, 17 November 2023, p 25.

175 See for example, Submission 164, UNSW Indigenous Health Education Unit (IHEU) and the Illawarra Aboriginal Medical Services (IAMS), p 2; Evidence, Mrs Majorie Anderson, National Manager, 13YARN, 16 October 2023, p 51.

Education Unit (IHEU) and the Illawarra Aboriginal Medical Services (IAMS) also called for greater reciprocal partnerships between ACCHOs and community mental health teams.[176]

2.84 As noted further at section 2.88, there is also a need for more specialised care for CALD and migrant communities which takes in account the intersectional nature of trauma and mental health.

2.85 In addition, the committee as heard that within the umbrella of LGBTQIA+ there are populations with specific needs, particularly trans and gender diverse people, and people who are attracted to more than one gender (termed bi+). Stakeholders expressed the need for specialised care to cater for these populations.[177]

2.86 Further, some stakeholders argued that common treatments such as cognitive behavioural therapy may be less effective than alternatives for people with autism, and that specialised care for neurodivergent consumers would better support health outcomes.[178]

2.87 On the other hand, some stakeholders advocated strongly for specialised supports to be embedded within mainstream services to build their capacity as preferable to separate specialised service delivery.[179]

Trauma-informed care

2.88 A number of stakeholders highlighted the specific needs of consumers who have experienced significant trauma, emphasising the importance of trauma-informed care for both consumers and carers.[180]

2.89 Mr Ben Benazzouz of SSI commented that many refugees and asylum seekers come from parts of the world where trauma, and specifically complex trauma, is very common.[181] Dr Karen Williams highlighted the significant proportion of women in psychiatric wards – around 70 per cent – who have experienced sexual abuse.[182] In calling for more trauma informed care for First Nations peoples, the Community Restorative Centre emphasised the ongoing role of

176 Submission 164, UNSW Indigenous Health Education Unit (IHEU) and the Illawarra Aboriginal Medical Services (IAMS), p 2.

177 See for example, Submission 45, SSI, p 3-4, Submission 41, ACON, p 14.

178 Submission 50, NeuroAccess, p 2.

179 Evidence, Dr Janelle Weise, Department of Developmental Disability Neuropyschiatry, UNSW, 22 September 2023, p 14.

180 See for example: Evidence, Mr Ben Benazzouz, Provisional Psychologist, Mental Health Clinician, SSI, 22 September 2024, p 31; Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 3; Submission 135, Community Restorative Centre, p 14; Evidence, Ms Kelly Banister, CEO, Northern Rivers Women and Children's Services, 13 February 2024, p 4; Evidence, Ms Fay Jackson, Former Deputy Commissioner, Mental Health Commission of NSW and General Manager, Flourish Australia, 13 February 2024, p 15.

181 Evidence, Mr Ben Benazzouz, Provisional Psychologist, Mental Health Clinician, SSI, 22 September 2024, p 31.

182 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 3.

colonisation in perpetuating trauma.[183] Ms Kelly Banister, CEO, Northern Rivers Women and Children's Services, also advocated for more awareness of gender within approaches to mental health. In particular, Ms Banister noted the intersectional nature of gender and trauma in relation women's experiences in the aftermath of the 2022 floods in the Northern Rivers and how more training is needed around the implications of gender and gendered stereotypes when providing care.[184]

2.90 Despite recognition of its importance, the committee also received evidence that the current standard and availability of trauma-informed care could be improved. For example, the Royal Australian & New Zealand College of Psychiatrists stated that whilst most NSW Health services claim to be 'trauma-informed', their capacity to deliver specific evidence-based therapies were 'negligible'.[185] Similarly, Dr Karen Williams lamented that notwithstanding the prevalence of domestic violence and sexual abuse amongst consumers seeking mental health care, only one psychiatric bed is publicly funded for the dedicated treatment of these survivors.[186]

2.91 SSI also highlighted that service access for culturally appropriate mental health support is limited, and even more limited for transgender clients – which is further exacerbated in non-metropolitan areas.[187] The organisation noted that for some clients there is a reluctance to use interpreters as they feel unable to disclose information about their gender identity for fear of abuse.[188] Their submission also stated that some mental health services do not feel physically safe or trauma-informed for transgender clients from culturally diverse backgrounds, with some consumers being asked their gender in crowed waiting room in triage, or having to use their former or 'dead' name on identity cards which is then repeated on wrist labels and files.[189]

2.92 As a result of this intersection of marginalised identities, gender diverse or transgender consumers from culturally diverse backgrounds can have an 'extreme' reluctance to access mental health services unless in crisis, this can lead to untreated mental and physical health conditions due to avoidance of services.[190]

2.93 Recommendations to improve the provision of trauma-informed care included increasing funding, as well as a re-design of the way in which the method of care is taught. On the former, Dr Williams called for increased funding for the development of trauma-informed care and services as well as funding to increase the workforce, to remove the time constraints on current clinicians that prevented them from being able to provide such care.[191] She also suggested trying to teach the method of care via modules and classes is not the most effective means, and said that clinical support and supervision within organisations was most beneficial, as it allows direct

183 Submission 135, Community Restorative Centre, p 14.

184 Evidence, Ms Kelly Banister, CEO, Northern Rivers Women and Children's Services, 13 February 2024, p 4.

185 Submission 139, The Royal Australian and New Zealand College of Psychiatrists, p 9.

186 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 2.

187 Submission 45, SSI, pp 3-4.

188 Submission 45, SSI, pp 3-4.

189 Submission 45, SSI, pp 3-4.

190 Submission 45, SSI, pp 3-4.

191 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 5.

interaction with staff on the front line and exposes clinicians to some of the complexities that may arise.[192]

Telehealth

2.94 The benefits and risks of online and digital (collectively telehealth) services from the perspectives of consumers and their carers were discussed extensively throughout the inquiry. For a discussion of the views of mental health staff on telehealth, see Chapter 3.

2.95 There was a range of perspectives from consumers and community health organisations on whether telehealth services are as effective as or *on par*[193] to face-to-face services. In his oral submission, Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute, told the committee that 'there is a lot of evidence that shows that digital solutions can be very effective—almost similar levels of effectiveness and safety—within mild and moderate cases of depression and anxiety, which are the most common mental illnesses.'[194]

2.96 On this point Marathon Health agreed, stating that there appears to be very little difference in outcome measure, with both in person and telehealth modes delivering similar improvements in outcomes.[195]

2.97 The NSW ACT PHN Mental Health Network also reported that evidence suggests comparable experience and outcomes between face to face, online and telehealth services.[196] However, their submission noted that there is limited evidence regarding the efficacy of online and telehealth services with people who are socially disadvantaged and people experiencing low prevalence mental health conditions (e.g., schizophrenia).[197]

2.98 In addition, One Door noted that it is also important to recognise that a person's situation or illness may prevent them from utilising telehealth services.[198] For example, online services may not be suitable for individuals in crisis or those who require immediate intervention, as there may be a delay in response. The Community Restorative Centre also noted that telehealth may not be appropriate for certain mental health conditions such as people experiencing paranoid schizophrenia and whose paranoia may be associated with virtual communication.[199]

192 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 4.

193 Submission 58, NSW ACT PHN Mental Health Network, p 19.

194 Evidence, Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute, 17 November 2023, p 13.

195 Submission 40, Marathon Health, p 4.

196 Submission 58, NSW ACT PHN Mental Health Network, p 19.

197 Submission 58, NSW ACT PHN Mental Health Network, p 19.

198 Submission 60, One Door, p 6.

199 Submission 135, The Community Restorative Centre, p 12.

Increased accessibility

2.99 Increased accessibility, including to more specialised or tailored services, was identified as key benefit of online and telehealth services. Telehealth services can minimise or eliminate geographical barriers, ensuring that those in regional, rural and remote areas and those who have difficulty traveling, can access mental health services[200] For example, one stakeholder said access to telehealth was vital for her son to receive support:

> 'At times my son can't leave his bed, let alone leave the house, get in the car, go into a foreign environment and then talk to an adult about his most upsetting thoughts face to face. Without Telehealth, he would not have been able to access many essential appointments, from psychology, psychiatry, general practice and neurology.'[201]

2.100 Several submissions also identified telehealth as beneficial option in the following circumstances:

- For expectant and new parents, with perinatal mental health disorders, the Gidget Foundation Australia reported that telehealth provides an accessible option when leaving the house may be challenging.[202]
- For the LGBTIQA+ community, ACON conveyed that telehealth has also been useful to clients who have concerns around experiencing street-based harassment, discrimination, homophobia, and transphobia.[203] ACON stipulated that being able to seek mental health care without compromising safety is of huge benefit.[204]
- For some people with a physical disability or neurodivergent people, Annie Crowe, Founder and Consultation NeuroAccess, said that getting out of the house sometimes is not possible and telehealth may be the only option. Ms Crowe explained that:

  > '[F]or people with autism, leaving the house takes a lot of executive functioning, which is making decisions and choosing times and keeping track of everything, getting there on time, going the right way—it is a very complex executive function task to get anywhere. On top of that, the sensory overwhelm of leaving the house can be really debilitating for many autistic people, especially those who are experiencing mental health crises or even just any sort of mental health struggle.[205]

Convenience, comfort and privacy

2.101 One of the greatest advantages to telehealth reported by participants is that it allows individuals to receive mental health care services at a time that suits them, in the comfort and privacy of their homes. Telehealth services offer greater flexibility in scheduling appointments, with

200 See for example; Submission 155, Full Stop Australia, p 16; Evidence, Ms Anita McGregor, Forensic Psychologist, Member of the College of Forensic Psychologists of the Australian Psychological Society, 16 October 2023, p 34; Evidence, Ms Zoë Robinson, Advocate for Children and Young People, 22 September 2023, p 46.

201 Submission 129, Name suppressed, p 3.

202 Submission 78, Gidget Foundation Australia, p 8.

203 Submission 41, ACON, p 12.

204 Submission 41, ACON, p 12.

205 Evidence, Ms Annie Crowe, Founder and Consultation NeuroAccess, 22 September 2023, p 17.

enhanced options across the week, weekends, during and outside business hours.[206] This convenience can make it easier for individuals to seek help and continue with treatment.

2.102 In terms of being able to remain at home, Full Stop Australia said that this can be particularly reassuring for trauma survivors, who may feel safer discussing their experiences in familiar surroundings.[207]

2.103 In contrast, some submissions noted that telehealth can present a challenge for people who do not have a private home environment,[208] including victim survivors of family and domestic violence. ACON noted that a lack of privacy is especially difficult for LGBTIQ+ people who have not disclosed their sexuality or gender to those they live with.[209] The Advocate for Children and Young People also acknowledged privacy as a consideration for young people and reported that some 'individuals may not be able to properly answer questions due to fear of someone within their surroundings over hearing.'[210]

2.104 Some submissions suggested that consumers may also feel more comfortable seeking help through online platforms, as these can provide a level of anonymity and reduce the stigma associated with seeking mental health care.[211]

2.105 BEING stated that many consumers in rural and remote communities not only rely on telehealth mental health care because there are few or no services within their area, but also because in small and close-knit communities, consumers do not always want to be seen by other community members accessing mental health care.[212] Consumers may also wish to access telehealth as alternative to a service in which a family or friend works.[213]

2.106 Dr Tara Hunt, Deputy Chief Research Officer, Lifeline Research Office, said one of the limitations of offering online crisis support that is anonymous and confidential is continuity of care.

> We are definitely working on our capability to be able to have more of an understanding of what exactly happens at the end of the call, but one of the limitations inherent within a one-off crisis support service where the benefit is anonymity and confidentiality, that adds a significant challenge to us, in terms of continuity and knowing what happens at the end of the call [214]

206 Submission 58, NSW ACT PHN Mental Health Network, p 18.

207 Submission 155, Full Stop Australia, p 16.

208 Submission 114, Name suppressed, p 8.

209 Submission 41, ACON, p 12.

210 Submission 133, The Office for the Advocate of Children and Young People, p 22.

211 Submission 77, Western Sydney Health Alliance, p 14; Submission 136, BrainStorm Mid North, p 10; Black Dog Institute, p 22; Submission 146, Nurses and Midwives' Association, p 20.

212 Submission 67, BEING, p 6.

213 Submission 67, BEING, p 6.

214 Evidence, Dr Tara Hunt, Deputy Chief Research Officer, Lifeline Research Office, 15 February 2024, p 28.

Technological barriers

2.107 Technological barriers from online or telephone services can also hinder consumer engagement, as not everyone has access to the necessary technology, internet connection or technological literacy for effective telehealth sessions, which can exacerbate existing disparities in access to care.[215]

2.108 In terms of access to technology and internet, Flourish Australia cited a study conducted by Thomas et al., which found that in Australia, looking at a group of people with serious mental illness connected to an inner-city mental health service, 86 per cent of respondents owned a mobile phone, but only 51 per cent had access to the internet services (a data plan) attached to their phone, and only 45 per cent had access to the internet at home.[216] The Western Sydney Health Alliance reported that in the Western Parkland City, digital technology access is intermittent and there are many black spot and connectivity issues.[217]

2.109 One submission stated that telehealth is simply not an option, as they do not have adequate reception to receive messages:

> Rural and remote communities are offered telehealth as a way of accessing medical help. This system failed for me when I tried to use it from home. I could not get past step one. Telehealth required me receiving an SMS message for validation purposes. I do not have mobile reception at home. I cannot access telehealth from my residence.[218]

2.110 Poor internet connectivity may lead to technical glitches or other technological challenges which can disrupt the session and potentially lead to frustration for both the individual and the provider. One submission also noted that telehealth may not be suitable for people experiencing homelessness as they may not have a stable phone number.[219]

2.111 Digital literacy was also noted as a barrier to telehealth being an appropriate method for consumers and carers:

> The technological literacy and the literacy levels required [for telehealth] are often beyond many people. We often set up health services that are convenient for people like me, who work at a computer on my desk and are used to using the internet and finding services like that and are really comfortable doing that. That's often not the case for people without as obvious access or not quite as easy access, and also where the relational aspect is really important to them—about engaging with a human being and talking about a problem together to solve that. There's no doubt that telehealth is really important and adds something to face-to-face care, but it doesn't replace it. We need to do it in a way that doesn't worsen health inequities just because we assume that everyone can do it.[220]

215 See for example, Submission 136, BrainStorm Mid North Coast, p 10, Evidence, Ms Andrea Angeles, Policy Lead, NSW Council of Social Workers, 15 February 2024, p 39.

216 Submission 49, Flourish Australia, p 11.

217 Submission 77, Western Sydney Health Alliance, p 14.

218 Submission 110, Name suppressed, p 1.

219 Submission 121, Name suppressed, p 2.

220 Evidence, Dr Tim Senior, General Practitioner, 16 October 2023, p 3.

2.112 Greater digital inclusion and digital literacy, especially among older people, linguistically diverse people, and people with low incomes, is needed to ensure that telehealth is an option for all to choose.[221]

Committee comment

2.113 At the outset, the committee wishes to acknowledge the breadth of evidence presented by various stakeholders and thank them for sharing their experiences. We recognise that in retelling their stories, many may have relived painful memories and trauma in order to advocate for change. These stories came from individuals with lived experience, who described the difficulties of navigating the complex and confusing mental health system, as well as carers and family who spoke of supporting their loved ones through a system no one seems to have a map for.

2.114 Those on the front line, a diverse and dedicated workforce across the medical and health profession, community and NGO sector, justice and emergency space, also shared compelling evidence of the challenges and difficult choices they are forced to make every day. We also recognise the particular experiences of Aboriginal and Torres Strait people who are disproportionately affected by mental ill health and face additional barriers to accessing culturally safe care.

2.115 This inquiry has reinforced that mental health is complex, and that there are many interconnected factors that contribute to a person's mental health, including social and environmental factors. Social factors or 'social determinants of health' include but are not limited to housing, disability, cultural or linguistic background, literacy and health literacy, gender, sexuality, socio-economic status and living in a regional or remote area. Improving mental health therefore requires a comprehensive and holistic approach that considers all aspects of a person's life and the society and environment in which they live. The committee therefore recommends that the NSW Government undertake a whole of government reform approach to the mental health system, which addresses social and environmental determinants of health including housing, cost of living, transport, education, employment, climate change and impact of natural disasters.

Recommendation 1

That the NSW Government undertake a whole of government reform approach to the mental health system, which addresses social and environmental determinants of health including housing, cost of living, transport, education, employment, climate change and impact of natural disasters.

Finding 1

That cost, waiting times, and geographical or cultural inaccessibility can be significant barriers to accessing appropriate mental health care in New South Wales.

221 Submission 41, ACON, p 13.

2.116 The committee was particularly concerned regarding the lack of appropriate and accessible care for the 'missing middle' – those people who may be too unwell for primary care, but who are not severe enough to meet the criteria for more specialised mental health support. Our concern was compounded by evidence which suggested that it is only when people deteriorate to a point of crisis that acute services may be available, and even then, they often are not appropriate for complex and long-term care that is needed.

2.117 We note the evidence from the Black Dog Institute which attributes this 'missing middle' to the gap in funding between federal and state services. We also acknowledge the critical role community mental health services play in bridging Medicare-funded services and State-funded acute services as well as providing early intervention and preventative care within the community. The committee believes that a coordinated effort, both at the State and Federal level, is needed for any reform of the mental health system and calls on the NSW Government to make representations to the Australian Government to address the gaps in funding and workforce for primary care and mental health services, including improved equitability of the Better Access scheme, and incentive schemes equivalent to those for procedural skills to better enable primary care services to support mental health.

Recommendation 2

That the NSW Government make representations to the Australian Government to address the gaps in funding and workforce for primary care and mental health services, including improved equitability of the Better Access scheme, and incentive schemes equivalent to those for procedural skills to better enable primary care services to support mental health.

2.118 There is a clear consensus that the mental health system is complex, fragmented and difficult to navigate for everyone, including consumers, carers and medical practitioners. We were alarmed to hear of stories from consumers and carers, faced with a lack of information, who battled their way through long waiting periods and incorrect referrals to get the care they deserve, often having to re-tell their story at each stage. The experience of both young people, CALD and LGBTQIA+ communities were particularly concerning in this area, as witnesses from both described the added hurdles they often face in accessing care, including prohibitive costs and low mental health literacy. It is clear that the fragmentation of mental health services in NSW has led to extraordinary difficulty for people and their carers to access appropriate care and exacerbated their distress, as well as contributing to inefficient use of limited resources. The fragmentation of mental health funding in NSW through short term grants and program funding is also a factor in the overall fragmentation of mental health services.

Finding 2

The fragmentation of mental health services in NSW leads to extraordinary difficulties for mentally ill people and their carers to navigate and access appropriate services and care. This difficulty often exacerbates mental distress, and contributes to inefficient use of limited resources.

Finding 3

Fragmentation of mental health funding in NSW through short term grants and program funding is a factor in the overall fragmentation of mental health services.

2.119 On the other hand, we were encouraged by the work of organisations such as 13YARN, WayAhead and Flourish and others and the support they provide to consumers and carers to navigate the system. We were particularly interested in the new peer navigation project by the Mental Health Commission of NSW, and the opportunities it presents to further assist with access and navigation of mental health services. The evidence was clear that providing guidance to consumers and carers as they navigate the system has seen an improvement in referral pathways, a reduction in waiting lists and overall improved recovery outcomes. Given this, we call on the NSW Government to ensure funding for carer education, supports and resources, including respite services. We also call on the NSW Government to ensure that the existing mental health service directories are widely publicised, updated every three months, and search engine optimised, as appropriate for the type of directory.

2.120 We also encourage NSW Health to look for ways to enhance service pathways between State and Commonwealth Government agencies, non-government and community-managed organisations, and private health care services to facilitate better access, affordability, and navigation of services, and to look to expand the employment of peer navigators to strengthen service navigation. Finally, we call on the NSW Government, in providing grants to non-government organisations for mental health service provision, explore the inclusion of funding for the integration of programs within the sector and collaboration including information sharing with other providers.

Recommendation 3

That NSW Government ensure funding for carer education, supports and resources, including respite services.

Recommendation 4

That the NSW Government ensure that the existing mental health service directories are widely publicised, updated every three months, and search engine optimised, as appropriate for the type of directory.

Recommendation 5

That NSW Health enhance service and referral pathways and information sharing between State and Commonwealth Government agencies, non-government and community-managed organisations, and private health care services to facilitate better access, affordability, and navigation of services, and to look to expand the employment of peer navigators to strengthen service navigation.

Recommendation 6

That the NSW Government, in providing grants to non-government organisations for mental health service provision, explore the inclusion of funding for the integration of programs within the sector and collaboration including information sharing with other providers.

2.121 The committee also heard that consumers are frequently turned away from mental health care services if a particular service is not provided or is at capacity. It is clear that more often than not, there are too many wrong doors and not enough right ones, leading to consumers feeling confused and overwhelmed when trying to navigate the system. No one should be turned away from treatment and instead, consumers should be guided to the appropriate service using warm referrals and follow-ups. To improve access to mental health services, NSW Health should look to:

- Document care pathways for providers and make them visible to the community,
- Review and refine eligibility and appropriateness criteria and make this information readily accessible,
- Redesign service models to build more flexibility to meet diverse needs,
- Invest in navigational supports concentrated on support for priority populations.

Recommendation 7

That NSW Health improve access to mental health services by:

- Documenting care pathways for providers and making them visible to the community,
- Reviewing and refining eligibility and appropriateness criteria and making this information readily accessible,
- Redesigning service models to build more flexibility to meet diverse needs,
- Investing in navigational supports concentrated on support for priority populations.

2.122 While the committee was encouraged by the use of telehealth and other digital health services to lower costs and increase accessibility for some consumers, as well as increase the capacity of mental health professionals, it is clear that it cannot be used as a panacea for the broader issues facing the mental health system. In this regard, we believe that digital and telehealth services represent an opportunity to improve access to mental health care, but must be a supplement to, and not a replacement for, in-person treatment. Everyone in New South Wales, especially in regional, rural and remote areas, should have the option of both quality digital and in-person mental health support.

Finding 4

Digital and telehealth services represent an opportunity to improve access to mental health care, but must be a supplement to, and not a replacement for, in-person treatment. Everyone in New South Wales, especially in regional, rural and remote areas, should have the option of both quality digital and in-person mental health support.

2.123 The committee was concerned by the significant volume of evidence that priority populations, including First Nations people, people who are culturally and linguistically diverse (CALD), LGBTQIA+ people (particularly trans and gender diverse people), young people, and people with disability, with significant need for mental health support face enormous barriers to accessing care. While the experiences of members of these communities is explored further throughout this report, it is clear that there is a need for targeted, specialised services to support

the unique needs of these communities in addition to initiatives to improve cultural safety and accessibility of mainstream mental health services. We therefore recommend that the NSW Government look to initiatives that provide mental health care outside of traditional clinical settings, such as the Wellbeing and Health In-reach (WHIN) program, which assist target populations to access appropriate mental health services.

2.124 Finally, throughout the inquiry the committee heard about the specific needs of consumers who have experienced significant trauma, with stakeholders emphasising the importance of trauma-informed care for both consumers and carers. The committee also received evidence that the current standard and availability of trauma-informed care could be improved. We therefore recommend that the NSW Government consider establishing a centre of excellence for research, training, clinical supervision and support, in order to deliver specific evidence-based therapies in trauma informed care.

Recommendation 8

That the NSW Government look to initiatives that provide mental health care outside of traditional clinical settings, such as the Wellbeing and Health In-reach (WHIN) program, which assist target populations to access appropriate mental health services.

Recommendation 9

That the NSW Government consider establishing a centre of excellence for research, training, clinical supervision and support, in order to deliver specific evidence-based therapies in trauma informed care.

Chapter 3 Challenges facing the mental health workforce

This chapter examines the extreme challenges currently faced by the mental health workforce. The main challenges explored in this chapter include staffing shortages, increased caseloads, burnout, and workforce safety. These issues are compounded when combined with a lack of funding and inadequate data sharing in the mental health sector. The above are factors that contribute to the 'crisis-driven' system.

Finally, the chapter examines key aspects of the changing nature of the mental health workforce, exploring implications of the ageing workforce, the addition of peer workers to the workforce, and telehealth delivery.

A crisis-driven system

3.1 Throughout the inquiry, the committee heard that challenges faced by the mental health workforce, such as staff shortages, increased workloads and burnout are contributing to a 'crisis-driven' mental health system. These challenges are interconnected, with workforce shortages generally creating higher caseloads, and higher caseloads being one factor contributing to professional burnout.[222] Additionally, a number of stakeholders asserted that the sector is suffering from widespread lack of funding and inadequate data sharing, creating more pressures for the mental health workforce.

Staff shortages and excessive caseloads

3.2 A lack of staff in the mental health workforce, and the impact these shortages and increased workloads have on providing quality care, was a key theme of stakeholder evidence to the inquiry. As at June 2022, there were of 9,817 full time equivalent mental health professionals in the NSW mental health workforce.[223] These professionals include doctors, nurses and allied health professionals.[224]

3.3 NSW Health identified workforce shortages and barriers to recruiting and retaining staff as some of the key issues impacting the quality, supply, distribution and structure of the mental health workforce.[225] As a consequence, many stakeholders said that provision of care in the community mental health system is currently being driven by 'crisis responses' with only people in crisis being prioritized for access to limited resources.[226]

222 Submission 36, Occupational Therapy Australia, p 5.

223 Submission 148, NSW Health, p 23.

224 Submission 148, NSW Health, p 23.

225 Submission 148, NSW Health, p 23.

226 See for example; Submission 36, Occupational Therapy Australia, p 5; Submission 40, Marathon Health, p 2; Submission 2, Mr Marc Lamond, p 2; Submission 17, Name suppressed, p 1; Submission 57, Local Government NSW, p 10; Submission 101, Tresillian, p 4; Submission 103, Australian Salaried Medical Officers' Federation, p 7.

3.4 For example, Mr Marc Lamond, a registered nurse working in NSW said that care coordinators facing excessive caseloads and subsequent time pressures must focus on crisis management and addressing patients needing immediate care, resulting in a negative effect on the quality of the therapeutic interventions and care provided.[227] Barnardos Australia described a similar detrimental effect on consumers, claiming that waitlists are often so long that services miss the opportunity to treat a consumer before their situation becomes a crisis.[228]

3.5 Ms Kasia Thoms, a registered nurse employed in a community mental health team, referred to the staffing shortages in her team as 'severe', fueling exhaustion amongst workers:

> Community mental health teams are experiencing severe staff shortages whilst trying to provide a high-quality service to record high numbers of outpatient mental health services uses. The mental health clinicians who are employed are exhausted and burnt out, trying their best to provide a service with minimal resources.[229]

3.6 Ms Victoria Norris, another registered nurse and Perinatal and Infant Mental Health Service Nurse Manager, described the system in similar terms, referring to her team as 'very understaffed',[230] while Ms Gen Whitlam, Associate Director, Client Services, ACON, said that the system was 'buckling under the pressure of workforce shortages'.[231]

3.7 Occupational Therapy Australia identified workforce shortages as the main factor behind high caseloads for their mental health staff, forcing occupational therapists to decline student placements, due to lack of time.[232] Similarly, the Mental Health Coordinating Council described 'overwhelming caseloads', combined with 'too few practitioners', as placing considerable pressure on mental health outpatient services.[233] Dr Tim Senior, a General Practitioner, described GPs as 'picking up the slack' in the mental health system by trying to fill gaps caused by workforce shortages, despite already being at capacity themselves.[234]

3.8 The NSW Nurses and Midwives Association (NSWNMA) noted that a lack of experienced and available staff was requiring existing staff to work increased overtime.[235] At the hearing, Ms Helen Boardman, Clinical Nurse Consultant with the NSWNMA informed the committee that whilst guidelines recommend one full-time equivalent employee to handle no more than 35 patients, it was shown that some nurses were managing a case load of 80.[236] The NSWNMA

227 Submission 2, Mr Marc Lamond, p 2.

228 Submission 43, Barnardos Australia, p 5.

229 Submission 89, Miss Kasia Thoms, p 1.

230 Evidence, Ms Victoria Norris, Registered Nurse, Perinatal and Infant Mental Health Service Nurse Manager, North Sydney Local Health District, NSW Nurses and Midwives' Association, 16 October 2023, p 18.

231 Evidence, Ms Gen Whitlam, Associate Director, Client Services, ACON, 22 September 2023, p 22.

232 Submission 36, Occupational Therapy Australia, p 5.

233 Submission 39, Mental Health Coordinating Council (MHCC), p 5.

234 Submission 130, Dr Tim Senior, p 4.

235 Submission 146, New South Wales Nurses and Midwives' Association, p 16.

236 Evidence, Ms Helen Boardman, Registered Nurse, Clinical Nurse Consultant, NSW Nurses and Midwives' Association, 16 October 2023, p 20.

said the situation was particularly untenable in rural and regional areas, with caseloads ranging between 20-60 clients per staff member.[237]

3.9 The impact of inappropriate caseloads on consumers and carers was described by Amelia Klein who cared for a person who died by suicide while under the care of a community mental health service:

> It was clear to me that the CMH team was not funded to do the work to keep all of their patients safe and happy. Contact was incredibly sporadic; I recall that if XX was not able to take a call at the time that the CMH team made it because of their work or other commitments, it could be a week before there would be any follow up contact.[238]

3.10 The benefits of being able to access a range of professionals working in a multidisciplinary team were described both by workers within such teams and consumers accessing them.[239]

3.11 Similarly, regional community-managed organisations such as WardellCORE in the Northern Rivers, noted that their mental health team was 'completely overwhelmed', with the team having to constantly check on their own health to manage their caseloads,[240] Mr Joel Orchard, Executive Director, Wardell CORE described his team as working 'well beyond their scope', and having to increase their caseloads due to limited pathways for them to refer consumers.[241]

3.12 The NSW Council of Social Service reported that in a recent survey of social workers, 54 per cent of respondents voted that increased caseloads and demand, compiled with no additional funding, as impacting their personal wellbeing.[242]

3.13 Ms Deb Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience with the NSW Ministry of Health informed the committee of the national workforce taskforce (chaired by the NSW Health Secretary) aimed at improving workforce shortages.[243]

3.14 Witnesses identified a number of reasons for these staffing shortages. These challenges included an overall difficulty in filling advertised vacancies, attracting skilled staff due to poor perception of the working conditions, attracting staff to regional areas, a shift towards locum work and staff leaving the profession prematurely. These are explored in further detail below.

A difficulty filling advertised vacancies

3.15 Struggles with recruitment and a difficulty in filling advertised vacancies were identified as one of the contributors to staff shortages and high caseloads across the mental health workforce. For example, the Royal Australian and New Zealand College of Psychiatrists discussed the

237 Submission 146, New South Wales Nurses and Midwives' Association, p 9.

238 Submission 88, Amelia Klein, p 1.

239 Submission 6, Mr Michael Daley, p 1.

240 See for example, Evidence, Mr Joel Orchard, Executive Director, Wardell CORE, 13 February 2024, p 24, Evidence, Ms Kelly Banister, CEO, Northern Rivers Women and Children's Services, 13 February 2024, p 4.

241 Evidence, Mr Joel Orchard, Executive Director, Wardell CORE, 13 February 2024, pp 24-25.

242 Submission 62, NSW Council of Social Service (NCOSS), p 2.

243 Evidence, Ms Deb Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health, 16 October 2023, p 43.

extreme difficulty of attracting psychiatrist trainees in NSW.[244] Similarly, members of Occupational Therapy Australia submitted that an entire Local Health District no longer employed any mental health occupational therapists, as they had been unable to recruit to vacancies.[245] The New South Wales Nurses and Midwives Association noted that despite positions being advertised, there remains a lack of clinicians applying for mental health roles,[246] while Dr Karen Williams of Ramsay Clinic Thirroul noted the difficulty in recruiting, given the income mental health jobs offer.[247]

3.16 Additionally, a lack of competitive pay is preventing individuals from entering the mental health workforce. Nurses in private sectors were seen to be earning up to three times more than that of public sector nurses.[248] The Australian Clinical Psychologists Association noted 'inadequate remuneration' as one of the factors driving practitioners to depart the mental health workforce,[249] with another stakeholder noting community mental health clinician salaries do not reflect their advanced level of skill.[250]

3.17 When asked about the issue at a hearing, Ms Willcox from the NSW Ministry of Health acknowledged that the Ministry was 'struggling to attract into the public health system', with many recruits entering the private system.[251]

A negative perception of working conditions

3.18 Other stakeholders attributed the shortage of skilled staff to a negative external perception of the working conditions. For example, Dr Angelo Virgona, Chair, NSW Branch, Royal Australian and New Zealand College of Psychiatrists, described how junior doctors are less likely to enter psychiatry programs after observing the strain of the occupation:

> Because the services have been so under the pump and so stressful, when a junior doctor comes and observes them they see that it is a really stressful occupation and I think they get turned off. That's one of the issues I think we face in New South Wales. Victoria have mandated that all their junior doctors get rotated through a psychiatric term during their first two years of training as a junior medical officer. We don't have that in New South Wales…but we know that the more exposure you have to doing psychiatry—having a term in psychiatry—the more likely you are to train in it and to see it as an option.[252]

244 Evidence, Dr Angelo Virgona, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists, 16 October 2023, p 12.

245 Submission 36, Occupational Therapy Australia, p 36.

246 Submission 146, New South Wales Nurses and Midwives' Association, p 14.

247 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 7.

248 Submission 146, New South Wales Nurses and Midwives' Association, p 16.

249 Submission 75, The Australian Clinical Psychology Association (ACPA), p 2.

250 Submission 89, Ms Kasia Thoms, p 1.

251 Evidence, Ms Deb Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health, 16 October 2023, p 45.

252 Evidence, Dr Angelo Virgona, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists, 16 October 2023, p 14.

3.19 Similarly, Ms Norris representing the NSWNMA attributed a 'high rate of burnout' as reasoning for vacancies in nursing,[253] with another stakeholder blaming the 'stressful working conditions' for shortages.[254] A number of stakeholders identified a distinct connection between the 'stress', or 'burnout' of the profession, which hinders recruitment and leads to workforce shortages. Burnout and caseloads will be discussed below.

Challenges attracting staff to regional or remote areas

3.20 Stakeholders including the Rural Doctors' Association of New South Wales (RDANSW) and the Australian Salaried Medical Officers' Federation NSW (ASMOF) described workforce shortages as particularly acute in rural and regional areas, with a lack of staff amplified by limited mental health services available to local consumers.[255] Specifically, Rural Doctors' Association of New South Wales said:

> Mental Health care is difficult for rural patients to access, not only due to limited transport options, distance, financial resources, work commitments and ability to take time away from family, but also the actual number of services available, thus leading to inequity of access to outpatient mental health services.[256]

3.21 The Royal Australian College of General Practitioners agreed that there is a lack of service provision in rural and regional NSW,[257] while a stakeholder from rural NSW described having access to a local GP as a 'rare event'.[258] Lifeline Australia also suggested that the effects of geographic challenges and skill gaps are being exacerbated by short-term funding cycles.[259] Funding cycles are discussed at 3.63.

3.22 On the factors contributing to shortage of the mental health workforce in underserviced areas, Western Sydney Health Alliance noted the following:

- long commute to work
- stressful working conditions
- limited resources and career paths
- lack of "exciting" health collaborations that exist in urban/larger rural areas.[260]

3.23 Additionally, Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative claimed that the difficulty in recruiting and retaining staff in rural and regional areas was compounded by cost and availability of housing. For this reason, he argued

253 Evidence, Ms Victoria Norris, Registered Nurse, Perinatal and Infant Mental Health Service Nurse Manager, North Sydney Local Health District, NSW Nurses and Midwives' Association, 16 October 2023, p 16.

254 Submission 77, Western Sydney Health Alliance, p 12.

255 Submission 140, Rural Doctors' Association of New South Wales (RDANSW), p 1; Submission 103, Australian Salaried Medical Officers' Federation, p 5.

256 Submission 240, Rural Doctors' Association of New South Wales (RDANSW), p 1.

257 Submission 44, The Royal Australian College of General Practitioners (RACGP) Rural, p 1.

258 Submission 110, Name Suppressed, p 1.

259 Submission 25, Lifeline Australia, p 7.

260 Submission 77, Western Sydney Health Alliance, p 12.

that workforce allocations in regional areas need to be sufficient to cover the immense amount of travel staff need to undertake to support their clients.[261]

3.24 Incentives like higher pay, and benefits such as better staffing and ratios were suggested by the New South Wales Nurses and Midwives' Association as a way to increase mental health staff in regional areas.[262] The Australian Association of Psychologists Inc also recommended supporting the rural and regional workforce' by providing the following:

- financial incentives
- training opportunities and professional development programs
- rural loading
- covering location expenses
- subsidised housing
- reduced education debts for individuals who committee to a period of rural and regional practice.[263]

3.25 Stakeholders recommended both State and Federal Governments to develop strategies to attract mental health and allied health professionals in both regional and rural and regional areas.[264] At the hearing, Ms Willcox of NSW Health acknowledged the difficulty to 'attract and retain' mental health staff in the 'harder environment' of rural and regional areas, noting the issue was a source of separate focus for the Department.[265]

3.26 Social workers and accredited mental health social workers were found to be more 'readily available' than other mental health professionals, particularly in regional or remote areas.[266] The Australian Association of Social Workers found that:

- 47 per cent of workers were living in regional, rural or remote locations
- 50 per cent were able to take on new clients
- 37 per cent had ability to take on more clients
- 9 per cent were able to see clients on the same day of the booking.
- 16 per cent had a wait list of one week
- 60 per cent had a wait list of two weeks or less.[267]

261 Evidence, Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2024, pp 49-50.

262 Submission 146, New South Wales Nurses and Midwives' Association, p 15.

263 Submission 35, Australian Association of Psychologists Inc (AAPi), p 4.

264 Submission 63, North Coast Allied Health Association, p 2.

265 Evidence, Ms Deb Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health, 16 October 2023, p 43.

266 Submission 97, Australian Association of Social Workers (AASW), pp 6-7.

267 Submission 97, Australian Association of Social Workers (AASW), p 5.

3.27 The Australian Association of Social Workers thus recommended that accredited mental health workers and social workers should be taken into consideration when undertaking workforce planning and allocation of resources for the mental health workforce.[268]

Reliance on locum doctors

3.28 Stakeholders identified the use of locum doctors (due to shortages) as fostering a reliance on them, as well as disrupting continuity of care for consumers.[269] Locum doctors are doctors who temporarily fill staffing gaps on a casual basis. In addition to making mental health services more reliant on locum doctors, the New South Wales Nurses and Midwives' Association asserted that the shortage of medical staff sees a 'constant turnover' of locums, creating a destabilising environment for consumers due to a lack of continuity of care.[270]

3.29 The Association also noted the difficulty in trying to recruit and retain permanent psychiatrists, as they are likely to earn more working as a locum.[271]

Lack of available clinicians for priority groups

3.30 For priority groups, stakeholders noted that shortages are even further exacerbated due to a lack of clinicians available to provide culturally sensitive and safe care. For example, 13YARN said that whilst there are Aboriginal community-controlled health organisations providing culturally and safe care, there remains a lack of Aboriginal clinicians.[272] Mrs Marjorie Anderson, National Manager at 13YARN further explained that work must be done to attract young Aboriginal people into clinical work, such as providing incentives and support:

> There are not enough Aboriginal clinicians in New South Wales. Australia-wide, there are not enough Aboriginal clinicians. I think we need to get back to the very beginning and really start to do some work on attracting young Aboriginal people into clinical work and supporting them through university – maybe not put a big HECS debt on them to go through university – and really support Aboriginal people to go through university on scholarships when we're going to build the clinical workforce. That's the problem. We're all fighting over the same clinicians.[273]

3.31 In addition, the UNSW Indigenous Health Education Unit (IHEU) and the Illawarra Aboriginal Medical Services (IAMS) expressed the view that community mental health services lack cultural safety for Aboriginal and Torres Strait Islander staff. This, compounded with the vicarious and intergenerational trauma often experienced, results in a high turnover of Aboriginal and Torres Strait Islander staff.[274]

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268 See for example, Submission 97, Australian Association of Social Workers (AASW), p 6; Evidence, Ms Angela Scarfe, Senior Policy Officer, Australian Association of Social Workers, 15 February 2024, p 42.

269 Evidence, Dr Angelo Virgona, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists, 16 October 2023, p 12.

270 Submission 146, New South Wales Nurses and Midwives' Association, p 14.

271 Submission 146, New South Wales Nurses and Midwives' Association, p 16.

272 Evidence, Mrs Marjorie Anderson, National Manager, 13YARN, 16 October 2023, p 51.

273 Evidence, Mrs Marjorie Anderson, National Manager, 13YARN, 16 October 2023, p 51

274 Submission 164, UNSW Indigenous Health Education Unit and the Illawarra Aboriginal Medical Services, p 1.

3.32 IHEU and IAMS also noted that many of these issues stem from the lack of Aboriginal and Torres Strait Islander identified positions in the mental health workforce. They advised that available identified positions are bottom-heavy, with many being trainee and entry-level graduate positions. The lack of positions at the management and executive level means a gap in strategic direction and appropriate support for lower-level staff, which can deter Aboriginal and Torres Strait Islander people from applying to entry-level positions as there is little chance of career progression. Career progression is also made more difficult as many of the mainstream position descriptions do not recognise experience as an Aboriginal Mental Health Worker or Clinician as appropriate experience.[275]

3.33 Similarly, Mr Ben Benazzouz, Provisional Psychologist, Head of Practice Management, Settlement Services International whose organization which provides refugee resettlement and asylum seeker programs, described the limited numbers of specialized psychologists available to provide support to their clients:

> We know that a lot of refugees and asylum seekers come from a part of the world where trauma is very common, and specifically complex trauma—to have those psychologists who are linguistically competent and also clinically competent to work with these types of multicultural diverse background clients is quite difficult.[276]

3.34 Ms Justine Harris, Clinical Psychologist, Head of Practice Management at Settlement Services International, expanded that psychologists with a CALD background are frequently barred from entering the workforce due to not meeting English language requirements.[277]

Burnout

3.35 The prevalence of burnout in the mental health workforce was another key feature of the evidence. Ms Victoria Norris, Registered Nurse representing the NSW Nurses and Midwives' Association told the committee that there was a high burnout rate across mental health settings in metropolitan Sydney, with a noted lack of support for frontline clinicians.[278]

3.36 A number of stakeholders described experiencing burnout as a consequence of feeling like they had nowhere to send consumers to receive the help they needed, due to a lack of available services or pathways. For example, consultant psychiatrist Dr Karen Williams described the difficult situation of bonding with a consumer, then having 'nowhere to send them', and feeling she was only able to dispense medication and not holistic care:

> You do feel really frustrated and depressed and anxious about the fact that you're sending people that you've developed a bond with and you care about. You've got nowhere to send them… You're actually financially penalised to spend a long time with

275 Submission 164, UNSW Indigenous Health Education Unit and the Illawarra Aboriginal Medical Services, p 2.

276 Evidence, Mr Ben Benazzouz, Provisional Psychologist, Head of Practice Management, Settlement Services International (SSI), 22 September 2023, pp 30-1.

277 Evidence, Ms Justine Harris, Clinical Psychologist, Head of Practice Management, Settlement Services International (SSI), 22 September 2023, p 31.

278 Evidence, Ms Victoria Norris, Registered Nurse, Perinatal and Infant Mental Health Service Nurse Manager, North Sydney Local Health District, NSW Nurses and Midwives' Association, 16 October 2023, p 16.

> people. You're better off seeing patients every 15 minutes and writing a script than… you get a shift away from the things that are actually meaningful and you do the shallow work that actually doesn't provide that sort of satisfaction. [279]

3.37 Dr Vicki Mattiazzo, Deputy Chair, RACGP Rural Faculty, Royal Australian College of General Practitioners Rural, said that some GPs reported finding it challenging to get service providers to take responsibility for care of a patient, leaving it up to GPs to work out the best pathway – something which many found 'devastating', 'frustrating' and 'disheartening', and contributing to burnout.[280]

3.38 The Australian Paramedics Association also reported that their members described having limited options of appropriate care pathways for consumers, which they referred to as creating a 'deep sense of unease and exhaustion'.[281] Ms Anita McGregor, Forensic Psychologist, Member of the College of Forensic Psychologists of the Australian Psychological Society also identified long waitlists and an underfunded system as contributing to burnout.[282]

3.39 Burnout was also described as being caused by the unpredictable nature of providing mental health support, as well as by a general disillusionment with the system's ability to help people get better. For example, Dr Tim Senior, General Practitioner mentioned driving to work 'every day feeling anxious', speculating what complex mental health situation he might have to deal with.[283] Dr Williams, a consultant psychiatrist in Thirroul, identified a similar disillusionment, describing individuals as entering medicine 'to see people get better…', however, '…that's not happening in the mental health system…its not inspiring new people to do it at all'.[284] Similarly, the Australian College for Emergency Medicine submitted that emergency physicians often feel 'frustrated and demoralised' in trying to provide safe and quality care for people in extreme distress in emergency departments.[285]

3.40 On the effect of burnout on staff and service provision, Mrs Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc said that staff were reducing their work hours to cope, which could lead to both financial instability for individual staff and a general reduction in the available support for consumers.[286]

Reducing the prevalence of burnout

3.41 A number of stakeholders made suggestions around how burnout in the mental health workforce could be reduced. Mrs Amanda Curran, Chief Services Officer, Australian

279 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 6.

280 Evidence, Dr Vicki Mattiazzo, Deputy Chair, RACGP Rural Faculty, Royal Australian College of General Practitioners Rural, 16 October 2023, p 23.

281 Submission 149, Australian Paramedics Association (NSW), p 16.

282 Evidence, Ms Anita McGregor, Forensic Psychologist, Member of the College of Forensic Psychologists of the Australian Psychological Society, 16 October 2023, p 33.

283 Evidence, Dr Tim Senior, General Practitioner, 16 October 2023, p 5.

284 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 7.

285 Submission 66, Australasian College for Emergency Medicine, p 4.

286 Evidence, Mrs Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc., 16 October 2023, p 33.

Association of Psychologists Inc said that additional financial resourcing for supervision of the psychological workforce was important, to ensure workers had adequate support.[287] Dr Tim Senior agreed, recommending 'formal clinical supervision to prevent emotional burnout from high mental health loads for GPs', along with the provision of clinical supervision and support for primary health workers.[288] Noting a lack of capacity to follow up with consumers, Dr Graham Brereton, a Registered Nurse and Psychologist, recommended mental health workers partner with GPs to check in with clients who miss appointments in order to relieve some of the stress on GPs.[289] Similarly, the committee heard from a doctor with 20 years experience who recommended teams to support public psychiatrists, and also called for trainees to be 'nurtured'.[290]

3.42 The Australian Salaried Medical Officers' Federation NSW also emphasised the importance of training and support from senior management, particularly for junior doctors and stressed the importance of retaining highly experienced senior workforce to provide support and training to junior doctors.[291] Similarly, the Australian Paramedics Association (NSW) (APA) reported that participants in a survey they conducted reported 'insufficient access to managerial support', further exemplifying importance of providing care to more junior frontline workers.[292]

3.43 On the topic of support and supervision, the Australian Psychologist Society recommended more clinical supervision to support mental health workers, and that the supervision requirement be raised to more than just 10 hours a year.[293] Ms Anita McGregor, Forensic Psychologist, also called for psychologists to have access to external supervision and support, rather than have supervision with line administrators in order to provide safety for psychologists.[294] The North Coast Allied Health Association recommended extending clinical supervision to all allied health professionals.[295] Additionally, Dr Tim Senior stressed the importance of adequate support for mental health staff, in terms of appropriate funding, proper workforce capacity, and psychological supervision, to prevent psychological burnout and stop individuals leaving the workforce.[296]

3.44 Additionally, Ms Kylie Coventry, Head of Policy, Australian Psychological Society (APS) said that external factors such as natural disasters like floods and fires are impacting frontline and mental health workers' personal and professional lives, as they are required to provide quality support the affected communities they also live in.[297] Both the APS and Local Government

287 Evidence, Mrs Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc., 16 October 2023, p 33.

288 Evidence, Dr Tim Senior, General Practitioner, 16 October 2023, pp 4-5.

289 Evidence, Mr Graham Brereton, Registered Nurse and Psychologist, 16 October 2023, p 5.

290 Submission 121, Name Suppressed, p 2.

291 Submission 103, Australian Salaried Medical Officers' Federation NSW (ASMOF), p 6.

292 Submission 149, Australian Paramedics Association (NSW), p 17.

293 Evidence, Ms Anita McGregor, Forensic Psychologist, Member of the College of Forensic Psychologists of the Australian Psychological Society, 16 October 2023, p 33.

294 Evidence, Ms Anita McGregor, Forensic Psychologist, Member of the College of Forensic Psychologists of the Australian Psychological Society, 16 October 2023, p 33.

295 Submission 63, North Coast Allied Health Professionals, p 5.

296 Submission 130, Dr Tim Senior, p 7.

297 Evidence, Ms Kylie Coventry, Head of Policy, Australian Psychological Society, 16 October 2023, pp 33-34.

NSW called for greater access to mental health services in times of natural disasters for consumers, noting access and availability is more difficult during natural disasters[298].

Compassion fatigue and vicarious trauma

3.45 Similar but distinct experiences to burnout identified by stakeholders were compassion fatigue and vicarious trauma. Compassion fatigue refers to the psychological and physical impact of helping others, caused by a depleted ability to cope with their everyday environment and can lead to workers entering a state of physical and mental exhaustion[299] The APA asserted that compassion fatigue can impact standards of patient care, as well as contributing to anxiety or depression in staff and that members had described feelings of 'emotional and mental fatigue' and burnout.[300]

3.46 Compassion fatigue was described by ACON as creating a lack of empathy in service provision,[301] while the Mental Health Coordinating Council and Suicide Prevention Australia reported that compassion fatigue was impacting the quality of care received.[302] Suicide Prevention Australia noted that compassion fatigue was even causing workers to label some patients as 'too hard to engage' with.[303] ACON attributed a combination of burnout, stress, compassion fatigue and vicarious trauma as leading to a high turnover of staff.[304]

3.47 The APA also discussed 'moral injury', which refers to the significant impacts that can occur when staff betray their own moral beliefs in response to events or high-stakes situation.[305] They described the difficult decisions paramedics have to make when dealing with extremely vulnerable patients, noting feelings of guilt felt when facing limited referral pathways.[306]

3.48 A number of witnesses were asked about the effect of vicarious trauma on service providers, particularly frontline workers.

3.49 Ms Tara Hunter, Director, Clinical and Client Services, Full Stop Australia, described the 'absolute sense of overwhelm' that frontline staff experience, and argued for trauma-informed care systems to acknowledge that clinicians can be impacted by consumer's stories of trauma.

> Again, it doesn't matter where you're working, the impacts of things like vicarious trauma, where we are, as frontline workers, bearing witness to people's trauma and their stories—and actually having the appropriate acknowledgement around how that might impact on workforce as well. Because all those things—if we have people in our workforce who are already distressed, then they have a shutdown when they are hearing someone else's story. [307]

298 Submission 57, Local Government NSW, p 7.

299 Submission 149, Australian Paramedics Association (NSW), p 16.

300 Submission 149, Australian Paramedics Association (NSW), p 16.

301 Submission 31, ACON, p 7.

302 Submission 39, Mental Health Coordinating Council, p 4; Submission 62, Suicide Prevention Australia, p 7.

303 Submission 62, Suicide Prevention Australia, p 8.

304 Submission 31, ACON, p 7.

305 Submission 149, Australian Paramedics Association (NSW), p 17.

306 Submission 149, Australian Paramedics Association (NSW), p 17.

307 Evidence, Ms Tara Hunter, Director, Clinical and Client Services, Full Stop Australia, 15 February 2024, pp 6-7.

3.50 Using their firsthand experience working in mental health, a stakeholder described the burnout felt from their experiences:

> I wanted to mention working in the system too as it gives me a 360% view of its tragic failings and the moral injury this does to health workers, especially lived experience workers and clinicians working in humanistic ways. I actually got into this line of work thinking that mental health organisations would be best placed to offer psychologically supportive workplaces which would benefit my personal recovery. I was wrong, however, as it turned out that the system was deeply broken, full of the vicarious trauma of being complicit in a system that routinely hurts and disappoints consumers…'[308]

3.51 When questioned about the relationship between vicarious trauma and burnout, Dr Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, responded that service providers felt they had neither the time nor the resources to adequately support people in a satisfying way, leading to the work feeling 'shallow' and contributing to burnout.[309] North Coast Allied Health Association echoed the view that there is insufficient time allocated for clinical sessions for staff to respond effectively to people with trauma, and that this created challenges in establishing effective boundaries to safe-guard themselves.[310]

3.52 Various stakeholders recommended vicarious trauma education and training for mental health workers as a means to better support and protect staff.[311] Others also called for a greater focus on trauma informed care, given its benefit to both consumer and clinician, with Ms Hunter, Full Stop Australia, stating that without this method of care, distressed staff are at risk of shutting down when hearing a consumer's story.[312]

Workforce safety

3.53 Stakeholders also raised concerns over the current state of worker safety in the mental health system, and discussed how workforce safety creates challenges for the mental health workforce. For example, the APA discussed occupational violence against paramedics, given patients in crisis and experiencing a distressing mental state can become agitated, and verbally or physically abuse paramedics.[313] The APA referred to data from a 2016 NSW Ambulance report which showed that 51 per cent of recorded instances of occupational violence over a six-month period were attributed to mental health patients.[314]

3.54 The Australasian College for Emergency Medicine also identified safety risks for the mental health workforce, stating that emergency department staff can often suffer vicarious trauma and

308 Submission 111, Name Suppressed, p 1.

309 Evidence, Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul, 15 February 2024, p 6.

310 Submission 63, North Coast Allied Health Association, p 5.

311 See for example; Submission 61, Suicide Prevention Australia (NSW), p 8; Sub 62, NSW Council of Social Service (NCOSS) p 2; Submission 63, North Coast Allied Health Association, p 1; Submission 39, Mental Health Coordinating Council (MHCC), p 4.

312 Evidence, Ms Tara Hunter, Director, Clinical and Client Services, Full Stop Australia, 15 February 2024, p 5.

313 Submission 149, Australian Paramedics Association (NSW), p 13.

314 Submission 149, Australian Paramedics Association (NSW), p 13.

physical and verbal violence from agitated patients.[315] Dr Angelo Virgona, Chair, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists, explained how there has been a shift away from providing home-based treatment in the mental health system now due to fears about worker health and safety:[316]

> There are places that you don't send your staff because the areas can be dangerous for them. A lot of work is done over the phone, increasingly.[317]

3.55 In this regard, Marathon Health praised telehealth as a means to increase workforce safety, noting that telehealth provides access to clients with a history of aggressive or dangerous behaviour, without risking staff safety.[318] Similarly, Ms Helen Boardman of NSW Nurses and Midwives Association informed the committee that mental health teams may call police for assistance, based on a risk assessment of how safe a visit would be for a mental health team.[319]

Lack of funding

3.56 A lack of funding was a common theme in stakeholders' evidence, with many drawing links between a lack of funding and the creation of a crisis-driven system. This was consistent across both staff and consumers. Ms Sahra O'Doherty, Acting President of the Australian Association of Psychologists Inc., said she could not treat, case manage and advocate for her patients without adequate funding, describing the current lack of funding for community managed organizations as creating a system that is 'understaffed and overburdened'.[320]

3.57 Along with identifying a lack of funding as a cause of many of the strains on the system, stakeholders also referred to specific ways in which an increase in funding would benefit the provision of services.

3.58 For example, various organisations and witnesses backed increased funding for more positions in university degrees to encourage students to study affiliated degrees, as well as greater funding for students to complete professional practicums in rural and remote areas.[321] Ms Anita McGregor emphasised the financial burden of studying psychology, noting that even with Commonwealth-support, there still remains a huge financial burden in supporting students through a two-year full-time program.[322]

315 Submission 66, Australasian College for Emergency Medicine, p 4.

316 Evidence, Dr Angelo Virgona, Chair, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists, 16 October 2023, p 14.

317 Evidence, Dr Angelo Virgona, Chair, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists, 16 October 2023, p 14.

318 Submission 40, Marathon Health, p 5.

319 Evidence, Ms Helen Boardman, Registered Nurse, Clinical Nurse Consultant, NSW Nurses and Midwives' Association, 16 October 2023, p 19.

320 Evidence, Ms Sahra O'Doherty, Acting President, Australian Association of Psychologists Inc., 16 October 2023, p 32.

321 Evidence, Ms Kylie Coventry, Head of Policy, Australian Psychological, 16 October 2023, p 28.

322 Evidence, Ms Anita McGregor, Forensic Psychologist, Member of the College of Forensic Psychologists of the Australian Psychological Society, 16 October 2023, p 34.

3.59 Others, such as Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council called for more funding for NGOs, in appreciation of the impact these services offer to consumers:

> They work collaboratively with public services to provide person-centred wraparound care and support to meet both needs and personal aspirations. The Mental Health Coordinating Council highlights that, when appropriate non-government services are available at the right time in the right place, there are fewer demands on public services. People require fewer inpatient admissions and outpatient services, leading to a reduction in public health costs overall. We strongly recommend enhanced funding for NGOs, channelled through a reallocation of funds generated by cost savings in the public services.[323]

3.60 Mrs Amanda Curran, Chief Services Officer Australian Association of Psychologists Inc, argued for additional Medicare funding for psychologist sessions, which she asserted would allow children and families to be seen at lesser cost, decreasing the current strain on acute mental health services.[324]

3.61 For organisations currently providing services to priority populations, witnesses commented that additional funding would help them from having to limit service hours and staff, increasing accessibility. Volunteer organisations spoke of having little to no funding, especially when providing to support to the LGBTQIA+ community, with Mx Georgie Fischer, Board Member, Sydney Bi+ Network describing the historical lack of funding for bi+ people as leaving them feeling like an 'afterthought'.[325]

3.62 Aboriginal community-controlled health organisations also called for more funding. Mrs Majorie Anderson of 13YARN said she struggled to think of a service that is 'well-funded' in NSW,[326] while Mr Shane Sturgiss, Chief Executive Officer, BlaQ noted that only 'mainstream white services' with the resources to request grants receive funding:

> It's that mainstream white services, bigger organisations that have the grant-writing teams attached to them, have the means to be able to put in submissions to get these big funding grants, and then they're commissioning out to smaller Aboriginal community controlled organisations to deliver their cultural competencies for a very small amount of money—a tokenistic amount of money—to deliver a majority of their contract when it comes to cultural compliance. This money needs to start going straight to the organisations, and access to this money and the funding submissions for smaller Aboriginal community-controlled health organisations and Aboriginal community-controlled organisations.[327]

3.63 There was a clear call from stakeholders for funding cycles to be extended to a minimum of three to five years.[328] At the hearing, Dr Evelyne Tadros of the Mental Health Coordinating

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323 Evidence, Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council, 16 October 2023, p 36.

324 Evidence, Mrs Amanda Curran, Chief Services Officer Australian Association of Psychologists Inc., 16 October 2023, p 32.

325 Evidence, Mx Georgie Fischer, Board Member, Sydney Bi+ Network, 22 September 2023, p 23.

326 Evidence, Mrs Marjorie Anderson, National Manager, 13YARN, 16 October 2023, p 51.

327 Evidence, Mr Shane Sturgiss, Chief Executive Officer, BlaQ Aboriginal Corporation, 16 October 2023, pp 51-52.

328 See for example; Submission 142, headspace, National Youth Mental Health Foundation, p 13; Submission 39, Mental Health Coordinating Council (MHCC), p 3; Submission 62, Suicide Prevention Australia, p 3; Submission 165, Queer Family, p. 8.

Council said that this would increase recruitment, retention, evaluation of services and continuity of care for patients, encouraging the NSW Government mimic the Commonwealth government in delivering deliver five-year contracts, with an additional five years pending performance.[329]

3.64 Ms Cara Varian, CEO, NSW Council of Social Service agreed that shorter funding cycles affected staff retention, noting that contracts of less than five years limit the ability of service providers to provide job security for their staff, causing staff to leave.[330] Ms Louise Ingall, Manager of Strategy, Research and Engagement, HealthWISE New England North West told the committee that an increase to a minimum of five year cycles had been recommended by the 2020 Productivity Commission Inquiry Report into Mental Health, with service providers to be made aware of funding decisions at least six months before the end of the cycle.[331]

3.65 General funding of mental health in New South Wales, compared with other jurisdictions, was also discussed by stakeholders. The Black Dog Institute described New South Wales as 'falling behind' other States and Territories in terms of mental health funding.[332] As a way to increase funding in this area, they praised the Mental Health and Wellbeing Tax Surcharge introduced in Victoria in 2022, as well as a similar scheme implemented in Queensland in 2023.[333]

3.66 The levy in Victoria imposes a 0.5 per cent surcharge on employers whose taxable wages are more than $10 million and a 1 per cent surcharge on employers with a total of more than $100 million. In the 2023-24 financial year, the Victorian State Government raised $912 million for mental health services through this levy. [334]

3.67 The Mental Health Coordinating Council explained that money generated from the Victorian levy is pledged to mental health programs and can only be used for funding mental health care.[335] Noting its success, the Black Dog Institute, Mental Health Coordinating Council, and One Door Mental Health all recommended a similar mental health payroll surcharge be implemented in New South Wales.[336]

Insufficient information and data sharing

3.68 Many stakeholders expressed the view that a lack of data sharing presents a major challenge for the mental health workforce. Data in the mental health system refers to both available information about consumers, as well as data shared between service providers. Data sharing

329 Evidence, Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council, 16 October 2023, p 36.

330 Evidence, Ms Cara Varian, CEO, NSW Council of Social Service, 15 February 2024, p 40.

331 Evidence, Ms Louise Ingall, Manager of Strategy, Research and Engagement, HealthWISE New England North West, 15 February 2024, p 48.

332 Submission 138, Black Dog Institute, pp 13-14.

333 Submission 138, Black Dog Institute, pp 13-14.

334 Submission 138, Black Dog Institute, p 13-14.

335 Submission 39, Mental Health Coordinating Council (MHCC), p 4.

336 Submission 138, Black Dog Institute, pp 13-14; Submission 39, Mental Health Coordinating Council (MHCC), p 4; Submission 60, One Door Mental Health, p 5.

across the mental health system was described as a 'challenge',[337] with another witness calling the lack of communication between services as a 'systemic failure'.[338]

3.69 The importance of good, accurate data, and the negative consequences of incomplete data, were stressed in a number of contexts. Some witnesses, such as Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute, referred to the need to improve data collection around the rate of service usage to better understand where resources should be deployed.[339] He called for data points demonstrating service demand by area, current levels of services and workforce and current vacancies to better inform workforce planning.[340] In his view, it is a 'scandal' that workforce and consumer data was not readily available, given that the 2020 Productivity Commission Inquiry Report into Mental Health recommended the publication of data by the Australian Institute of Health and Welfare to help coordinate and develop the national workforce:

> We should be collecting this data regularly to be monitoring how the system is working and then improving it over time. This data should be transparent. It should be made public for both policymakers like you and the sector like us to be able to adjust and make recommendations on how the system should change. It's also not a new idea. I'd like to take credit for it, but I absolutely cannot. It was actually raised as a recommendation in the 2020 Productivity Commission that all States should publicly be publishing this data, collecting this data and using the National Mental Health Service Planning Framework to be able to coordinate workforce development nationally.[341]

3.70 Mr Craig Parsons, General Manager, Partnerships and Innovation, Sydney North Primary Health Network supported this view, stating that a lack of data prevents the 'full understanding' of the needs in the community, what needs are being met, and where gaps remain.[342]

3.71 The Health Services Union recommended a mechanism be created within NSW Health to collect data on workforce gaps, and unfilled staff vacancies,[343] with Dr Angelo Virgona agreeing that getting the data 'right' would allow appropriate workforce planning.[344]

3.72 Witnesses also emphasised that data should be current, and specific enough to provide helpful insights. When questioned about data sharing between governments and organisations, Mr Parsons noted that agreements exist between LHDs and PHNs to exchange data regarding

337 Evidence, Ms Lizz Reay, Chief Executive Officer, Nepean Blue Mountains Primary Health Network, 17 November 2023, p 39.

338 Evidence, Ms Siobhan Hannan, Team Leader, Counselling Services, ACON, 22 September 2023, p 29.

339 Evidence, Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute, 17 November 2023, p 12.

340 Evidence, Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute, 17 November 2023, p 12.

341 Evidence, Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute, 17 November 2023, p 12.

342 Evidence, Mr Craig Parson, General Manager, Partnerships and Innovation, Sydney North Primary Health Network, 17 November 2023, p 39.

343 Submission 134, Health Services Union – NSW ACT QLD (HSU), p 1.

344 Evidence, Dr Angelo Virgona, Chair, NSW Branch, Royal Australian and New Zealand College of Psychiatrists, 16 October 2023, p 14.

suicide, however, he commented that the way this data was provided meant it was 'not necessarily available for forward planning', limiting its utility.[345] Similarly, he said that whilst census data was available, it was often out of date, with a lag between data collection and publication.[346]

3.73 In terms of the data being specific, some stakeholders also stressed the need for more data on the location and needs of priority groups. For example, Dr Fiona Kumfor, Associate Professor, School of Psychology, University of Sydney, Clinical Neuropsychologist and Co-Founder of the Dementia Law Network described how there isn't 'good data' on Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, regional and remote Australians or lower socio-economic groups.[347]

3.74 Similarly, Ms Gen Whitlam, Associate Director, Client Services ACON, said there was a lack of data on members of the LGBTQ+ community in regional and rural areas, noting that the Australian Bureau of Statistics did not collect 'adequate' data on gender and sexuality, and that a lack of data on where the LGBTQ+ community generally live creates challenges in referral options and planning.[348]

3.75 Additionally, Dr Janelle Weise, Senior Researcher, Department of Developmental Disability Neuropsychiatry, University of New South Wales informed the committee that data surrounding people with intellectual disability is not identified in routine information collected across health services, precluding staff from tracking consumers and limiting their ability to support these consumers.[349]

3.76 When asked about the issue of a lack of data at the hearing, NSW Health expressed awareness of concerns surrounding a lack of live data about current mental health workforce.[350] NSW Health informed the committee of a division within the Ministry of Health which monitors the health workforce, conducts modelling and planning.[351]

Improved information sharing

3.77 Various stakeholders also called for an improvement in the way information is shared between service providers, in order to improve outcomes for consumers and prevent consumers from having to retell their story each time they presented at a new service. Ms Siobhan Hannan, Team

345 Evidence, Mr Craig Parsons, General Manager, Partnerships and Innovation, Sydney North Primary Health Network, 17 November 2023, p 40.

346 Evidence, Mr Craig Parsons, General Manager, Partnerships and Innovation, Sydney North Primary Health Network, 17 November 2023, p 40.

347 Evidence, Dr Fiona Kumfor, Associate Professor, School of Psychology, University of Sydney, Clinical Neuropsychologist and Co-Founder of the Dementia Law Network, 30 October 2023, p 10.

348 Evidence, Ms Gen Whitlam, Associate Director, Client Services, ACON, 22 September 2023, p 27.

349 Evidence, Dr Janelle Weise, Senior Researcher, Department of Developmental Disability Neuropsychiatry, University of New South Wales, 22 September 2023, p 20.

350 Evidence, Ms Deb Willcox, AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health, 16 October 2023, p 14.

351 Evidence, Ms Deb Willcox, AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health, 16 October 2023, p 14.

Leader, Counselling Services, ACON described a lack of coordination of care and poor communication of information between services as 'very harmful' and a 'systemic failure'.[352]

3.78 Amidst these calls for better information sharing, the importance of maintaining confidentiality and obtaining consent was clearly articulated. For example, Ms Hannan said that a system which requires staff to communicate and exchange pertinent information 'within the framework of consent, privacy and confidentiality' would enhance care and improve outcomes'.[353]

3.79 Beyond just information sharing, stakeholders have called for mental health professionals, including mental health nurses and peer workers, to be embedded within primary care.[354] An example of this approach is the Uniting NSW ACT pilot informed by the Churchill Fellowship project undertaken by Dr Paul Fung, to consider improved interaction between primary and mental health care systems.[355] Embedding a wellbeing clinician within general practice has demonstrated improved access to mental health care for patients who are First Nations people, unemployed, and older persons, as well as more effective multidisciplinary teamwork enabled by sharing the same medical record system. The NSW ACT PHN Mental Health Network also presented the benefits of their GP Shared Care program, where a mental health Clinical Nurse Consultant is employed in a liaison capacity to support GPs working towards formalized shared care arrangements.[356] The committee was also presented with evidence regarding the psychiatric liaison service widely utilized in New Zealand and trialled in Western Sydney, where a psychiatrist working in an acute setting is also able to provide services within primary care part time, with a focus on supporting and increasing capacity of primary care services. This service was found to provide better management of care in the community as well as coordinating continuity of care between hospital and primary care.[357] An alternative approach suggested by the Mental Health Coordinating Council is for physical health programs to be embedded within community mental health programs.[358]

3.80 Integrating mental health care within a holistic health service was also suggested as a means of improving accessibility of services in small communities where consumers may not want to be identified as accessing a mental health service.[359]

A changing workforce

3.81 This section examines the changing nature of the mental health workforce, including the utilisation of peer workers in the mental health workforce, increasingly ageing staff, and delivery of telehealth.

352 Evidence, Ms Siobhan Hannan, Team Leader, Counselling Services, ACON, 22 September 2023, p 29.

353 Evidence, Ms Siobhan Hannan, Team Leader, Counselling Services, ACON, 22 September 2023, p 29.

354 See for example; Submission 64, Royal Australian College of General Practitioners, p 2; Submission 147, Mental Health Commission of NSW, p 11.

355 Submission 54, Uniting NSW ACT, p 1.

356 Submission 58, NSW ACT PHN Mental Health Network, p 14.

357 Submission 98, Independent Community Living Australia (ICLA), p 3.

358 Submission 39, Mental Health Coordinating Council, p 11.

359 Submission 136, Brainstorm Mid North Coast, p 5.

Peer workers

3.82 Peer workers are people with lived experience as well as qualifications in providing lived experience mental health support. [360]

3.83 Peer workers purposefully use their lived experience to connect and support consumers.[361] Their utilization across the mental health system is increasing, as is professional recognition and demand for their services.[362]

3.84 Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council, reported that the most recent survey conducted by the Council found that 14 per cent of the community managed workforce included peer workers.[363] Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health told the committee that New South Wales has approximately 200 peer workers working in local health districts and specialty health networks.[364]

Role of peer workers

3.85 As outlined in Chapter 2, peer workers provide a valuable support to people navigating the mental health system. Various stakeholders further discussed the benefits peer workers bring to consumers of mental health services.[365] Mr William Campos, CEO of Independent Community Living Australia said his organisation was focused on developing a lived-experience workforce, and that peer workers were well equipped to help consumers navigate the complex mental health system.

> '…the previous person who was here talked about that it is good to have a person on the side who you can connect with. Part of navigation is to do with supporting someone to walk through and discover the services that are available to you. But I often find that that particular service or that navigation type of service is better done by, usually, peer workers or lived experience or a group of support workers that have some experience.'[366]

360 Evidence, Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2024, p 52.

361 Evidence, Ms Fay Jackson, Former Deputy Commissioner, Mental Health Commission of NSW and General Manager, Flourish Australia, 13 February 2024, p 15.

362 Evidence, Ms Anne Galloway, Mental Health Manager, HealthWISE New England North West, 15 February 2024, p 53.

363 Evidence, Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council, 16 October 2023, p 36.

364 Evidence, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, 16 October 2023, p 44. See also Submission 148, NSW Health, p 27.

365 See for example; Evidence, Mr Kyzar Jing, Lived Experience Advisor, Office of the Advocate for Children and Young People, 22 September 2023, p 40; Evidence, Dr Janelle Weise, Department of Developmental Disability Neuropyschiatry, UNSW, 22 September 2023, p 18; Evidence, Ms Siobhan Hannan, Team Leader, Counselling Services, ACON, 22 September 2023, p 24.

366 Evidence, Mr Williams Campos, Chief Executive Officer, Independent Community Living Australia, 15 February 2024, p 15.

3.86 The Australasian College for Emergency Medicine agreed, observing that peer workers provide value due to their distinct understanding of the system from their own lived experience.[367] Similarly, the Black Dog Institute noted the 'level of empathy and understanding' peer workers bring from their own experience with mental health services utilization,[368] while the Mental Health Commissioner commented on the 'resounding impact' in communities where trial navigation peer models were piloted.[369]

3.87 Other witnesses described peer workers having a 'personal narrative of understanding',[370] allowing consumers to easily 'check in' with someone who was not a clinician,[371] and providing reassurance to consumers that they were not alone.[372] Mrs Amanda Curran referred to the 'additional perspective' that peer worker often have and how this could assist individuals to access mental health services to ensure they did not end up 'slipping out of the system'.[373]

3.88 Sharing his journey as a peer worker, Mr Glen Cotter illustrated the deep personal experience that comes with the unique role, and how this can be leveraged to help others:

> …I've been working as a peer worker for 5½ years in this role, and I've watched it transition over the years. When it first started, a lot of people really didn't understand what a peer worker did. As a lived-experience peer worker, be it from suicidality, be it from drug and alcohol, be it from trauma, the concept of lived-experience peer worker means that I don't have any pieces of paper on the wall. I know what it's like to be curled up in the fetal position on the end of the bed. As such, from that I can take a phone call at nine o'clock in the morning that just says, "Give me one good reason why I don't die today?" When you give them the answer that you're supposed to give them, they just tell you, "Wrong answer." And then you draw a breath and you sit there and you go, "Because I just don't want you to." From that the answer comes back as, "That's all I needed to hear, thank you.[374]

3.89 Some witnesses, including Ms Fay Jackson, Former Deputy Commissioner, Mental Health Commission of NSW and General Manager, Inclusion, Flourish Australia called for peer workers to be introduced across the entirety of the mental health system, including emergency

367 Evidence, Dr Clare Skinner, Former President and New South Wales Faculty Board Member, Australasian College for Emergency Medicine, 15 February 2024, p 20.

368 Evidence, Ms Nicole Cockayne, Director, Policy and Research Operations, Black Dog Institute, 17 November 2023, p 17.

369 Evidence, Ms Catherine Lourey, Commissioner, Mental Health Commission of New South Wales, 17 November 2023, p 30.

370 Evidence, Mr Williams Campos, Chief Executive Officer, Independent Community Living Australia, 15 February 2024, p 17.

371 Evidence, Dr Anna Brooks, Chief Research Officer, Lifeline Research Office – Government and Stakeholder Relations, Lifeline Australia, 15 February 2024, p 28.

372 Evidence, Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2024, p 53.

373 Evidence, Mrs Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc, 16 October 2023, p 30.

374 Evidence, Mr Glenn Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2024, p 52.

departments, hospital wards, inpatient care and community settings.[375] Another peer worker suggested they also be involved in the training of mental health workers.[376] Others, such as Ms Lillie Mellin, Mental Health Spokesperson, Justice Action, recommended that peer workers be more utilized to support people experiencing mental health crises.[377] This is further explored in Chapter 4.

Lack of funding

3.90 Despite their relatively new role in the mental health system, stakeholders also reported that peer workers were facing a lack of funding and staff shortages. One stakeholder commented on the inconsistent funding practices across NSW, noting that some Local Health Districts directly provide and fund peer group supervision, whereas others do not.[378] From a workforce planning perspective, the Mental Health Coordinating Council also observed that peer workers and workers with lived experience are under extreme pressure and that due to data gaps, they remain 'invisible' in national workforce planning and assessment processes.[379]

3.91 HealthWISE said that peer workers form a critical part of treatment for many patients, but are often unavailable due to lack of funding,[380] while BrainStorm North Coast noted that peer workers are 'underestimated and underutilised'.[381]

3.92 Peer worker Mr Glen Cotter described the scarcity of peer workers in rural and regional areas, noting his team consisted of himself, one clinician and one other peer worker and that current funding only allowed access to services in Bega and immediate surrounds.[382] Distances between rural and regional areas limit the time peer workers can spend with clients and hinders their ability to attend training and development.[383] For this reason, Mr Cotter recommended that funding take into account the travel needed in rural and regional locations, to allow time for meaningful lived-experience engagement.[384]

Framework, qualifications and training

3.93 Stakeholders also commented on the need to better define the qualifications and training required for peer workers, as well the need to better recognise the value they bring to an

375 See for example, Submission 155, Full Stop Australia, p 8; Submission 42, Name Suppressed, p 3; Evidence, Ms Fay Jackson, Former Deputy Commissioner, Mental Health Commission of NSW and General manager, Inclusion, Flourish Australia, 13 February 2024, p 17.

376 Submission 42, Name Suppressed, p 3.

377 Evidence, Ms Lillie Mellin, Mental Health Spokesperson, Justice Action, 15 February 2023, p 33.

378 Submission 42, Name Suppressed, p 3.

379 Submission 39, Mental Health Coordinating Council (MHCC), p 11.

380 Submission 68, HealthWISE, p 4.

381 Submission 136, BrainStorm Mid North Coast, p 8.

382 Evidence, Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2024, p 49.

383 Evidence, Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2024, p 49.

384 Evidence, Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2024, p 49.

organisation, and provide career advancement pathways for peer workers to obtain additional qualifications.[385]

3.94 Dr Clare Skinner, Immediate Past President & NSW Faculty Board Member, Australasian College for Emergency Medicine, made similar comments about recognizing the value peer workers and warned against them being blocked from senior decision-making roles due to their lack of official qualifications, arguing that peer workers must be empowered in the decision-making hierarchy.[386]

3.95 Noting the relatively new nature of the role, the committee asked a number of witnesses how a peer worker with a specific lived experience might support a consumer experiencing a different mental health condition. Mr Cotter stressed that it was more important that the peer worker build trust and understanding with the individual and that in mental health, whether it be suicidality, sexual abuse, or domestic violence, all have commonalities, and that much of mental health 'folds together'.[387] Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council, agreed that while it would be a 'perfect match' to pair a peer worker who had a lived experience with an eating disorder with a consumer with similar lived experiences, the success of the engagement and relationship was more about drawing on the strength of their experience as a tool to show what they have learnt.[388]

3.96 On the qualification required for peer workers, Ms Corinne Henderson, Principal Policy Advisor, Mental Health Coordinating Council, said that the Council had worked with the Mental Health Commission to develop a Certificate IV qualification.[389] The Mental Health Commissioner, Ms Catherine Lourey, called for more funding and scholarships to allow more spaces in Certificate IV courses, noting that while 100 scholarship places had been funded by the Commission and the Mental Health Coordinating Council, these were for a two-year period only.[390]

3.97 Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, said that as of October 2023 a peer workforce framework was still in development but that even once it was established, there was still 'significant work to do… to make sure that peer workers feel supported in terms of their educational needs and in terms of looking after their health while they do that important work'.[391]

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385 Evidence, Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2024, p 49.

386 Evidence, Dr Clare Skinner, Former President and New South Wales Faculty Board Member, Australasian College for Emergency Medicine, 15 February 2024, p 20.

387 Evidence, Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2024, pp 52.

388 Evidence, Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council, 16 October 2023, p 37.

389 Evidence, Ms Corinne Henderson, Principal Policy Advisor, Mental Health Coordinating Council, 16 October 2023, pp 36-37. See also Evidence, Ms Catherine Lourey, Commissioner, Mental Health Commission of New South Wales, 17 November 2023, p 35.

390 Evidence, Ms Catherine Lourey, Commissioner, Mental Health Commission of New South Wales, 17 November 2023, pp 35-36.

391 Evidence, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, 16 October 2023, p 44.

An ageing workforce

3.98 Another issue raised by stakeholders was how the mental health workforce is ageing, and how this change could impact the mental health system overall.[392]

Dr Angelo Virgona, Chair of the NSW Branch of the Royal Australian and New Zealand College of Psychiatrists said that there were 'many psychiatrists over the age of 55'.[393] Similarly, the Western Sydney Health Alliance described the ageing health workforce as a 'significant concern', with the Blue Mountains, Fairfield, Liverpool and Penrith local government areas having 20 per cent of GPs over the age of 65.[394]

3.99 The Western Sydney Health Alliance connected the ageing workforces of these areas to shortages, questioning whether the ageing workforce would have capacity to meet 'impending growth' of needs. [395] They asserted that the ageing workforce presents challenges for succession planning, noting that there may be insufficient GPs to replace retiring GPs, creating service gaps and shortages in the community.[396]

Telehealth

3.100 Many stakeholders, including members of the mental health workforce and representatives from service providers, discussed the impacts of telehealth on the mental health system. This section focuses on workforce perspectives of telehealth and how it is changing the delivery of mental health services.

3.101 Various service providers spoke of the benefits of telehealth to the workforce. The Australian Psychological Society praised telehealth for allowing psychologists to provide remote care to communities experiencing natural disasters, as well as its effect on decreasing waitlists and improving response time.[397]

3.102 Other stakeholders were clear that telehealth, whilst beneficial, still poses risks, particularly around miscommunication. Dr Jannelle Weise, Senior Researcher, Department of Developmental Disability Neuropsychiatry, University of New South Wales mentioned that telehealth involved a risk for clinicians in not being able to 'directly see or communicate as clearly as possible'.[398] Ms Annie Crowe, Founder and Consultants at NeuroAccess, agreed that telehealth possessed a disadvantage for professionals wanting a more nuanced understanding of body language, but also explained that for many, telehealth is the only option.[399]

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392 Submission 139, The Royal Australian and New Zealand College of Psychiatrists (RANZCP), p 8.

393 Evidence, Dr Angelo Virgona, Chair, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists, 16 October 2023, p 14.

394 Submission 77, Western Sydney Health Alliance, p 7.

395 Submission 77, Western Sydney Health Alliance, p 7.

396 Submission 77, Western Sydney Health Alliance, p 12.

397 Submission 143, Australian Psychological Society, p 5.

398 Evidence, Dr Janelle Weise, Senior Researcher, Department of Developmental Disability Neuropsychiatry, University of New South Wales, 22 September 2023, p 17.

399 Evidence, Ms Annie Crowe, Founder and Consultant, NeuroAccess, 22 September 2023, p 17.

3.103 Mr Graham Brereton, Registered Nurse and Psychologist echoed this fact, noting that a problem with telehealth is the risk of misreading the consumer, as much of the non-verbal communication is lost.[400] Ms Sonja Habenicht, Trauma Counsellor, Psychologist, Women's Outreach Trauma Health Service, Northern Rivers Women and Children's Service, noted that telehealth services may preclude workers from seeing the 'full presentation' of the consumer, noting difficulty especially for staff engaging with people with eating disorders.[401]

3.104 The Royal Australian College of General Practitioners (Rural) reported finding telehealth services to be adequate in allowing supplementary check-ins for consumers, however noted that where telehealth was the only option available, the 'scope of support was greatly impacted'.[402] They also observed that telehealth limits the provision of certain therapies, such as EDMR.[403] One psychologist recounted that telehealth is 'best used as an adjunct to in-person attendance', with in person meetings most helpful to solidify therapeutic relationships prior to incorporating telehealth.[404]

3.105 Given the increased potential for miscommunication or misreading of consumers, service providers and clinicians recommended telehealth be used in conjunction with in-person consultations. Services such as Full Stop Australia advocated for a 'mixed model'[405] between telehealth and in-person care, and Lifeline Australia agreed that telehealth and online mental health services should complement and work alongside local mental health services.[406]

3.106 Additionally, Dr Clare Skinner, Former President and New South Wales Faculty Board Member, Australasian College for Emergency Medicine, said that telehealth was a good support for clinicians' decision-making, helping them determine which patients should be transferred and preventing people from travelling long distances, unless required.[407]

3.107 Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute, discussed how Black Dog Institute was looking at how to integrate digital tools into therapeutic and clinical practice, known as 'blended care', where a consumer could see a clinician in person one week, and then use a digital tool to conduct a self-paced module the next week, then return to the clinician for in-person consultation after essentially doubling the amount of treatment, for far smaller costs.[408]

3.108 Despite the benefits of telehealth, some members of the mental health workforce expressed a continued preference for face-to-face care. Dr Tim Senior, General Practitioner, explained that in his view, the fundamental factor of success in mental health care was that care was based on

400 Evidence, Mr Graham Brereton, Registered Nurse and Psychologist, 16 October 2023, p 2.

401 Evidence, Ms Sonja Habenicht, Trauma Counsellor/Psychologist, Women's Outreach Trauma Health Service, Northern Rivers Women and Children's Service, 13 February 2024, p 2.

402 Submission 44, The Royal Australian College of General Practitioners (Rural), p 2.

403 Submission 44, The Royal Australian College of General Practitioners (Rural), p 2.

404 Submission 7, Name Suppressed, p 1.

405 Submission 155, Full Stop Australia, p 17.

406 Submission 25, Lifeline Australia, p 10.

407 Evidence, Dr Clare Skinner, Former President and New South Wales Faculty Board Member, Australasian College for Emergency Medicine, 15 February 2024, p 23.

408 Evidence, Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute, 17 November 2023, pp 13-14.

trusting, respectful relationships, which could not be achieved through 'impersonal transactions' of telehealth.[409] Feedback received by members of the New South Wales Nurses and Midwives' Association was that nurses found it difficult to build meaningful rapport with patients over videoconference, and that telehealth creates difficulty in conducting comprehensive assessments of clients.[410]

Committee comment

3.109 It is clear that the mental health system is in crisis. Evidence received in this inquiry demonstrated that workforce shortages and high caseloads are contributing to a system within which workers feel burnout, overwhelmed and despondent in supporting those who need help without being resourced to be able to provide the quality of care that they ought to.

3.110 We were saddened and occasionally, angered, to hear of the challenges that people in the mental health workforce are facing. We were particularly struck by the stories of overworked and distressed staff, and the way they described feeling helpless and defeated, knowing that consumers will often not receive appropriate care after referral. We recognise that people enter this line of work to help people, so to feel they do not have the time, resources or available services to do so is particularly concerning. The committee expresses our sincere gratitude to staff for their resilience within such a broken mental health system.

3.111 In this context, we are concerned for the welfare of the mental health workforce. Burnout, vicarious trauma, and compassion fatigue are heavily impacting staff both professionally and personally, and compromising the quality of care they can provide to consumers. We are further concerned of how shortages are being compounded by services being unable to fill vacancies, due to negative perceptions of roles in mental health. We find that safe workloads for clinicians working in public mental health services, as well as remuneration that reflects their skills and the challenges of their roles, can assist in the recruitment and retention of staff.

Finding 5

Safe workloads for clinicians working in public mental health services, as well as remuneration that reflects their skills and the challenges of their roles, can assist in the recruitment and retention of staff.

3.112 Public mental health clinicians provide lifesaving care to the people of NSW. Given how important their role is to the mental health system, it is worrying to hear how many workers are lost to the private sector or to other jurisdictions due to wage disparity and conditions. We recommend that NSW Government immediately increase pay for NSW public mental health clinicians including staff specialists, junior doctors, nurses, and allied health professionals to at a minimum on par with other states and territories, with consideration given to the number of staff lost to the private sector. Changes to pay grades for staff working in community mental health services should also take into account the level of expertise, further training, independent practice and risk associated with a role.

409 Submission 130, Dr Tim Senior, p 5.

410 Submission 146, New South Wales Nurses and Midwives' Association, p 19.

Recommendation 10

That NSW Government immediately increase pay for NSW public mental health clinicians including staff specialists, junior doctors, nurses, and allied health professionals to at a minimum on par with other states and territories, with consideration given to the number of staff lost to the private sector. Changes to pay grades for staff working in community mental health services should also take into account the level of expertise, further training, independent practice and risk associated with a role.

3.113 The committee heard from stakeholders from within the medical profession that more clinical supervision for mental health clinicians would provide additional support and go some way to preventing burnout. As such, we recommend NSW Health increase resourcing for formal clinical supervision for all clinicians providing mental health care, as well as GPs with a high case load of mental health patients. We also call on NSW Health to explore mechanisms to enable the greater application of therapeutic services and discipline specific expertise to ensure clinicians are working to the top of their scope of practice in order to provide safe, effective, patient-centred care including assertive outreach.

Recommendation 11

That NSW Health increase resourcing for formal clinical supervision for all clinicians providing mental health care in NSW Health, as well as General Practitioners with a high case load of mental health patients.

Recommendation 12

That NSW Health explore mechanisms to enable the greater application of therapeutic services and discipline specific expertise to ensure clinicians are working to the top of their scope of practice in order to provide safe, effective, patient-centred care including assertive outreach.

3.114 The committee also heard that there are barriers for those wanting to pursue qualifications in mental health care, including financial burdens and the challenges associated with relocating for studying or training purposes. To alleviate these barriers, we urge the NSW Government to urgently request the Federal Government to provide HELP fee relief for mental health priority courses. We also call on the NSW Government to provide fee free TAFE courses and qualifications in mental health care. The NSW Government facilitate relocation and housing for mental health care workers in the public system and address social and cultural barriers to relocation.

Recommendation 13

That the NSW Government urgently request the Federal Government provide HELP fee relief for mental health priority courses.

Recommendation 14

That the NSW Government provide fee free TAFE courses and qualifications in mental health care. The NSW Government facilitate relocation and housing for mental health care workers in the public system and address social and cultural barriers to relocation.

3.115 Evidence presented to the committee also made it apparent that peer workers, social workers, clinical support officers, pharmacists, dieticians and exercise physiologists are currently underutilised in community mental health multidisciplinary teams. Moreover, it appears that the relationship between primary care and mental health services could be improved, as it currently lacks integration and adequate support. To remedy this, we urge the NSW Government to explore opportunities for integration between primary care and mental health services including embedding mental health clinicians within general practice.

Finding 6

Peer workers, social workers, clinical support officers, pharmacists, dieticians and exercise physiologists are currently underutilised in community mental health multidisciplinary teams.

Finding 7

Integration between primary care and mental health services is not well supported.

Recommendation 15

That the NSW Government explore opportunities for integration between primary care and mental health services including embedding mental health clinicians within general practice.

3.116 It was clear to the committee that there is currently insufficient information and data on the workforce, preventing effective workforce allocation and that better data collection in this area will go some way in helping to better support the mental health workforce in allocation of resources and directing support where it is needed most. In particular we were struck by the evidence received regarding the 2020 Productivity Commission Inquiry Report into Mental Health and its recommendation that the Australian Institute of Health and Welfare (AIHW) publish all relevant data on mental health services at a national, State and Territory level, to help coordinate and develop the national mental health workforce. It is unacceptable that this recommendation remains unimplemented almost four years later and we call on the NSW Government to explore, with the Australian Institute of Health and Welfare, the provision of any information necessary for the timely publication of this data.

Finding 8

That there is currently insufficient information and data on the workforce, preventing effective workforce allocation.

Recommendation 16

That the NSW Government explore, with the Australian Institute of Health and Welfare, the provision of any information necessary for the timely publication of data on mental health services at a national, State and Territory level, to help coordinate and develop the national mental health workforce.

3.117 Additionally, the committee recognises the benefits in sharing patient data between the workforce, allowing greater quality of care, and preventing consumers from having to re-tell their story multiple times. Unfortunately, this is not the case in NSW at the moment, where a

lack of integrated data sharing between mental health services in NSW is inhibiting quality and coordinated care for consumers and creating barriers for the workforce.

Finding 9

The lack of integrated data sharing between mental health services in NSW is inhibiting quality and coordinated care for consumers and creating barriers for the workforce.

3.118 We also heard that there is a lack of comprehensive data on consumers, particularly members of the LGBTQIA+ community in regional and rural areas. We note that the Australian Bureau of Statistics (ABS) does not currently collect adequate data on gender and sexuality and that this gap in data creates challenges in referral options and planning for members of the LGBTQIA+ community. To remedy this, we recommend that the NSW Government investigate and implement the best means for the collection of data on gender and sexuality to assist with service referral and planning.

Recommendation 17

That the NSW Government investigate and implement the best means for the collection of data on gender and sexuality to assist with service referral and planning.

3.119 The committee heard consistently that consumers value the support of peer workers. Consumers and mental health workers alike were enthusiastic about this new role and the potential it had to provide greater support based on one's lived experience. At the same time, it was clear that people believe that a lack of funding, professional framework for the occupation and role definition are hindering peer workers expansion and utilisation. We believe that the Peer Workforce Framework, currently under development by NSW Health, will provide essential guidance in this area. To further assist, we recommend that the NSW Government look for ways to integrate peer workers into the broader mental health workforce, determine clear role definitions, framework and qualifications, and funding additional scholarship places for the Certificate IV qualification in Mental Health Peer Work. The development of role definitions should include a consideration of whether all people experiencing mental illness have the same peer assistance needs, or whether because of different experiences and presentations, different peer support needs will be required.

Finding 10

The Peer Workforce Framework, which is currently under development by NSW Health, is essential and eagerly anticipated.

Recommendation 18

That the NSW Government look for ways to integrate peer workers into the broader mental health workforce, determine clear role definitions, framework and qualifications, and funding additional scholarship places for the Certificate IV qualification in Mental Health Peer Work.

3.120 The committee strongly recognises the inadequate funding across the entire mental health system. We understand that various issues and challenges, for both the workforce and system overall, can be addressed with additional funding. Calls for more funding were made by almost

every organisation, recognising the importance of appropriately supporting community-based mental health services. Noting this, we call on the Government to immediately commit to increasing and maintaining funding across the entire mental health system to support both the workforce and consumers, with a priority investment in community-based mental health services.

Finding 11

Inadequate total funding is creating multiple, compounding issues and challenges for consumers, carers and the mental health workforce.

Recommendation 19

That the NSW Government immediately commit to increase and maintain funding across the entire mental health system to support both the workforce and consumers, with a priority investment in community-based mental health services.

3.121 On the issue of funding, we also recognise the benefits of increasing funding cycles from three to five years, noting this provides greater job security for the workforce, and allows them to provide better continuity of care for consumers. We call on the NSW Government to explore the increase of funding cycles to five years to support the growth and stability of the workforce and improve the consistency of care for consumers. All government funding is to be contingent on programs and services demonstrating that they meet agreed KPIs relating to mental health outcome, that their program or service has met and engaged successfully with a consumer need, and that this need is ongoing.

Recommendation 20

That the NSW Government explores the increase of funding cycles to five years, to support the growth and stability of the workforce and improve the consistency of care for consumers. All government funding is to be contingent on programs and services demonstrating that they meet agreed KPIs relating to mental health outcomes, that their program or service has met and engaged successfully with a consumer need, and that this need is ongoing.

3.122 Finally, we heard evidence from stakeholders calling on NSW to implement a mental health payroll tax surcharge, similar to that implemented in Victoria and Queensland, as a way to increase funding for mental health services. Given the significant gap in funding for community mental health services compared to need, there is a need for the NSW government to explore innovative revenue streams to fund mental health services.

Recommendation 21

That the NSW Government explore innovative revenue streams to fund mental health services.

Chapter 4 Responses to mental health crises

This chapter canvasses key issues raised by stakeholders during the inquiry in relation to responses to mental health crises. The chapter explores the provision of crisis support helplines and the rising number of presentations to the emergency department for mental health crisis support, and specifically the suitability of emergency departments (EDs) to provide mental health care, aftercare and the impact this has on first responders. The chapter also discusses Safe Havens and Housing and Accommodation Support Initiative Plus as alternatives to EDs and provides case studies on these initiatives. Finally, police involvement in mental health crises and possible alternatives to emergency responses are also examined.

Crisis support helplines

4.1 In more severe instances of mental ill health or psychological distress, a person may seek help from a crisis support helpline. This section discusses the types of crisis support available and stakeholder views on adequacy of information about these services.

Types of crisis support provided

4.2 As outlined in Chapter 1, there are several services available for people experiencing a mental health crisis. These include non-government organisations that offer free mental health advice and referrals, counselling and online programs, as well as some services that provide crisis support.

4.3 In addition, the NSW Mental Health Line is NSW Health's Statewide telephone service that provides 24/7 access to trained mental health professionals who offer mental health advice and can make referrals to NSW Health mental health services.[411]

4.4 Lifeline, Australia's largest suicide prevention service provider, also delivers digital services to people in crisis via several platforms including a crisis telephone line, a crisis support chat and text service, a dedicated disaster recovery support line, an Aboriginal and Torres Strait Islander 24/7 Crisis Support telephone service (13YARN), and a range of online self-help and referral resources.[412]

4.5 In their submission Lifeline emphasised that NSW residents are reporting significant increases in levels of psychological distress due to concurrent and compounding stressors including the 2019 bushfires, the COVID-19 pandemic, and subsequent cost-of-living issues, resulting in an increase in demand for services.[413]

4.6 Similarly, headspace, the National Youth Mental Health Foundation providing early intervention mental health services to 12-25 year olds via online and phone support services, highlighted the growing rates of mental ill-health in young people more than any other age.[414]

411 Submission 148, NSW Health, p 7.

412 Submission 25, Lifeline, p 4.

413 Submission 25, Lifeline, p 3.

414 Submission 142, headspace, p 2.

In addition, both headspace and Doctors for the Environment Australia identified climate change, the trauma of natural disasters, and worries about the future as contributing factors to mental ill-health in young people.[415]

4.7 The committee heard that some groups of people have a disproportionately increased risk of suicide more than that of other populations. These priority groups include Aboriginal people, young people, older people, people of diverse sexualities and/or genders, culturally and linguistically diverse (CALD) communities, and men.[416]

4.8 On this topic, Lifeline emphasised advice from the National Suicide Prevention Taskforce which identified the importance of delivering targeted interventions for people whose life experiences and societal factors can make them more vulnerable to suicide.[417] Lifeline highlighted 13YARN as a useful model for providing tailored service provision to a priority population.[418]

4.9 Further to this point, Mrs Marjorie Anderson, National Manager, 13Yarn explained the importance of having a crisis support service specifically for Aboriginal and Torres Strait Islander people. For example, by having this service, Aboriginal and Torres Strait Islander callers do not have to educate crisis supporters, which when someone is in crisis can be 'exhausting and triggering and often makes things worse'.[419]

4.10 Mr Shane Sturgiss, CEO, BlaQ Aboriginal Corporation, the New South Wales peak organisation for LGBTQ+SB Aboriginal and Torres Strait Islander people, further emphasised this point, stating that 'First Nation people know how to support First Nations people.'[420] He explained that the importance of kinship and culture which is valued by First Nations people, is something that is lacking from government and health-driven services.[421]

4.11 Whilst the committee heard of the crucial role crisis support lines play in providing mental health support, it also heard of some of the challenges of such services, including access for consumers, and the ability to make warm referrals for service providers.[422]

4.12 Youth Action stated that some young people were unable to access timely support when in crisis, despite reaching out to services, citing long hold or slow response times and callers having to repeat details to several different people as elevating their distress.[423] The organization relayed the story of one young person who waited over an hour to hear back from a crisis text service, while another young person was on hold for six hours when they called the suicide hotline.[424]

415 Submission 142, headspace, p 2; Submission 47, Doctors for the Environment Australia, p 1.
416 Submission 148, NSW Health p 14.
417 Submission 25, Lifeline, p 10.
418 Submission 25, Lifeline, p 10.
419 Evidence, Mrs Marjorie Anderson, National Manager, 13YARN, 16 October 2023, p 53.
420 Evidence, Mr Shane Sturgiss, CEO, BlaQ Aboriginal Corporation, 16 October 2023, p 51.
421 Evidence, Mr Shane Sturgiss, CEO, BlaQ Aboriginal Corporation, 16 October 2023, p 51.
422 Submission 16, Name suppressed, p 1.
423 Submission 74, Youth Action, p 12.
424 Submission 74, Youth Action, p 12.

4.13 For service providers, a key challenge is the ability for crisis support lines to make warm referrals when needed.[425] Dr Anna Brooks, Chief Research Officer, Lifeline Research Office, Lifeline Australia explained that while warm referrals are always better than giving someone a telephone number or the name of a contact, it can be challenging if a referral is to a service outside of the umbrella of Lifeline services that is not open outside of business hours.[426]

> It has forever been a challenge. It remains one. We're working on it, but technically it's quite tricky. I mean, 13 11 14 is open 24 hours a day, seven days a week; many, many, many other services, as you would be well aware, are business-hour services. When you have someone who calls in at 2.00 a.m. and would benefit from support from another service, it's well-nigh impossible a lot of the time to actually do a warm transfer at that time. It is a significant challenge.[427]

4.14 Another inherent limitation to being a crisis support service is that Lifeline cannot track what happens after a call. Dr Tara Hunt, Deputy Chief Research officer, Lifeline Research Office, Lifeline Australia noted whilst there is the benefit of anonymity and confidentiality to the service, it also adds a significant challenge for continuity of care.[428]

Adequacy of information available about crisis support services

4.15 An issue raised during the inquiry was the amount and adequacy of information available about crisis support services. [429] In particular, some carers expressed uncertainty about knowing which service to contact when someone they cared was experiencing distress.

4.16 Mental Health Carers NSW informed the committee that carers of a loved one experiencing greater distress, such as suicidality or symptoms of psychosis, find themselves lacking adequate information about crisis services and how to access them.[430] They also indicated that there was a broad lack of awareness among the public and conflicting information about which service is most appropriate to access in different circumstances (such as their purpose, scope, hours of operation, and contact information) which leads to confusion about where to turn in times of crisis.[431]

4.17 As a result, carers are often forced to seek help from emergency services which places unnecessary pressure on police, ambulance, and hospital emergency departments.[432] This is examined further from section 4.24.

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425 Evidence, Dr Anna Brooks, Chief Research Officer, Lifeline Research Office – Government and Stakeholder Relations, Lifeline Australia, 15 February 2024, p 27.

426 Evidence, Dr Anna Brooks, Chief Research Officer, Lifeline Research Office – Government and Stakeholder Relations, Lifeline Australia, 15 February 2024, p 27.

427 Evidence, Dr Anna Brooks, Chief Research Officer, Lifeline Research Office – Government and Stakeholder Relations, Lifeline Australia, 15 February 2024, p 27.

428 Evidence, Dr Tara Hunt, Deputy Chief Research officer, Lifeline Research Office, Lifeline Australia, 15 February 2024, p 28.

429 Submission 132, Mental Health Carers NSW, p 6.

430 Submission 132, Mental Health Carers NSW, p 6.

431 Submission 132, Mental Health Carers NSW, p 6.

432 Submission 132, Mental Health Carers NSW, p 6.

4.18 Mental Health Carers NSW recommended the development of a wide-reaching media and public education campaign to educate the community on how to identify different types of mental health crisis and which available crisis service is appropriate to contact for different mental health presentations.[433]Lifeline Australia stressed the critical role that crisis support lines have in supporting people to navigate outpatient and community health services.[434]

4.19 Full Stop Australia stated that lack of funding and service availability can lead to long waiting times for people attempting to contact mental health crisis lines, which can be a significant problem for trauma survivors. This is highlighted by a trauma survivor's story of trying to call a crisis line:

> When you're sitting in the car, and you're unsure whether you will even make it home safe, it is crushing when no one picks up on the other end of the line.[435]

4.20 A young person who had used crisis support lines also expressed frustration with the wait times and the limited counselling available during calls:

> In other terms of support, I believe the help lines already implemented are a good support for people who are feeling unsafe, however wait times mean that the amount of good they could do is limited at a certain point. Sometimes it also feels like the operator just takes your name and details and explanation of what led up to the moment and then tells you to go see your local doctor at your earliest convenience, with almost no input to the dialogue and no form of crisis counselling which isn't beneficial when the number and service is displayed as a helpline.[436]

4.21 Separately, the committee heard differing opinions on the operation of NSW Health's Mental Health Line. According to NSW Health, the Statewide telephone service provides 24/7 access to trained mental health professionals who offer mental health advice and where indicated, complete a brief assessment and make recommendations for care including referral to NSW Health mental health services.[437]

4.22 The NSW Nurses and Midwives' Association voiced its concern that in several Local Health Districts (LHD) the NSW mental health line had been outsourced to Medibank Solutions.[438] The NSW Nurses and Midwives' Association claimed that the privatisation of the service offered little benefit to staff or consumers.[439] Other concerns with the outsourcing of the mental health line include:

- The quality of referrals, as Medibank Solutions staff work from all over Australia and are not as aware of local services and teams in NSW,
- Medibank Solutions does not have access to NSW health records so treats every call as a new triage, creating inconsistencies and confusion,

433 Submission 132, Mental Health Carers NSW, p 6.
434 Submission 25, Lifeline, p 6.
435 Submission 155, Full Stop, p 16.
436 Submission 82, Name suppressed, p 4.
437 Submission 148, NSW Health, p 25.
438 Submission 146, NSW Nurses and Midwives' Association, p 19.
439 Submission 146, NSW Nurses and Midwives' Association, p 19.

- Consumers have to repeat their story every time they call which is not consistent with a trauma informed approach,
- Delays and loss of information in transfer of care between one LHD to another.[440]

4.23 When asked about the privatisation of the mental health line in some LHDs, NSW Health advised that the service had been run by Medibank for many years and that there is no policy to outsource any further mental health services to the private sector.[441]

Presentations to emergency departments

4.24 As outlined above, crisis support lines are often a first step taken by people experiencing acute mental illness or a crisis in seeking help. However, sometimes this is not sufficient for either the individual, or the carers or family who are seeking help on the consumer's behalf. As noted above, people can also sometimes be unsure about which services to call in event of a crisis and so default to contacting emergency services. In these cases, the person or their carers or family may decide to engage with crisis and emergency services, by presenting at an emergency department (ED) to receive assessment, observation and clinical treatment if needed.

4.25 The reasons behind a decision to present at an emergency department may vary. As outlined in Chapter 2, stakeholders have argued that the limited access to community mental health and preventative mental health care leaves consumers and their carers with no option but to present at an ED for mental health care.[442] As a consequence, emergency departments have become a frequent point of entry into the mental health system. The impacts of this on consumers, first responders, and EDs are explored in detail below. Alternatives to presenting at EDs, such as Safe Havens and Housing and Accommodation Support Initiative Plus are then examined.

A growing reliance on emergency departments

4.26 Hospitals and EDs have a vital role in providing care to those in crisis or experiencing severe mental distress. However, the Royal Australian and New Zealand College of Psychiatrists has identified a growing trend in the ED becoming the 'front door of public community mental health services'[443] for people experiencing a mental health crisis.

4.27 NSW Health noted that the number of young people presenting to EDs with mental health concerns is on the rise.[444] Their submission states that 'presentations to the ED for self-harm or suicidal ideation have been increasing by 8.4% annually before the COVID-19 pandemic but that this has accelerated to 19.2% since the COVID-19 outbreak'.[445]

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440 Submission 146, NSW Nurses and Midwives' Association, p 19.

441 Evidence, Ms Deb Willcox, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health, 16 October 2023, p 45.

442 See for example; Submission 146, New South Wales Nurses and Midwives' Association, p 8; Submission 138, Black Dog Institute, p 3; Submission 136, BrainStorm Mid North Coast, p 7.

443 Submission 139, The Royal Australian and New Zealand College of Psychiatrists, p 7.

444 Submission 148, NSW Health, p 26.

445 Submission 148, NSW Health, p 26.

4.28 The committee heard that for many people in NSW, calling an ambulance or presenting to the ED was the 'default'[446] or 'only option'[447] to receive care as they are unable to find or cannot afford appropriate mental health care in the community.[448] Particularly for people in regional, rural and remote areas, EDs are usually the only place they can go when experiencing suicidal distress and hospitals can sometimes be many hours away.[449]

4.29 The Black Dog Institute stated that first responders have reported seeing patients unable to access 'the right care at the right time'[450] and becoming more and more unwell overtime as a result.[451] For example, in response to a survey conducted by the Australian Paramedics Association (NSW) (APA), one Paramedic wrote:

> 'Mental health jobs make up a large portion of ambulance and ED presentations and time. A large portion of these patients are 'regulars'. It highlights that there are not adequate services available to them in the community to live their lives normally and get the appropriate care they need.'[452]

4.30 On this point, many stakeholders described getting mental health care as an endless cycle of not being able to access primary mental health care and their mental health deteriorating over time.[453] Eventually they would reach a crisis point and call an ambulance or present at an ED as this is their only perceived option for care, which would then lead to waiting for hours in the ED, sometimes without ever receiving care.[454]

4.31 In its submission to the inquiry, the APA noted that this was not the 'burden or fault of dedicated professionals on the frontlines of the mental health crisis'[455] but rather 'a systemic failure of our healthcare system.'[456]

4.32 To address the issue of overrepresentation of mental health presentations in EDs, stakeholders recommended that consideration should be given to how to prevent consumers deteriorating to the point where ED and bed-based services are required.[457] For example, the APA suggested that if more care was available in the community through experienced and specialised mental

446 Submission 19, Name Suppressed, p 1.

447 Submission 149, Australian Paramedics Association (NSW), p 7.

448 See for example; Submission 66, Australasian College for Emergency Medicine, p 2; Submission 149, Australian Paramedics Association (NSW), p 7; Submission 139, The Royal Australian and New Zealand College of Psychiatrists, p 10; Submission 19, Name Suppressed, p 1; Submission 133, Office of the Advocate for Children and Young People (ACYP), p 25.

449 Submission 138, Black Dog Institute, p 17.

450 Submission 138, Black Dog Institute, p 17.

451 Submission 149, Australian Paramedics Association (NSW), p 5.

452 Submission 149, Australian Paramedics Association (NSW), p 7.

453 See for example, Submission 149, Australian Paramedics Association (NSW), p 5; Submission 99, Lived Experience Australia Ltd, p 5; Submission 92, Ms Lynne Jennings, p 1.

454 See for example, Evidence, Mr Any Hamilton, Therapeutic Lead and Founder, Human Nature, 13 February 2024, p 12; Evidence, Mr Cooper Smeaton, Individual, 30 October 2023, p 2; Submission 149, Australian Paramedics Association (NSW), p 7.

455 Submission 149, Australian Paramedics Association (NSW), p 5.

456 Submission 149, Australian Paramedics Association (NSW), p 5.

457 Submission 149, Australian Paramedics Association (NSW), p 7.

health care professionals, emergency health care may be reserved for emergencies, and patients will have better outcomes.[458]

4.33 Prevention is better than cure, as outlined by Dr Evelyne Tadros, CEO, Mental Health Coordinating Council, who advocated for more support to the Community Managed Organisation sector to provide services in the community, arguing that 'if we get people earlier on in their time of need, we're stopping them from entering the emergency departments or getting that support too late.'[459]

4.34 The committee also heard that for communities in the Northern Rivers, compounding challenges has resulted in local organisations, such as community hub Wardell CORE, seeing more presentations involving complex crises.[460]

> Food relief is a really big part of what we offer now as well. Increasingly, we're seeing the compounding impacts of the disaster, with the cost-of-living crisis having cascading effects on people's mental health and then the exacerbation of preconditions of things, like domestic violence—the rates of presentation even in the past 12 months in difference to the first 12 months have escalated substantially. Homelessness and housing insecurity is clearly having a massive impact on the health and wellbeing of people.[461]

4.35 Mr Joel Orchard, Executive Director, Wardell CORE, also noted that the organisation was seeing much higher rates of suicide and suicidality, as well as severe post-traumatic stress disorder symptoms.[462]

Suitability of emergency departments for mental health care

4.36 The committee also heard that whilst many people experiencing a mental health crisis, suicidality or severe psychological distress often go to EDs to seek help, this is not the most effective environment to provide care in most cases.[463]

4.37 For example, Ms Katie Thorburn, Policy Manager, Mental Health Carers NSW described EDs as 'ill placed' to deal with mental health crises:

> EDs are really ill-placed to be the site of a mental health crisis or situation. EDs have the bright lights and the physical traumas happening, and it's not well resourced. There are not enough beds. There are not enough spaces. There are not appropriate spaces. You will have people in intense emotional, psychological distress and their loved ones waiting in ED waiting rooms for 17 hours or overnight. [464]

458 Submission 149, Australian Paramedics Association (NSW), p 7.

459 Evidence, Dr Evelyne Tadros, CEO, Mental Health Coordinating Council, 16 October 2023, p 38.

460 Evidence, Mr Joel Orchard, Executive Director, Wardell CORE, 13 February 2024, p 24.

461 Evidence, Mr Joel Orchard, Executive Director, Wardell CORE, 13 February 2024, p 23.

462 Evidence, Mr Joel Orchard, Executive Director, Wardell CORE, 13 February 2024, p 24.

463 See for example, Submission 104, Australasian College of Paramedicine, p 9; Submission 149, Australian Paramedics Association (NSW), p 7; Submission 72, Suicide Prevention Collaborative, p 2.

464 Evidence, Ms Katie Thorburn, Policy Manager, Mental Health Carers NSW, 22 September 2023, p 4.

4.38 Similarly, Dr Anna Brooks, Chief Research Officer, Lifeline Australia referred to EDs as 'one of the worst environments' for someone who's experiencing significant psychological distress, given the noise and busyness.[465]

4.39 Other stakeholders concerns regarding the suitability of EDs include:

- That EDs are busy, stressful, high stimulus environments with loud noises and bright lights,[466]
- There are often long wait times for care for mental health patients[467]
- Can cause more distress and can be further traumatising[468]

4.40 EDs, for the reasons above, reportedly can also contribute to the escalation of behaviours and symptoms for which people are seeking care, and can be further exacerbated by extended lengths of stay.[469]

4.41 Ms Sharon Grocott, Chief Executive Officer, WayAhead, gave a firsthand description of her challenging experience in an ED, as she sought crisis care for her daughter, highlighting the wait times, the availability of beds, and the traumatising nature of emergency care:

> 'Families are left to manage that because there are just not either hospital beds available—the experience of the emergency system is traumatising. We have stood there for 12 hours at a time where [my daughter] is in an acute, distressed state, waiting to be seen. Then I've been told by the staff that she would be safer in the psychiatric emergency care unit, because the adult ward is frightening for someone with an intellectual disability. Even the staff have advised me that I'm better off going home. That's sort of what carers and families are living with. I think, "Gee, I'm a person with clinical experience, and we're struggling. How are other families going that don't have that clinical basis and they don't have that knowledge?" …But it is really challenging to manage with the current way that the hospital system works.'[470]

4.42 Stakeholders working in the emergency sector also commented on the unsuitability of EDs to manage patients with chronic and complex conditions that require long-term care. [471] On this point, the APA highlighted that of the 85,251 presentations to public hospitals in 2021/22 only 24,358 led to an admission and of those, 50 per cent had been discharged within 7.14 hours.[472]

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465 Evidence, Dr Anna Brooks, Chief Research Officer, Lifeline Australia, 15 February 2024, p 28.

466 See for example, Submission 66, Australasian College for Emergency Medicine, p 2; Evidence, Mr Jeffry Andrew, Delegate, Australian Paramedics Association (NSW), Critical Care Paramedic, 15 February 2024, p 45.

467 Submission 66, Australasian College for Emergency Medicine, p 2.

468 See for example, Submission 149, Australian Paramedics Association (NSW), p 6; Evidence, Mr Jeffry Andrew, Delegate, Australian Paramedics Association (NSW), Critical Care Paramedic, 15 February 2024, p 45.

469 Submission 66, Australasian College for Emergency Medicine, p 2.

470 Evidence, Ms Sharon Grocott, Chief Executive Officer, WayAhead, 15 February 2023, p 12.

471 See for example, Submission 149, Australian Paramedics Association (NSW), p 7; Submission 66, Australasian College for Emergency Medicine, p 2.

472 Submission 149, Australian Paramedics Association (NSW), p 7.

4.43 The Australasian College for Emergency Medicine (ACEM) explained that while EDs can assess and triage patients, make a determination for further psychiatric assessment, support de-escalation and stabilisation, and transfer or discharge, they are not places for ongoing psychiatric care.[473] ACEM noted that primary presentations for mental health to the ED, that 'are not acute enough to warrant admission, yet do not receive a clear picture of longer-term support can be distressing for patients and their families and carers.'[474]

4.44 In addition, people presenting to EDs in mental health crisis often have other complex needs including physical health comorbidities, drug and alcohol abuse problems, or require support to address broader social circumstances, including homelessness.[475]

4.45 In respect to these concerns, recommendations from stakeholders included:

- having separate spaces in EDs for people in significant mental distress that would ensure a calming environment while people wait for care[476]
- a safe environment for people experiencing mental distress and people who have an intellectual disability[477]
- further mental health training for ED staff.[478]

Flow on effect on others seeking emergency care

4.46 In addition to being inappropriate places for most people experiencing mental health crisis, other stakeholders highlighted the negative flow on effect for others who may need emergency care. Ms Jessica Whittaker, a Paramedic and Delegate of the Australian Paramedics Association (NSW), expressed frustration that people who should be seen in the community and referred on for appropriate care are needing to use an emergency resource to transport them to hospital for mental health care, affecting other patients who may need to use emergency services:

> 'We know they are doing this because there is no other option for them in a difficult time. It just feels so unnecessary, but we keep doing it over and over again because we are so limited in other services we can direct them to safely. It adds to their trauma, creates a risk for staff and other patients in the ED and uses a lot of resources in security when things escalate.'[479]

4.47 Ms Katie Thorburn, Policy Manager, Mental Health Carers NSW, also noted that while waiting for a bed in a psychiatric facility, people in mental health crisis were 'jammed up in the system'[480]

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473 Submission 66, Australasian College for Emergency Medicine, p 2.

474 Submission 66, Australasian College for Emergency Medicine, p 2.

475 Submission 66, Australasian College for Emergency Medicine, p 2; Evidence, Dr Trevor Chan, Chair, NSW Faculty, Australasian College for Emergency Medicine, 15 February 2024, pp 21-22.

476 Submission 84, Ms Sharon Grocott, p 4.

477 Submission 60, One Door Mental Health, p 3.

478 See for example, Submission 84, Ms Sharon Grocott, p 4; Submission 22, Mrs Rachel O'Connell, p 1; Submission 138, Black Dog Institute, p 17.

479 Evidence, Ms Jessica Whittaker, Delegate, Australian Paramedics Association (NSW), Paramedic, 17 November 2023, p 42.

480 Evidence, Ms Katie Thorburn, Policy Manager, Mental Health Carers NSW, 22 September 2023, p 4.

and waiting in ED beds including resource-intensive resuscitation beds when this is not medically necessary.[481]

4.48 Further, Dr Clare Skinner, Immediate Past President and NSW Faculty Board Member, Australasian College for Emergency Medicine, observed that emergency staff are increasingly dealing with conditions that are not acute, but there is 'literally nowhere else to go'[482] for treatment. For staff, this can be distressing as there is not appropriate therapeutic spaces available and as generalists, there can be a limit to where new skills can be maintained.[483]

4.49 Dr Skinner also expressed frustration with available referral pathways, explaining that are a lot of 'wrong doors' to mental health services, making it hard for both staff and patients to navigate:

> 'But if there is nowhere to go from those systems and they come into the emergency department, we become a catch-all and then we're having to navigate a lot of wrong doors on the way out, which becomes really frustrating but also really damaging for patients who are anxious and in crisis, and we can't navigate it either.'[484]

4.50 Overall, while EDs will continue to play a critical role in the provision of mental health care, particularly for the assessment of undifferentiated symptoms including psychosis or delirium, and in cases where there is an acute risk of harm to a patient or others, stakeholders made it clear that further investment in community and primary mental health care would provide many lower acuity patients with more appropriate care in the community.[485] This would divert people away from ED when appropriate, and would be better for consumers and staff as well as the broader healthcare system.

Impact on first responders

4.51 Continuing the discussion of the challenges of using emergency services to respond to mental health crisis, the committee also received evidence on the effect on first responders as they provide care.

4.52 Paramedics are often the first responders to mental health care crises in NSW, with 49 per cent of mental health related ED presentations in public hospitals over 2021-2022 arriving by ambulance.[486] In comparison, presentations to hospitals arriving by police accounted for only 6 per cent.[487]

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481 Evidence, Ms Katie Thorburn, Policy Manager, Mental Health Carers NSW, 22 September 2023, p 4.

482 Evidence, Dr Clare Skinner, Immediate Past President and NSW Faculty Board Member, Australasian College for Emergency Medicine, 15 February 2024, p 20.

483 Evidence, Dr Clare Skinner, Immediate Past President and NSW Faculty Board Member, Australasian College for Emergency Medicine, 15 February 2024, p 20.

484 Evidence, Dr Clare Skinner, Immediate Past President and NSW Faculty Board Member, Australasian College for Emergency Medicine, p 20.

485 See for example, Submission 66, Australasian College for Emergency Medicine, p 3; Submission 61, Suicide Prevention Australia, p 6.

486 Submission 149, Australian Paramedics Association (NSW), p 8.

487 Submission 149, Australian Paramedics Association (NSW), p 8.

4.53 The Australian Paramedics Association (NSW) (APA) reported that paramedics are generally frustrated and demoralised by trying to provide safe quality care when attending a patient with mental health concerns.[488] Many felt limited by the lack of treatment and referral options available to them[489] and the vicarious trauma this causes when patients are unable to receive appropriate care.[490]

4.54 According to the APA, paramedics attending a mental health crisis are presented with an 'all or nothing' choice – either the patient is taken to the ED, or an assessment is made that they are not in need of emergency treatment and can therefore be left in the community, typically with a referral to a GP (Protocol P5).[491] However, for patients who are above the threshold for a P5, paramedics must transport them to the ED or a designated Mental Health Facility. In this scenario, if a patient does not want to attend an ED, paramedics are faced with a difficult decision to either 'section' a patient under the *Mental Health Act* 2007 and transport them to an ED involuntarily, or leave them in the community where they may be at further risk.[492]

4.55 According to the APA, individuals who are transported involuntarily less commonly have a positive experience of care than those receiving voluntary care, and the practice can be be distressing for both patients and Paramedics.[493]

4.56 Mr Brett Simpson, President APA (NSW) and Intensive Care Paramedic, claimed that mental health resources for paramedics are 'exceptionally limited'[494] and that better resources and referrals were needed in order to divert people away from EDs to receive more appropriate care in the community:

> Being able to consolidate resources for frontline paramedics, referral networks so that we don't have to take these people to an emergency department—where we know it will, more often than not, exacerbate their condition as we are at the most pointy end of mental health treatment in New South Wales—is crucial if we're going to be able to provide more substantial and more appropriate levels of care to these quite vulnerable people.[495]

Aftercare

4.57 Patient aftercare following a stay in an ED was another issue discussed by individuals with lived experience, carers, primary care providers and first responders. Some stakeholders emphasised the importance of the timely provision of discharge summaries, which provide GPs or community-based mental health services with information on the patient's care while in hospital,

488 Submission 149, Australian Paramedics Association (NSW), p 10.

489 Submission 149, Australian Paramedics Association (NSW), p 10.

490 Submission 66, Australasian College for Emergency Medicine, p 4.

491 Submission 149, Australian Paramedics Association (NSW), p 10.

492 Submission 149, Australian Paramedics Association (NSW), p 10.

493 Submission 149, Australian Paramedics Association (NSW), p 10.

494 Evidence Mr Brett Simpson, President APA (NSW) and Intensive Care Paramedic, 17 November 2023, p 46.

495 Evidence Mr Brett Simpson, President APA (NSW) and Intensive Care Paramedic, 17 November 2023, p 46.

to inform future treatment and referral.[496] Others questioned the appropriateness of the referral process more broadly, particularly the ability for EDs to connect with community mental health providers to ensure continuity of care. [497]

4.58 Stakeholders such as Dr Vicki Mattiazzo, Deputy Chair, RACGP Rural Faculty, Royal Australian College of General Practitioners (RACGP) Rural stressed that timely discharge summaries were key to GPs being able to support people with mental health issues and that in practice, that 'we do get them eventually, but we often see the patient before we get the paperwork'. [498] The NSW/ACT Primary Health Network (PHN) Mental Health Network said that there are also significant issues in the provision rates of discharge summaries, reporting that in the Southern NSW PHN only 65 per cent of discharge summaries successfully find their way to their intended primary care providers, impacting the continuity of care provided to patients.[499]

4.59 To improve the provision of discharge summaries and ensure continuity of care, the PHN Mental Health Network recommended enhancing information technology systems, including:

- implementing automatic notification systems that alert primary care providers and mental health services when a consumer is admitted to or discharged from the hospital, and
- establishing a feedback mechanism for primary care providers and mental health services to report missing or incomplete discharge summaries.[500]

4.60 Suicide Prevention Australia also suggested investment in outreach capacity of GPs to follow up mental health treatment when discharge summaries are received from hospitals.[501]

4.61 Some stakeholders also advocated for better referrals and connections between emergency departments and community mental health services.[502] Dr Claire Skinner, Former President and New South Wales Faculty Board Member, Australasian College for Emergency described the difference in governance responsibilities between emergency departments, and community mental health services as a barrier:

> Mental health services sit outside the way that—often, within the LHDs, the acute hospital services are governed in one stream and the mental health services sit outside that. From the patient perspective, that hopefully shouldn't create a barrier, but it creates a major governance barrier when there are two systems with different recruitment methods, different KPIs, different reporting lines. That means when someone is in the emergency department and you are trying

496 See for example, Submission 17, Name Suppressed, p 1; Evidence, Dr Vicki Mattiazzo, Deputy Chair, RACGP Rural Faculty, Royal Australian College of General Practitioners (RACGP) Rural, 16 October 2023, p 23; Submission 136, BrainStorm Mid North Coast, pp 2-3.

497 Evidence, Dr Vicki Mattiazzo, Deputy Chair, RACGP Rural Faculty, Royal Australian College of General Practitioners (RACGP) Rural, 16 October 2023, p 23; Submission 149, Australian Paramedics Association (NSW), p 7.

498 Evidence, Dr Vicki Mattiazzo, Deputy Chair, RACGP Rural Faculty, Royal Australian College of General Practitioners (RACGP) Rural, 16 October 2023, p 23.

499 Submission 58, NSW/ACT Primary Health Network (PHN) Mental Health Network, p 11.

500 Submission 58, NSW ACT Primary Health Network (PHN) Mental Health Network, p 10.

501 Submission 61, Suicide Prevention Australia, p 3.

502 See for example, Evidence, Dr Peter Schmiedgen, Policy Lead, BEING, 22 September 2023, p 5; Submission 66, Australasian College for Emergency Medicine, p 3.

> to navigate them across services, you've got services that sit in the community sector, run by the Federal Government and you've got community services run by local government.[503]

4.62 Adding another layer of complexity is when mental health consumers are discharged from hospital inpatient services back to community mental health services with a complex medication plan. In its submission, the Society of Hospital Pharmacists of Australia (SHPA), explained that without adequate access to community mental health services, the continuation of the treatment plan and the necessary monitoring may not occur, potentially leading to a relapse and hospital readmission.[504] SHPA recommended that pharmacists be embedded into community mental health teams to assist with better integration of care.

4.63 Carers described not being provided with sufficient support, guidance and information regarding what to look out for or who to contact regarding escalating symptoms following discharge from hospital.[505]

Police involvement in mental health crises

4.64 The committee received significant evidence about the involvement of police in responding to mental health crises. This section first explores views on police responses to mental health crises, including consumer, carer and police perspectives. It then examines alternatives including Police, Ambulance, Clinical, Early, Response (PACER) and finally looks at examples from other jurisdictions.

4.65 A number of stakeholders expressed the view that recent tragedies in NSW highlighted the need to comprehensively examine police responses to mental health crises.[506] Several stakeholders also referred to recent findings of the Law Enforcement Conduct Commission (LECC)'s review of NSW Police Force's critical incidents, which found that mental health crises are linked to nearly half of deaths or serious injuries in NSW police operations.[507]

4.66 In this context, a broad range of issues regarding police responding to mental health crises were documented by community members, organisations and peak bodies. Common issues conveyed to the committee included:

- Inadvertently criminalising mental health-related issues
- Erosion of trust
- Escalation of a situation due to prior negative interactions with police

503 Evidence, Dr Clare Skinner, Immediate Past President & NSW Faculty Board Member, Australasian College for Emergency Medicine, 15 February 2024, p 20.

504 Submission 59, Society of Hospital Pharmacists of Australia (SHPA), p 1.

505 Submission 88, Amelia Klein, p 2.

506 See for example, Submission 158, Redfern Legal Centre, p 5; Submission 51, Justice Action, p 19; Submission 152, Public Interest Advocacy Centre, p 4; Evidence, Ms Priscilla Bice, CEO, BEING, 22 September 2023, p 2.

507 See for example, Submission 67, BEING – Mental Health Consumers, p 19; Submission 152, Public Interest Advocacy Centre, p 5; Submission 158, Redfern Legal Centre, p 11.

- Contributing to stigmatization of mental health
- Promotion of the use of more coercive methods or use of force to manage patients
- Inability of police to provide mental health care
- Drawing resources away from other policing matters[508]

4.67 A number of the stories provided to the committee by members of the community are included below. Many stakeholders expressed serious concern with police involvement, with both people with lived experience and carers advising that they would avoid calling emergency services in times of crisis for fear of police involvement:[509]

- '[B]ecause the law is interwoven with providing Mental Health care the police often become involved. This has always been traumatic for my son and his family. The inconsistent approach from every police interaction we have had needs to be addressed by training and education with oversight by mental health practitioners.'[510]
- 'When our son has become unwell and required Police intervention, we have had mixed outcomes. Whilst some police are very experienced in handling mentally unwell people, others have completely missed the mark and require additional training.'[511]
- 'One of the times I was having a psychotic episode, the police were feeding into it.'[512]
- 'On one occasion when XX armed himself with a knife, I called 000. Some hours later, by which time I had removed the knife and he was calm, 8 police officers arrived. I felt that they were unhelpful and rough in their manner and that they escalated XX by the way in which they treated him. They eventually left at my request…I do not know what alternatives exist, but when 8 police officers came to my house when I called 000 during XX's psychosis, they appeared to have no knowledge or training in mental health and treated XX like a criminal rather than like a person who needed help. It was horrendous. I lodged a complaint with police which was dismissed'[513]
- 'My parents were staying at my house at the time to help me with my toddler. Immediately, my mum was quite distressed that police turned up first. That's a very common reaction because, to us, it is like this injection of maybe our liberty is going to be taken away or people are going to judge us or not understand our behaviours, which

508 See for example; Submission 104, Australasian College of Paramedicine, p 8; Submission 67, BEING – Mental Health Consumers, p 12; Submission 152, Public Interest Advocacy Centre, p 5; Submission 158, Redfern Legal Centre, p 11.

509 See for example; Submission 132, Mental Health Carers NSW, p 16; Submission 17, Name suppressed, p 1; Evidence, Ms Katie Thorburn, Policy Manager, Mental Health Carers NSW, 22 September 2023, p 3; Submission 60, One Door Mental Health, p 6; Evidence, Ms Gen Whitlam, Associate Director, Client Services ACON, 22 September 2023, p 28.

510 Submission 17, Name suppressed, p 1.

511 Submission 27, Name suppressed, p 1.

512 Submission 74, Youth Action, p 13.

513 Submission 18, Name suppressed, p 1.

we have experienced our whole lives. It can be really scary, to the point that many of my community don't even reach out to begin with, and that's why our suicide rate is seven times the general population. That is just not acceptable.'[514]

- '…I had to make a decision to contact 000 and expressed over the phone that this individual was a trans person. I reiterated their pronouns and that this was requiring a mental health response, and unfortunately the police, several police, turned up, misgendered this individual, and it created more harm.'[515]

4.68 A common theme in the stories of stakeholders was that having police respond to mental health crises was 'inappropriate and dangerous'[516] as well as 'heavy-handed and can be extremely threatening'.[517] In its submission, Flourish expressed the view that police are not equipped to respond alone to mental health crises as they do not have the qualifications, skills or experience to do so, and as such 'it is unfair and unreasonable to expect them to respond effectively.[518] According to Ms Priscilla Bice, CEO, BEING, the fatal outcome of a number of recent police responses to mental health crises had led consumers to feel more scared:

> I guess our view is that we've seen four deaths in as many months at the hands of police. I know that police didn't go into those mental health situations wanting to kill, but that was the outcome. We're seeing that consumers are becoming more scared of the outcome that they might experience if police are called.[519]

4.69 One Door Mental Health reported that carers, including parents of adult children with severe and complex mental health concerns who have been involved with the police, are afraid that officers are 'shooting to kill rather than employing alternative methods to de-escalate situations involving people in mental distress.[520] The organization acknowledged that while carers respected and appreciated that police often need to 'make split-second decisions for the safety of themselves and others' they felt that more could be done to protect people who are vulnerable.[521]

4.70 Other participants reported that the police force's complex relationship with vulnerable communities including First Nation people and the LGBTQIA community is another reason why a police response to a mental health response may be inappropriate. Some argued that police involvement could further exacerbate tensions and contribute to the over criminalisation of these communities.[522]

514 Evidence, Ms Annie Crowe, Founder and consultant, NeuroAccess, 22 September 2023, p 20.

515 Evidence, Ms Gen Whitlam, Associate Director, Client Services ACON, 22 September 2023, p 28.

516 Submission 132, Mental Health Carers NSW, p 16.

517 Submission 75, The Australian Clinical Psychology Association, p 13.

518 Submission 49, Flourish Australia, p 13.

519 Evidence, Ms Priscilla Bice, CEO, BEING, 22 September 2023, p 2.

520 Submission 60, One Door Mental Health, p 6.

521 Submission 60, One Door Mental Health, p 7.

522 See for example, Evidence, Mr Shane Sturgiss, CEO, BlaQ Aboriginal Corporation, 16 October 2023, p 56, Evidence, Ms Gen Whitlam, Associate Director, Client Services ACON, 22 September 2023, p 28.

4.71 Mr Shane Sturgiss, Chief Executive Officer, BlaQ Aboriginal Corporation, elaborated on why police responding to an Aboriginal and Torres Strait Islander person experiencing a mental health crisis could be detrimental to the situation:

> …Aboriginal and Torres Strait Islander people have an inherent distrust of government, of police, regardless. Too many times we've seen, and we have been the victims of, very public abuse by police. Having police show up for it, in regard to a mental health crisis or a psychosis, is a triggering element, which I think we could all agree on.[523]

Case study Police response to a mental health crisis as presented by Mrs Marjorie Anderson

Mrs Marjorie Anderson is the National Manager at 13YARN. She told the committee of a story of a young man she had worked with whose experience she felt demonstrated the unnecessary escalation of a mental health crisis by the attendance of police:

> 'We had a young man one time, when our 13YARN crisis supporters up in Dubbo were out to dinner, who was going to jump off a bridge. His actual psychologist heard about it and went down there. The police wouldn't let the psychologist talk to him. We had 13YARN crisis supporters down there and they weren't allowed near him. His mother came down; they kept her back. And the younger police who were there in the beginning had him settled down, but it was when the old police sergeants turned up and it was the heavy-handed thing that it just escalated. They ended up arresting him and throwing him in the back of a paddy wagon, and the whole community was distressed. My 13YARN crisis supporters were distressed. Everybody that was involved in that was distressed. They say, "This is why we don't trust the police." It is because we get those heavy-handed old sergeants come in who want to flex their nightsticks, and it's just a terrible outcome for everybody. But the younger police seem to have a different approach. I'm not sure if the training has changed, but they seem to have a different approach. It depends on personality as well, with police, but I don't think they get enough training around dealing with people who are in psychosis or people who are having episodes of mental health issues.'[524]

4.72 However, the view that police were not best placed to respond was not unique to consumers, their carers or mental health service providers. Mr Kevin Morton, President, Police Association of NSW agreed that police should not always be responding to mental health crises, and that having to do so was affecting their officers' ability to do their duty:

> Police are not mental health clinicians. More often than not, the mere sight of a police officer's uniform will only exacerbate a person dealing with a mental health issue. The use of police officers to prop up a failing mental health system not only affects those involved in the incidents but affects the broader community, as we see more and more police officers consistently taken away from their core duties of protecting their communities.[525]

523 Evidence, Mr Shane Sturgiss, Chief Executive Officer, BlaQ Aboriginal Corporation, 16 October 2023, p 50.

524 Evidence, Mrs Marjorie Anderson, National Manager, 13Yarn, 16 October 2023, p 57.

525 Evidence, Mr Kevin Morton, President, Police Association of NSW, 30 October 2023, p 12.

4.73 His colleague, Mr Tony Bear, Manager, Strategy and Relationships, Police Association of NSW echoed Mr Morton's comments about the effects of responding on police officers:

> …our members are burning out. Our members are upset and traumatised by putting people into police cars or having to be physical with people. We don't want it, and nor do we want the fallout when things ultimately go pear-shaped.[526]

4.74 In Mr Bear's view, responding to mental health incidents was a health issue, and health and ambulance services should be resourced effectively to respond.[527] Mr Bear accepted that in the instance that an incident was violent, police would be the appropriate responding agency:

> When there's a violent incident, police will be called… If people call 000 and there is a person who is in a public area being violent, then police will need to be the primary agency. What we are saying is that on occasion—and on a lot of occasions—the primary agency should be Health and that sometimes when police are called the mere fact that police are present can escalate the situation.'[528]

4.75 Mr Bear provided some insight into how police responses to incidents involving a weapon could escalate, stating that police must act in accordance with their oath of office to preserve life and property:

> The trouble is that you can know you're going to a mental health issue but we don't see mental health when a person is carrying a weapon, who is next to five other people or needs to be kept within an area. That then becomes another ball game altogether. That's the problem that, when it gets to that point, when police must act on the training that they're provided, and so be it. And I think the public expect that to be preserved: life and property. That's our oath of office.[529]

4.76 The committee heard that the inherent role and function of police means that they are not best placed to respond to mental health crises and that instead of training police, resources would be better allocated to the health sector. Mr Shane Sturgiss, CEO, BlaQ Aboriginal Corporation explained:

> The police have a very specific function in the community—to keep the peace. Ambulance and mental health workers have a very specific role in caring for community. If everyone just did their job that they're actually allocated, then that would be great. And if that means putting more resources into mental health ambulance paramedic teams, that would be money better spent than training and educating the police force in mental health and psychosis.[530]

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526 Evidence, Mr Tony Bear, Manager, Strategy and Relationships, Police Association of NSW, 30 October 2023, p 15.

527 Evidence, Mr Tony Bear, Manager, Strategy and Relationships, Police Association of NSW, 30 October 2023, p 14.

528 Evidence, Mr Tony Bear, Manager, Strategy and Relationships, Police Association of NSW, 30 October 2023, p 13.

529 Evidence, Mr Tony Bear, Manager, Strategy and Relationships, Police Association of NSW, 30 October 2023, p 14.

530 Evidence, Mr Shane Sturgiss, Chief Executive Officer, BlaQ Aboriginal Corporation, 16 October 2023, p 50.

4.77 Overall, the committee heard from both members of the community and police that the status quo is taking a toll on individuals with lived experience, carers and police themselves. One carer acknowledged the difficult position police find them in when dealing with a person in the midst of a mental health crisis, and how traumatising it can be for everyone involved, including police:

> The police regularly find themselves in the very deep waters of a mental health crisis and I want to acknowledge that they have been my safety net. It is hard to be grateful for this as we are ALL traumatised by a mental health crisis.[531]

Improving and providing alternatives to the emergency response approach

4.78 The committee sought to understand how emergency responses could be improved to better support individuals experiencing mental health crises. It also considered alternative measures to lessen the potential for police attendance to lead to escalation, as well as services that could support an individual who would otherwise present at an emergency department. As part of this, the committee also examined existing programs in other jurisdictions both within Australia and internationally.

4.79 As discussed above, there was a clear sentiment from stakeholders that preventing the occurrence of crises in the first place, through earlier, more accessible treatment and better community mental health support, should be the main focus.[532] However, where an emergency response was required, stakeholders argued that this should include mental health workers and peer workers, both for a more trauma informed response as well as to improve outcomes for those experiencing crisis.[533] Ms Gen Whitlam, Associate Director, Client Services, ACON called for a total reimagining of the current approach to emergency response, to better integrate mental health workers:

> We recommend reimagining the emergency response to include mental health workers—to be led by mental health workers and peer workers. It is so critically important that we have a trauma-informed response for community when they are in distress. We have heard from community of instances or hesitations to reach out for support when they most need it because they know that the emergency response is police arriving at their doorstep, which can be retraumatising for many people. We have mental health workers and peer workers who are skilled. It is their job or their role to work with community to de-escalate, to support and to connect.[534]

4.80 The committee heard many other suggestions for alternatives to police responses to mental health crises including:

- Allocating specialised teams to respond, with police to become involved within co-responder teams only when required for the safety of mental health workers,[535]

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531 Submission 17, Name suppressed, p 1.

532 Submission 132, Mental Health Carers NSW (MHCN), p 6; Evidence, Dr Evelyne Tadros, CEO, Mental Health Coordinating Council, 16 October 2023, p 38; Submission 149, Australian Paramedics Association (NSW), p 7.

533 See for example, Evidence, Ms Gen Whitlam, Associate Director, Client Services ACON, 22 September 2023, p 28; Submission 67, BEING - Mental Health Consumers, p 2; Submission 149, Australian Paramedics Association (NSW), p 9.

534 Evidence, Ms Gen Whitlam, Associate Director, Client Services, ACON, 22 September 2023, p 28.

535 Submission 104, Australasian College of Paramedicine, p 9.

- Tripartite co-response between paramedics, mental health staff and police
- Paramedic-mental health clinician teams
- Embedding a mental health paramedic in the emergency call-centre[536]

4.81 The sections below outline evidence received by the committee regarding current programs in NSW that provide both an emergency alternative to police, and as an alternative to EDs for consumers.

Mental Health Acute Assessment team (MHAAT)

4.82 Operating in Western Sydney since 2013, the MHAAT is a partnership between Western Sydney Local Health District and NSW Ambulance, where a paramedic co-responds with a mental health nurse to 000 acute mental health calls within the local health district.[537]

4.83 The model is credited with reducing the trauma associated with inappropriate admissions to the emergency department, providing better clinical pathways to persons in mental health distress, establishing patient trust and easing the pressure on hospital resources.[538]

Mental Health, Ambulance and Police Project (MHAAP)

4.84 MHAPP is a trial partnership involving Illawarra Shoalhaven Local Health District Mental Health Service, NSW Ambulance and Wollongong Police District.

4.85 MHAPP involves an experienced mental health clinician who works with ambulance and police during periods of peak demand to provide telephone and onsite support for people experiencing a mental health crisis, as well as de-escalation support.[539]

4.86 As part of the response, a person in crisis is provided access to a mental health assessment, transport and referral options.[540]

4.87 The Australian Paramedics Association advised that the program has been hugely successful in reducing ED presentations and that it provides paramedics more options for treatment and continuity of care for a patient.[541]

Mental Health First Responder (MHFR) Program

4.88 NSW Health briefly discussed the Mental Health First Responder Program being trialed in the Hunter New England area. Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health explained that the program connects emergency services, both ambulance and police, to specialised mental health triage services who provide clinician assistance:

536 Submission 104, Australasian College of Paramedicine, p 10.

537 See for example, Submission 104, Australasian College of Paramedicine, p 9; Submission 149, Australian Paramedics Association (NSW), p 22.

538 Submission 104, Australasian College of Paramedicine, p 9.

539 Submission 149, Australian Paramedics Association (NSW), p 29.

540 Submission 149, Australian Paramedics Association (NSW), p 29.

541 Submission 149, Australian Paramedics Association (NSW), p 29.

> There is a system that's called "mental health first responder" that uses virtual technology, and in this case it's an iPad that is carried by both ambulance and police. It allows them to—if it's safe, if it's appropriate, and generally if the consumer is agreeable to it—rather than transport that person to a declared facility, rather than take a police or ambulance crew out of town, that person can have a brief assessment and work out what their disposition should be.[542]

4.89 Mr Flynn noted that while it was early days of the program, the service had assessed roughly 130 people in the last 12 months and use of MHFR had seen over 80 per cent of people who have been assessed diverted from ED.[543]

Suicide Prevention Outreach Teams (SPOT)

4.90 The committee also heard about SPOT, which is a mobile service that responds to suicidal emergencies.

4.91 Ms Priscilla Bice, CEO, BEING recommended SPOT, which uses a clinician and a peer worker working together to respond to people experiencing suicidality, as an alternative to a police response.[544]

4.92 Ms Bice emphasised that having a peer worker involved is very beneficial as often the peer worker has possibly been in the situation before or something similar, while the clinician brings their clinical training.[545]

4.93 Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative also described the SPOT program as doing "amazing" work in regional areas, despite funding and staffing challenges.[546]

Mental health training for police

4.94 Noting many of the issues discussed above, there was a strong consensus amongst stakeholders that police require additional mental health training.[547]

4.95 According to Justice Reform Initiative, police should be trained to work effectively and safely with people experiencing mental illness, and in a way that carries minimal risk of harm to any person.[548] This includes ensuring that 'the use of minimum force and preservation of life are top priorities when responding to mental health crises' and that police officers are accountable for their interactions with vulnerable members of the community.[549]

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542 Evidence, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health 16 October 2023, p 47.

543 Evidence, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health 16 October 2023, p 47.

544 Evidence, Ms Priscilla Bice, CEO, BEING, 22 September 2023, p 2.

545 Evidence, Ms Priscilla Bice, CEO, BEING, 22 September 2023, p 3.

546 Evidence, Mr Glenn Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2024, p 55.

547 See for example, Submission 67, BEING - Mental Health Consumers, p 13; Submission 76, Justice Reform Initiative, p 4; Submission 158, Redfern Legal Centre, p 3. Submission 152, Public Interest Advocacy Centre, p 6.

548 Submission 76, Justice Reform Initiative, p 11.

549 Submission 76, Justice Reform Initiative, p 11.

4.96 In addition, Dr Fiona Kumfor, Associate Professor, School of Psychology, University of Sydney, Clinical Neuropsychologist and Co-Founder of the Dementia Law Network, recommended that police be better educated about how to identify and better manage people living with dementia and how to de-escalate situations where there is a severe change in behaviour.[550]

4.97 When asked about the type of training police officers receive to assist them in responding to mental health crises, the NSW Police Association explained that police receive mental health training and other core training. He explained the most important training related to the use of force teaches officers to constantly adjust their level of force as a situation changes:

> So the number one use of force is your mouth, and then you have a circle—and what we have, it's a circle because you go forwards and backwards on it. It's not one size fits all. You may take a taser out, put it back in, continue to talk, assess. One may need to have a firearm out. One may need to have a baton out. But it's never once you've pulled something out that you've got to use it. It's always using your communication to get the best results for everybody in that circle[551]

Police, Ambulance and Clinician Response (PACER)

4.98 The existing Police, Ambulance and Clinician Early Response (PACER) model was the subject of a significant volume of evidence received by the committee.

4.99 NSW Health described PACER as an 'innovative mental health co-responder model that supports NSW first responders when attending people experiencing a mental health emergency in the community.'[552]

4.100 Under the PACER model:

- NSW Health senior mental health clinicians are embedded in police stations,
- Mental health clinicians can provide on-scene and telephone assistance to police when responding to people experiencing a mental health emergency in the community
- If needed, police can activate the mental health clinician as a secondary response who attends on-scene to assess the person's mental health needs and organise appropriate care.[553]

4.101 Currently, PACER operates in 17 Police Area Commands across greater Sydney and the Central Coast, within 8 Local Heath Districts (LHD) and St Vincent's Health Network.[554]

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550 Evidence, Dr Fiona Kumfor, Associate Professor, School of Psychology, University of Sydney, Clinical Neuropsychologist and Co-Founder of the Dementia Law Network, 30 October 2023, p 6.

551 Evidence, Mr Tony Bear, Manager, Strategy and Relationships, Police Association of NSW, 30 October 2023, p 14.

552 Submission 148, NSW Health, p 25.

553 Submission 148, NSW Health, p 25.

554 Submission 148, NSW Health, p 25.

4.102 The committee heard that rural and regional LHDs have adapted the PACER model, complemented with virtual technology, to enhance access due to the geographical dispersion of communities and resources.[555]

4.103 While Redfern Legal Centre (RLC) noted that the PACER program is in its infancy, it reported that clients who have come into contact with the program described it as producing positive outcomes for them by reducing trauma and preventing further physical and psychological harm.[556] RLC clients also reported feeling safer in the presence of police with a PACER clinician present.[557] A report by NSW Ambulance also found that PACER decreased Emergency Department presentations.[558]

4.104 Stakeholder views on PACER were varied. Some were supportive of the model and advocated for it to be further funded and rolled out across NSW.[559] One community member described their positive personal experience with PACER in the Nepean Blue Mountains local health district:

> The PACER program is vital to the Nepean Blue Mountain LHD. I had the PACER called for me on 2 occasions. Plus another visit via the Assertive Team. The PACER clinician was friendly and able to see me while the police waited outside. The PACER clinician organised for a direct admission into hospital and we rode in the PACER car instead of the back of a police vehicle which was a more dignified experience.[560]

4.105 The same community member recounted their contrasting experience when police responded without PACER:

> 'During a police callout without PACER the police took me to a household where family violence was present, I told them that I couldn't go there for the reason of family violence but they took me anyway in the middle of the night. This wasn't a safe alternative for me and put me at further risk of trauma and abuse.'[561]

4.106 RLC asserted that a health-focused response rather than a law and order-focused one is necessary when dealing with people experiencing an acute mental health crisis. In their submission, RLC stated that while RLC prefers that police are not included in such a response, it noted that PACER's advantages outweigh its disadvantages.[562]

555 Submission 148, NSW Health, p 25.

556 Submission 158, Redfern Legal Centre, p 12.

557 Submission 158, Redfern Legal Centre, p 12.

558 Submission 152, Public Interest Advocacy Centre, p 6.

559 See for example, Submission 132, Mental Health Carers NSW p 16; Submission 108, Legal Aid NSW, p 22; Evidence, Dr Fiona Kumfor, Associate Professor, School of Psychology, University of Sydney, Clinical Neuropsychologist and Co-Founder of the Dementia Law Network, 30 October 2023 p 7.

560 Submission 26, Name suppressed, p 3.

561 Submission 26, Name suppressed, p 3.

562 Submission 158, Redfern Legal Centre, p 12-13.

4.107 The committee heard that a limitation of the program was that PACER is not able to respond to incidents that are deemed high-risk incidents or incidents that involve the use of a weapon.[563]

4.108 Mr Bear of the Police Association acknowledged that whilst the PACER program is a good initiative that has helped police on the front line, his view was that Health should be leading responses to mental health incidents.[564]

4.109 Finally, some stakeholders also recommend that the program be evaluated to properly assess the efficacy of the program and to inform a decision about whether it should continue.[565]

4.110 In response to questions about police responding to mental health crises and PACER, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health recognized that PACER is not a one-size-fits-all solution to these issues. He advised the committee that NSW Health was looking at a range of other options 'to strengthen care for people who experience mental health crises.'[566]

4.111 Finally, the committee also heard from the Hon. Rose Jackson MLC, Minister for Mental Health, during the committee's Legislative Council Budget Estimates 2023-2024 hearing. When asked about the future of PACER, the Minister acknowledged the important role PACER has played but advised the committee that the program was not funded beyond 2025. The Minster also noted that NSW Police Force was conducting a review of police responses to mental health crises and indicated that consumers and advocates should be involved in the co-design of potential models being considered:

> 'In and of itself, PACER in its current delivery framework is not up to the task and we acknowledge that and we know that we need to do more. But I do think that PACER has played an important role…
>
> It's not funded beyond 2025… and that is because what is funded into the future is going to be different to what is delivered now. I think that's a good thing because there are opportunities for us to review where programs have done well, where they haven't done well.
>
> My understanding is that the review that the Commissioner of Police is leading, or has initiated, is due to wrap up by the end of the year. That in and of itself is not going to be adequate because that has not been informed by consumers. That has not been informed by their advocates. I think it is excellent that police are so open to acknowledging that things need to be done differently. I think that's incredible. We are very excited to have that collaboration opportunity. I would imagine that, leading into

563 See for example; Evidence, Mr Callum Hair, Senior Solicitor, Mental Health Advocacy Service, Legal Aid NSW, 15 February 2024, p 34; Evidence, Mr Tony Bear, Manager, Strategy and Relationships, Police Association of NSW, 30 October 2023, p 14.

564 Evidence, Mr Tony Bear, Manager, Strategy and Relationships, Police Association of New South Wales, 30 October 2023, p 13.

565 Submission 152, Public Interest Advocacy Centre, p 2; Submission 67, BEING - Mental Health Consumers, p 17; Submission 132, Mental Health Carers NSW, p 6.

566 Evidence, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, 16 October 2023, p 44.

next year, there will be that opportunity for dialogue and elements of co-design, I would hope, with consumers about how we might do things differently.'[567]

Other jurisdictions

4.112 Continuing its exploration of emergency responses to mental health crises, the committee heard evidence on various examples from other jurisdictions, both within Australia and internationally.

International

4.113 At the third hearing, Mr Kevin Morton, President, Police Association of New South Wales informed the committee that the NSW Premier had recently sent NSW Police Force officers to the United Kingdom (UK) to examine and review their alternate model of responding to mental health incidents.[568] Mr Morton told the committee that the model, called Right Care, Right Person[569] involved a tiered process to determine what response police will have when responding to a mental health incident.[570]

4.114 The committee also heard about other models in the United States that have had some success. These programs include:

- Crisis Assistance Helping Out On The Streets (CAHOOTS) (Eugene, Oregon) – is a 24-hour mobile mental health crisis intervention program. The service dispatches two unarmed crisis workers and medics to respond to 911 and non-emergency calls involving people experiencing a mental health crisis. If the situation involves a crime, violence or life-threatening emergencies, police will attend as co-responders.[571] In 2019, police backup was needed during less than 1% of the 24,000 calls they responded to.

- Support Team Assisted Response (STAR) (Denver, Colorado) – is an alternative response team that includes behavioral health clinicians and paramedics to engage individuals experiencing mental health distress and substance use disorders. STAR responds to low-risk calls where there are no significant safety concerns.[572] This is a new program to Denver that started in 2020. In the program's first six months, they responded to 2,500 calls, only 748 of which required police assistance.[573]

567 Evidence, Hon. Rose Jackson MLC, Minister for Mental Health, 1 November 2023, pp 32-32.

568 Evidence, Mr Kevin Morton, President, Police Association of NSW, 30 October 2023, p 12.

569 Evidence, Mr Kevin Morton, Police Association of NSW, 30 October 2023, p 12.

570 Evidence, Mr Kevin Morton, Police Association of NSW, 30 October 2023, p 18.

571 See for example, Submission 135, Community Restorative Centre, p 16; Evidence, Ms Lillie Mellin, Mental Health Spokesperson, Justice Action, 15 February 2024, pp 32 and 35, Submission 152, Public Interest Advocacy Centre, p 11; Submission 158, Redfern Legal Centre, p 10.

572 Denver Public Safety, Support Team Assisted Response (STAR) 2022 Mid-Year Report, https://www.denvergov.org/files/assets/public/v/1/public-health-and environment/documents/cbh/2022_midyear_starreport_accessible.pdf

573 See for example, Submission 51, Justice Action, p 20; Evidence, Ms Lillie Mellin, Mental Health Spokesperson, Justice Action, 15 February 2024, pp 32 and 35.

South Australian model

4.115 The South Australian Mental Health Co-Responder program (MH CORE) partners paramedics with a community mental health clinician to respond to people experiencing a mental health crisis.[574]

4.116 As explained by Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service (SAAS), MH CORE was implemented as a way to provide alternative care pathways and improve patient outcomes whilst at the same time diverting presentations to emergency departments.[575] The program is used primarily to respond to low to medium acuity mental health incidents.[576]

4.117 Echoing the sentiments of representatives from the Police Association of NSW, Mr Lemmer said that the South Australian position was that mental health emergency responses should be health-led:

> 'I think one of the things in South Australia is that a very clear decision was made that mental health is a health problem; it's not a police problem. We've been really, really clear as a State in trying to say response to mental health consumers should not be SAPOL led; it should be ambulance led or health led, and police come in and support, if there is a safety risk, but it's not a primary response.'[577]

4.118 On the topic of police responding to mental health emergencies, Mr Lemmer commented that SAAS had seen a very low rate of South Australian Police (SAPOL) attendance when MH CORE is involved in cases. In his view, this is because having a mental health clinician within the team who has access to the mental health records system allows for a much more informed risk assessment:

> 'What we now have is a much better linked-up, informed response and comfort in dealing with this particular patient cohort. It's resulted in a much lower rate of SAPOL involvement.'[578]

4.119 As part of the MH CORE program SAAS has developed a series of referral pathways which includes:

- General practitioners
- Community mental health teams
- Mental health triage program

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574 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 2.

575 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 2.

576 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 2.

577 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 3.

578 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 3.

- Private psychologists and counsellors
- Support services
- Urgent mental healthcare centres (walk-in or community referral centre)[579]

4.120 Noting that an 'ED is not the ideal environment, 90 per cent of the time, for these people' Mr Lemmer advised that the MH CORE team is able to build linkages with some social services so they can try to help people stay within the community and refer them for community-based care, rather than divert them into the hospital system.[580]

4.121 The committee heard that another benefit of the MH CORE program was the limited sectioning of patients for involuntary treatment, which would usually also involve SAPOL transporting patients for medical treatment. Mr Lemmer explained that the use of the MH CORE team to de-escalate and transport patients in a voluntary manner if needed meant that no third-party agency was required to help.[581]

4.122 There was some discussion about the scalability of the MH CORE to regional areas. While Mr Lemmer noted that the expansion of MH CORE to regional South Australia had not been looked at due to the work volume, he advised that SAAS was looking at how to diversify emergency responses to mental health crises by hybridising components of the MH CORE program.[582]

4.123 In addition, the committee heard that in some regional areas, in additional to normal paramedics, SAAS has access to a 'community paramedic', who plays a more 'non-traditional ambulance role' performing tasks like taking blood pressure, and starting conversations with people about how they are feeling. For example, in Ceduna, a remote town in South Australia which has a high First Nations population, there is a community paramedic who has a more proactive role in providing primary health care including mental health care. [583]

4.124 Mr Lemner also discussed the challenges the SAAS has faced in implementing the MH CORE program. An initial challenge was the apprehension of paramedics about the idea of working with a clinician, rather than their usual paramedic partner who they may have developed a trusting relationship with:

> [T]there is a lot of confidence in our profession or our sector with working with each other. People are really comfortable that their partner will understand and read a room. Suddenly having to work with a clinician who comes from a different specialty and

579 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 2.

580 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 5.

581 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 3.

582 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 4.

583 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 4.

> hasn't cut their teeth, if you like, working in that true community emergency setting, that led to some apprehension around safety and where that would sit.[584]

4.125 In response to safety concerns, SAAS have put the following processes in place:

- Duress alarms
- Regular contact from the Emergency Operations Centre
- AVL on all vehicles
- Risk assessments
- Safety Learning System that records and reports incidents including acts of violence
- High-risk address register[585]

4.126 The committee heard from Mr Lemmer that concerns around safety for staff have been successfully mitigated through the above processes. Mr Lemmer advised the committee that there have been no incidents of harm to staff in the MH CORE program.[586]

4.127 He also explained how the high-risk address register assists with responding to cases where there may be a risk of violence:

> We have a high-risk address register. If we were to go to a case and experience physical violence or threats of physical violence, that would come into one of our regional officers, who would undertake a review, link in with SAPOL, link back in with mental health and develop a response plan. It may mean that we have a particular response plan assigned to an address that says we won't send the MH CORE team because of the arrangement, or it might be that we will send them but we will involve SAPOL. We develop a co-response plan with local police and have an agreed response plan to that particular consumer at that particular address.[587]

4.128 Finally, in relation to remuneration, Mr Lemmer advised that the MH CORE enterprise agreement has a particular classification for a single responder which is slightly higher rate of pay than a traditional paramedic. Whilst MH CORE paramedics work with a mental health worker and not alone, they are as if they were working alone, given some of the paramedic-specific tasks may rely on their individual expertise, without the support of the mental health worker.[588]

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584 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 5.

585 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 6.

586 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 5.

587 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 6.

588 Evidence, Mr Paul Lemmer ASM, Executive Director of Operations, South Australia Ambulance Service, 17 November 2023, p 7.

Australian Capital Territory (ACT) Model

4.129 The committee also received evidence about a tri-agency program in the Australian Capital Territory, between Canberra Health Services, ACT Ambulance and ACT Policing, also called Police, Ambulance and Clinician Early Response (PACER).[589] Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government explained that the objective of the program is to provide a safe, health led response to persons involved in acute mental health related crises, whilst reducing demand on frontline emergency services and EDs, invocation of involuntary detention and associated police transport.[590]

4.130 Ms McKenzie explained that the ACT PACER program involves a mental health clinician, a police officer and a paramedic responding to situations that have been triaged as a mental health crisis.[591] In contrast to the NSW PACER program, which is a police-led response, the role of the police officer in the ACT PACER program is different, and is 'to ensure the safety of the whole team, the community and the patient.'[592]

4.131 In correspondence to the committee Mr Doug Boudry, Deputy Chief Police Officer, ACT Policing, advised that one police officer is dispatched under the ACT PACER team, however if there is a situation where there is an apprehension of violence, co-attendance by additional police officers for the full duration of the incident, or until released by the PACER police officer is required.[593]

4.132 In terms of feedback on the program, Ms McKenzie commented that the therapeutic intent of the PACER team has been shown to be critically important to de-escalating situations and allowing people to remain in the community and get support.[594] However, she also explained that there has been some mismatch in consumers' expectations of the level of care they expect to receive when receiving a mental health response, noting that PACER is a crisis response:

> When you say it is a mental health response, there is an expectation that, potentially, there might be more coming than what does come. It is, at its core, a crisis and assessment response done by a skilled mental health clinician. For people that need more than that, it requires them to be linked or to follow up at a later time. So there are some differences in expectation.[595]

589 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 8.

590 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 8.

591 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 8.

592 Correspondence from Mr Doug Boudry, Deputy Chief Police Officer, ACT Policing to Chair of Portfolio Committee No.2 - Health, 20 December 2023.

593 Correspondence from Mr Doug Boudry, Deputy Chief Police Officer, ACT Policing to Chair of Portfolio Committee No.2 - Health, 20 December 2023.

594 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 8.

595 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 8.

4.133 Ms McKenzie elaborated on this point, observing that there can be tension between services trying to divert people away from EDs and consumers or carers wanting or expecting to be transported to hospital:

> I think there's tension in how we measure success, and I think that has particularly come across for carers, because if you're a carer in that environment, actually staying out of the emergency department, which is a success for us, is not necessarily what is right for them in that moment.[596]

4.134 The committee heard that an evaluation of the ACT PACER program showed that it saved police and emergency time, as well as having other non-monetized benefits such as consumers not being retraumatised by going to the ED.[597]

4.135 The ACT PACER program operates under a Memorandum of Understanding between the three agencies which allows for clinical information sharing. Whilst all three agencies record information, the database is maintained by ACT Policing and it is the responsibility of the PACER Mental Health Clinician to share the information.

4.136 When asked about re-creating an ACT model in NSW, Ms McKenzie observed that the ACT, being a singular-city jurisdiction and having one digital health record meant that the ACT does not have the same record keeping challenges that NSW may face.[598] She also acknowledged the challenges of working in a jurisdiction with the geographic scale of NSW, particularly for service delivery.[599]

4.137 Similar to the challenges faced in South Australia, Ms Mc Kenzie confirmed that ACT PACER mental health clinicians are a multidisciplinary workforce who have not necessarily been exposed to the frontline situations that come with the PACER space.[600]

4.138 To overcome these challenges, Canberra Health Services has implemented the following:

- mental health clinicians receive an allowance for being in the PACER team,
- the mental health clinician role is a senior role
- strengthened clinical supervision
- enhanced debriefing with the input of ACT Policing.[601]

596 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 8.

597 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 9.

598 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 9.

599 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 10.

600 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 10.

601 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 10.

4.139 The committee heard that apart from the 'longer-term psychosocial effects of working in such a raw, fast-paced environment'[602] there have not been any safety issues.[603]

Alternatives to reduce presentations to emergency departments

4.140 In addition to increasing the availability of, and access to, community mental health services for people in crisis and to prevent escalations of symptoms to the point of crisis as outlined above, the committee received a significant volume of evidence relating to alternatives to emergency departments for people experiencing severe mental distress.

4.141 The committee heard of several initiatives in NSW that have demonstrated reduced mental health related presentations to emergency departments, reduced admissions, improved societal impact (productivity gains, carer impact) and overall economic benefits.[604]

4.142 Some of these initiatives include Housing and Accommodation Support Initiative (HASI) Plus and Safe Havens which are further are explored in turn below.

Housing and Accommodation Support Initiative (HASI) Plus

4.143 The Housing and Accommodation Support Initiative (HASI) is a statewide program that supports people with a severe mental illness to live and recover in the community in the way that they want to. HASI is part of a suite of community-based psychosocial programs for adults called the NSW Mental Health Community Living Programs.[605] HASI Plus is a higher intensity transitional program which 'integrates clinical and intensive psychosocial support with stable, community-based accommodation'.[606]

4.144 NSW Health advised that there are 70 HASI Plus places across eight accommodation sites hosted in four local health districts in NSW.[607]

602 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 10.

603 Evidence, Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services, ACT Government, 17 November 2024, p 10.

604 Submission 147, Mental Health Commission of New South Wales, p 8.

605 Answers to questions on notice, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, 14 March 2024, p 1.

606 Answers to questions on notice, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, 14 March 2024, p 1.

607 Answers to questions on notice, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, 14 March 2024, p 1.

4.145 There was clear support from stakeholders for the HASI model,[608] including Dr Angelo Virgona Chair, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists who called the program a 'terrific success in NSW' but stressed that it needs 'major further investment.'[609]

4.146 Dr Evelyne Tadros CEO, Mental Health Coordinating Council, referred to an 2022 evaluation of the HASI program which found the HASI program was effective from a cost-benefit as well as an individual, family and community perspective.[610] She also highlighted that the evaluation found that mental health related hospital admissions for HASI clients reduced by 74 per cent over two years.[611]

4.147 On this point, Ms Nicole Cockayne, Director Policy & Research Operations, Black Dog Institute explained that this reduction in hospitalisation and cost to the health system offsets the provision of the HASI, with a per-person saving of around $86,000 over five years.[612]

4.148 The committee had the opportunity to visit a HASI Plus space in Carlingford, Sydney. The committee's site visit is discussed in further detail in a case study below.

Case Study: Uniting Housing and Accommodation Support Initiative (HASI) Plus Carlingford

HASI Plus is a statewide program that supports people with a severe mental illness to live and recover in the community in the way that they want to. It aims to support people transitioning from long-term institutional care to independent living within the community.

In February 2024, the committee had the opportunity to visit the HASI Plus in Carlingford, Western Sydney and have a tour of the complex.

Inside, the common areas were inviting and filled with art, games and a social calendar of upcoming events and activities for residents. Outside, there was a vegetable garden and plenty of space for Diggs, the resident Greyhound, who is a therapy dog and provides extra care to residents.

The committee also took a tour of some of the accommodation where residents live and spoke to one resident about their experience of the HASI program. The resident spoke about the tailored support provided by the program, noting that it has helped him achieve his goals and facilitated his transition to a more independent life within the community.

Staff members championed the person-centred approach of the program which provides holistic care to address all aspects of a person's wellbeing, as well as providing individualised support to meet resident's unique needs and goals.

608 See for example; Evidence, Dr Evelyne Tadros CEO, Mental Health Coordinating Council, 16 October 2023, p 36; Magistrate Carolyn Huntsman, President of Mental Health Review Tribunal, 30 October 2023, p 21; Evidence, Ms Nicole Cockayne, Director Policy & Research Operations, Black Dog Institute, 17 November 2023, p 15.

609 Evidence, Dr Angelo Virgona Chair, NSW Branch, the Royal Australian and New Zealand College of Psychiatrists, 16 October 2023, p 11.

610 Evidence, Dr Evelyne Tadros CEO, Mental Health Coordinating Council, 16 October 2023, p 36.

611 Evidence, Dr Evelyne Tadros CEO, Mental Health Coordinating Council, 16 October 2023, p 36.

612 Evidence, Ms Nicole Cockayne, Director Policy & Research Operations, Black Dog Institute, 17 November 2023, p 15.

In addition, staff members highlighted the program's comprehensive support team, which comprised a diverse group of health professionals such as exercise physiologists and mental health support workers. However, the committee were advised that no wait list is kept for the HASI Plus program and that if there no place available people are likely diverted to alternative locations or services.

4.149 Following the site visit, the committee sought further evidence on waitlists. In response, NSW Health informed the committee that there is currently no statewide HASI Plus waitlist.[613] However, NSW Health did note that 'there is evidence to suggest that if more places became available in different locations, a waitlist might be required.'[614]

4.150 In addition, NSW Health stated that generally, people will not be added to the statewide waitlist unless they are assessed as eligible for the program, are willing to relocate, are able to wait for a vacancy to become available (dependent on hospital or correctional discharge timeframes) and are a 'good fit' for existing residents.[615]

4.151 The committee heard that some LHDs do hold waitlists for local referrals which are generally in higher demand as individuals do not have to relocate to access the program.[616]

4.152 Independent Community Living Australia (ICLA) called for transitions of care to be supported with the option of step-up and step-down services for people with complex and persistent mental health conditions. These services are known as Prevention and Recovery services (PARC) and as ICLA identified, can support individuals in a more cohesive way, providing continuity to care, with support from people with lived experience peer workers, that can assist with connecting with family, employers, GP and coordinating local community services. According to ICLA, these services have great outcomes for individuals, reducing rescheduling rates and are particularly beneficial for younger users who are scheduled for the first time in hospital.[617]

Safe Havens

4.153 As outlined above, many people experiencing acute mental health distress or suicidal thinking currently present to EDs, however these clinical environments are not the most appropriate point of care for people experiencing emotional or psychological distress which can be further exacerbated by this setting.[618]

613 Answers to questions on notice, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, 14 March 2024, p 1.

614 Answers to questions on notice, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, 14 March 2024, p 1.

615 Answers to questions on notice, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, 14 March 2024, p 1.

616 Answers to questions on notice, Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health, 14 March 2024, p 1.

617 Submission 98, Independent Community Living Australia, p 2.

618 See for example, Submission 138, Black Dog Institute, p 16; Submission 67, BEING - Mental Health Consumers, p 13.

4.154 Several witnesses recommended the use of Safe Havens as an alternative to emergency departments in these cases[619] Safe Havens are 'drop in' style spaces that offer a non-clinical setting for people experiencing emotional distress or suicidal crisis.[620]

4.155 Safe Havens are usually operated by a combination of mental health nurses and peer workers with a lived experience of suicidality and seek to offer brief assessment and care.[621] Consumers can also be connected to a mental health professional.[622]

4.156 In her evidence to the committee, Dr Anna Brooks, Chief Research Officer, Lifeline Australia spoke about the benefits of having a Safe Haven where people can talk to peer workers instead of going to the ED, suggesting the ability to 'check in' could be enough for some consumers:

> I think having Safe Haven as a physical option, somewhere people can go where there are peers available who can support them when they're doing it tough, is a positive development. In some ways, it's a physical manifestation of the sorts of things that Lifeline does. It's essentially peers that you're talking to, people who have training in the Lifeline context but are not clinicians. You can just check in when you feel like you need to in order to try to support your mental health, if you're experiencing distress.[623]

4.157 Many stakeholders who are strong proponents of the Safe Haven model expressed concern regarding its limited funding, availability across NSW and limited hours of operation.[624]

4.158 A common sentiment was that Safe Havens need to have extended opening hours to enhance access to care, even to make the service available 24/7.[625] On this point, in their submission BEING noted that out of the 19 Safe Havens listed on NSW Health's website, only two are open seven days a week. The limited operation hours can be 'problematic'[626] as those experiencing mental distress cannot predict or schedule a mental health crisis and need to be able to access safe spaces when they need it,[627] as highlighted by Ms Priscilla Bice, CEO, BEING:

619 See for example, Submission 138, Black Dog Institute, p 16; Submission 67, BEING - Mental Health Consumers, p 13; Evidence, Dr Evelyne Tadros CEO, Mental Health Coordinating Council, 16 October 2023, p 36; Submission 84, Ms Sharon Grocott, p 3; Submission 61, Suicide Prevention Australia, p 2.

620 See for example, Submission 61, Suicide Prevention Australia, p 12; Submission 39, Mental Health Coordinating Council, p 3.

621 Submission 138, Black Dog Institute, p 17.

622 See for example; Submission 39, Mental Health Coordinating Council, p 3; Submission 58, NSW ACT PHN Mental Health Network, p 10.

623 Evidence, Dr Anna Brooks, Chief Research Officer, Lifeline Australia, 15 February 2024, p 28.

624 See for example, Submission 67, BEING - Mental Health Consumers, p 13; Submission 138, Black Dog Institute, p 17; Evidence, Ms Katie Thorburn, Policy Manager, Mental Health Carers NSW, 22 September 2023, p 4.

625 See for example, Submission 138, Black Dog Institute, p 17; Submission 147, Mental Health Commission of New South Wales, p 9.

626 Submission 67, BEING - Mental Health Consumers, p 13.

627 Submission 67, BEING – Mental Health Consumers, p 13.

> There are 19 safe havens around New South Wales. Only two of them are open seven days a week. As a mental health consumer, I can't predict when I'm going to experience a mental health crisis, so that is not good enough.[628]

4.159 Further, Ms Bice also noted that Safe Havens can also be used by people who are experiencing suicidality as a waiting room for the ED. That way, people can wait at the Safe Haven, in a calm environment with peer works for support, before going to the ED when space is available.[629]

4.160 The need to have Safe Havens located near to EDs was stressed by One Door Mental Health, who noted that where they are not located close enough to hospitals, it can pose an issue if a person's mental health further deteriorates and they need more specialised care.[630]

4.161 Many stakeholders called for the Safe Havens program to be expanded across NSW, particularly in high-need rural, regional and remote areas.[631]

4.162 Ms Sharon Grocott, WayAhead, said it was perplexing that Safe Havens weren't more widely used, given they allow people to get clinical care whilst being supported by peer workers:

> It is perplexing that we do not have Safe Havens that operate 24/7 funded across every region in NSW. We need alternatives to Emergency Departments that are peer and clinician led. The alternative of sitting in Emergency for hours on end or phoning the after-hours mental health team is not good enough.[632]

4.163 In supporting the need for more Safe Havens in regional areas, Mr Glenn Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, added that a lack of transport options in regional areas, including public transport and taxis for participants is a barrier to accessing services such as the Bega Safe Haven.[633]

4.164 The committee conducted a site visit to the Lismore Safe Haven which was launched in 2022 as one of four Safe Haven hub sites in the Northern Rivers as part of the Northern NSW Flood Recovery Program. The committee's site visit is discussed in further detail in a case study below.

Case study: Lismore Safe Haven

The committee's visit to Lismore Safe Haven in mid-February 2024 allowed it to see first-hand the operation of a Safe Haven and to talk to staff about the benefits of the programs and its impact on the community.

Located in the centre of town, Lismore Safe Haven is one of four Safe Havens on the North Coast. It is operated by the Buttery and administered by Healthy North Coast. It is an inviting and softly lit

628 Evidence, Ms Priscilla Bice, CEO, BEING, 22 September 2023, p 5.

629 Evidence, Ms Priscilla Bice, CEO, BEING, 22 September 2023, p 5.

630 Submission 60, One Door Mental Health, p 3.

631 See for example; Submission 75, The Australian Clinical Psychology Association, p 13; Submission 133, Office of the Advocate for Children and Young People, p 11; Submission 61, Suicide Prevention Australia, p 4.

632 Submission 84, Ms Sharon Grocott, p 3.

633 Evidence, Mr Glenn Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative, 15 February 2023, p 49.

environment reminiscent of a lounge room, with couches, plants and board games. The space is open to community members of any age and offers a safe and supportive environment for those seeking mental health and wellbeing support. Participants can drop by without referral and receive immediate care depending on their level of distress and need. It is open seven days a week from 12.00 pm until 6.00 pm, including public holidays.

The Lismore Safe Haven team is made up of clinicians, including mental health nurses, who can provide brief interventions and counselling, as well as case managers who can provide wrap around care and referrals to support services such as psychosocial support services, housing, employment and domestic and family violence services. The Safe Haven is always staffed with a peer worker who has lived experience of mental ill health and understands recovery journeys.

The committee heard that participants find the space welcoming, safe and trauma informed. The Buttery informed the committee that 98 per cent of participants state that they would prefer to access a Safe Haven rather than an Emergency Department when experiencing distress or suicidality.

Staff who spoke to the committee noted that the space was already outfitted when the Buttery started its operations. Staff explained that while participants like the informal layout of the space, there has been feedback that it can be hard to have privacy for counselling. Participants have also strongly supported extending the opening hours to include the mornings.

There was also a lot of discussion about the impact of the 2022 floods on the region and the toll this has had on the Lismore community, particularly the impact on the mental health of residents. Staff explained to the committee that everyone was affected in one way or another, with staff even losing their homes in the disaster. They noted that the short-term funding of the program made it difficult to retain some staff particularly in a regional town.

Committee comment

4.165 The inquiry has heard evidence from a number of witnesses providing first-hand examples of inadequate or inappropriate responses to mental health emergencies and crises.

4.166 In particular, we heard that when someone is in crisis, the options of care available to them are often not suitable. They can call a crisis support line; however, they may be put on hold for a long time or even referred elsewhere. They may try to go to an emergency department, but it is likely they will wait for hours before they receive care – all the while the overstimulating and triggering environment may cause them to deteriorate further. Or, faced with no other option, they, or someone else, may call emergency services, resulting in the attendance of either ambulance or police which can result in escalation of distress or involuntary transport to hospital.

4.167 There is no doubt that a lack of early and affordable mental health services in the community contributes to people's mental health deteriorating to the point of crisis, such that there is an overreliance on these crisis services. It is also clear from evidence provided by consumers, carers, first responders and police, that these services are struggling, to the detriment of both staff and consumers. In particular, the committee was concerned by the rising number of mental health related presentations to emergency departments and the unsuitability of this environment for people in distress.

4.168 It is clear that emergency departments are not an appropriate setting to provide mental health care in the majority of presentations. They are high stimulus environments that can exacerbate

experiences of emotional or psychological distress, and people often wait many hours before they receive treatment. Given this, we believe there are a number of actions that could be taken to improve the experience of those who do present to emergency departments. In the first instance, we encourage NSW Health to support the additional provision of lower-stimulus and safer spaces within emergency departments for mental health assessment and care. We also call on NSW Health to examine opportunities for peer workers in emergency departments to support patients and staff.

Finding 12

Emergency departments are not an appropriate setting to provide mental health care in the majority of presentations. They are high stimulus environments that can exacerbate experiences of emotional or psychological distress, and people often wait many hours before they receive treatment.

Recommendation 22

That NSW Health support the additional provision of lower-stimulus and safer spaces within emergency departments for mental health assessment and care.

Recommendation 23

That NSW Health examine opportunities for peer workers in emergency departments to support patients and staff.

4.169 The committee acknowledges and appreciates the many doctors, nurses, paramedics and clinicians who shared their expertise and personal experiences to inform the inquiry of the issues they face in emergency settings, including their ideas about ways to improve the current situation. These accounts provided detailed and thoughtful evidence as to both the challenges and opportunities to address them. With this evidence in mind, we recommend that NSW Health look to improve both the experience of people with mental illness who present at an emergency department and emergency department staff, by providing mental health training for emergency department staff, in particular on suicide prevention.

Recommendation 24

That NSW Health look to improve both the experience of people with mental illness who present at an emergency department and emergency department staff, by providing additional mental health training for emergency department staff, in particular including suicide prevention.

4.170 The committee also heard that delays in timely discharge summaries being sent to General Practitioners (GPs) once someone has been discharged from the hospital presents a challenge for both consumers and doctors. In order for GPs to be able to provide informed and integrated mental health care and for consumers to receive quick aftercare, we encourage NSW Health to look to find ways to improve the timely provision of discharge summaries for people leaving hospital after mental health related admission. We also recommend that NSW Health ensure Local Health Districts better support emergency department staff with specific localised information and referral pathways to community and outpatient mental health services and address current barriers to appropriate information sharing.

Recommendation 25

That NSW Health improve the timely provision of discharge summaries for people leaving hospital after mental health related presentation or admission.

Recommendation 26

That NSW Health ensure Local Health Districts support emergency department staff with specific localised information and referral pathways to community and outpatient mental health services and address current barriers to appropriate information sharing.

4.171 The evidence that many people who present at emergency departments would be better served outside the hospital environment was resounding. With this in mind, we were encouraged to learn in particular about Safe Havens and Housing and Accommodation Support Initiative Plus (HASI+) both of which are benefitting consumers and the community and reducing unnecessary presentations to emergency departments.

4.172 We were fortunate enough to have the opportunity to experience these initiatives see first-hand, during our visit to the Lismore Safe Haven, and found the space to be a welcoming and warm alternative to an emergency department, as it is intended. We also heard that while stakeholders are very supportive of the Safe Haven model, there were concerns that the operating hours were too limited, noting someone can experience a crisis at any time and need a safe environment. Others noted that there are only 19 Safe Havens across the state and that the program needs to be expanded geographically. We believe there is great merit in this program and call on NSW Health to expand the Safe Haven program to be a 24/7 service where feasible, and to open additional Safe Havens in high-need rural, regional and remote areas.

Recommendation 27

That NSW Health expand the Safe Haven program to be a 24/7 service where feasible, with a view of opening additional Safe Havens in high-need rural, regional and remote areas.

4.173 The committee also visited the Uniting HASI+ in Carlingford to understand more about the need to provide supportive accommodation to those recovering in the community. We were convinced that by providing wrap around services, HASI+ facilities help keep people living securely and well in the community. Given that these facilities have been shown to be effective in reducing both mental health related hospital admissions and presentations to emergency departments, as well as cost-saving over the long term, we urge the Government to invest in the expansion of supported living services such as the Housing and Accommodation Support Initiative (HASI), Housing and Accommodation Support Initiative Plus (HASI+) and Pathways to Community Living Initiative (PCLI) programs.

Recommendation 28

That the NSW Government invest in the expansion of supported living services such as the Housing and Accommodation Support Initiative (HASI), Housing and Accommodation Support Initiative Plus (HASI+) and Pathways to Community Living Initiative (PCLI) programs.

4.174 The committee acknowledges the crucial role that crisis support lines play in providing an additional option for those seeking help and information when experiencing a mental health crisis. However, we were shocked to hear of the outsourcing of the NSW Mental Health Line in some Local Health Districts and the issues, such as the quality and delays of referrals, and the lack of integration information, that have developed as a result. We believe that the outsourcing of the NSW mental health line in some Local Health Districts has not enhanced the delivery of quality mental health care and does not benefit staff or consumers. Accordingly, we call on the NSW Government to return the mental health line to public operation in all Local Health Districts.

Finding 13

That the outsourcing of the NSW mental health line in some Local Health Districts has not enhanced the delivery of quality mental health care and does not benefit staff or consumers.

Recommendation 29

That the NSW Government return the mental health line to public operation in all Local Health Districts.

4.175 The committee acknowledges the evidence presented by inquiry participants on police responses to mental health crises. Recent tragedies in NSW involving police responses to mental health crises have led to fear and reluctance for some people to seek emergency care. We note that there was near unanimous agreement from all stakeholders, including the Police Association of NSW, that police are not best placed to respond to mental health crises.

4.176 There was overwhelming evidence that the attendance of police in mental health emergencies can escalate emotional and psychological distress and has been harmful in a significant number of cases. Moreover, the committee recognises that even if police are not called as first responders to mental health emergencies, police will encounter people experiencing psychological distress, psychosis, delirium, dementia or intoxication in their general duties and should be sufficiently trained and supported to be able to de-escalate mental health crisis situations. Given this, we call on the NSW Police Force to improve mandatory comprehensive mental health training currently provided to police officers in consultation with consumers and carers. We find that a broad range of stakeholders including police representatives support a health-led approach to mental health emergencies but recommend that in conjunction with NSW Health, NSW Police explore being activated as a secondary response to mental health emergencies only where required to support the safety of primary responders.

Finding 14

That the attendance of police in mental health emergencies can escalate emotional and psychological distress and has been harmful in a significant number of cases.

Finding 15

That a broad range of stakeholders including police representatives support a health-led approach to mental health emergencies.

Recommendation 30

That the NSW Police Force improve mandatory comprehensive mental health training currently provided to police officers in consultation with consumers and carers.

Recommendation 31

That in conjunction with NSW Health, NSW Police explore being activated as a secondary response to mental health emergencies only where required to support the safety of primary responders.

4.177 We also received significant evidence on the NSW Police, Ambulance, Clinical, Early, Response (PACER) team and its use as an alternative to a police-only response to mental health crises. Many stakeholders were supportive of the program and called for it to be expanded across NSW.

4.178 The committee was also interested to hear about other jurisdictions' approach to responding to mental health crises. In particular, we were encouraged to hear that NSW Police Force is conducting a review of the United Kingdom's Right Care, Right Person model and call on the NSW Police Force to publicly release their report into this model.

Recommendation 32

That the NSW Police Force publicly release their report on the UK Right Care, Right Person model.

4.179 In considering the development of a person centered and health-led approach to mental health crises, the committee sees merit in the South Australian Mental Health Co-Responder program (MH CORE). This program partners paramedics with a community mental health clinician to respond to people experiencing a mental health crisis with informed risk assessment through access to medical records, and with police as a secondary response only where required for the safety of health workers.

4.180 This model would fundamentally transform the NSW's approach to mental health responses by being health-led and without the automatic involvement of police. We are convinced that this model would reduce presentations to EDs, involuntary sectioning, trauma and would guarantee better outcomes for consumers, carers and first responders. We also believe it would reduce the need for police involvement and the risk of escalations, freeing up police resources to focus on core duties. Accordingly, we call on the NSW Government to continue to explore the implementation of a health-led response to mental health emergencies, informed by the experiences of the successful South Australian Mental Health Co-Responder program, the

Western Sydney Mental Health Acute Assessment Team and PACER, which includes an informed risk assessment through access to medical records, as well as support for carers of the person experiencing crisis.

Recommendation 33

That the NSW Government continue to explore the implementation of a health-led response to mental health emergencies, informed by the experiences of the successful South Australian Mental Health Co-Responder program, the Western Sydney Mental Health Acute Assessment Team and PACER, including informed risk assessment through access to medical records, as well as support for carers of the person experiencing crisis.

4.181 Finally, we also recommend that in seeking to develop a new approach to responding to mental health crises, NSW Police Force, NSW Health and NSW Ambulance ensure that any review or new model be co-designed with consumers and carers.

Recommendation 34

That in seeking to develop a new approach to responding to mental health crises, NSW Police Force, NSW Health and NSW Ambulance ensure that any review or new model be co-designed with consumers and carers.

Chapter 5 Community treatment orders

This chapter discusses the use of community treatment orders (CTOs) in New South Wales. It first examines how CTOs are made, including stakeholder views on the adequacy and transparency of the process, as well as their length, and how they may be overturned. It then explores their prevalence, with a particular focus on the reasons for their increase. Finally, stakeholder views on their effectiveness are considered, including both perceived benefits and harms.

The making of community treatment orders

5.1 A community treatment order (CTO) is a legal order made by the Mental Health Review Tribunal (MHRT) under section 51 of the *Mental Health Act 2007* authorising the compulsory treatment of a person in the community.[634] As the submission of the MHRT states, a CTO 'obliges a consumer to accept care and treatment set out in a treatment plan…includ[ing] acceptance of medication, therapy, counselling, management, rehabilitation, and other services'.[635] A CTO can be made irrespective of whether the affected person has the capacity to consent to the treatment.[636]

5.2 In addition to an authorized medical officer of mental health facility where a person is detained or is a patient, the following people can also apply for a CTO:

- a medical practitioner who is familiar with the clinical history of the patient, and
- designated carer, or the principal care provider, of the affected person.[637]

5.3 The making of a CTO requires evidence of:

- a history of treatment refusal and relapse for a person with a previous diagnosis of mental illness
- a likely relapse into an active phase of mental illness or continuing mental illness if no order is made
- the care and treatment to be the least restrictive alternative consistent with safe and effective care
- a treatment plan capable of implementation.[638]

5.4 Once made, a CTO is an enforceable treatment order, which may result in enforcement or compliance actions being taken, where there is also a risk of significant deterioration in the physical or mental health of the person subject to the order.[639] The enforcement of CTOs is discussed further at [5.21].

634 Submission 148, NSW Health, p 28. See also *Mental Health Act 2007*, s 51(1).

635 Submission 109, Mental Health Review Tribunal, p 5. See also *Mental Health Act 2007*, ss 54, 56.

636 Submission 108, Legal Aid New South Wales, p 9.

637 *Mental Health Act 2007* s 51(2)(b), Mental Health Regulations 2019 r 9(b).

638 Submission 109, Mental Health Review Tribunal, p 5.

639 Submission 109, Mental Health Review Tribunal, p 5.

5.5 Some stakeholders questioned the transparency and rigour of the process for the making of a CTO, particularly the support provided to persons during the process.[640]

5.6 Mental Health Carers NSW (MHCN) said that carers within their organization frequently reported not being notified of MHRT hearings to consider the making of a CTO for a person in their care or receiving notice too late to attend.[641] The MHCN also argued that while legal representation is provided at hearings to persons proposed to be subject to a CTO, this representation is not effective 'due to consumers and carers lacking sufficient access to solicitors in preparation for hearings and solicitors lacking sufficient information about and understanding of the medical practise'.[642] Another stakeholder agreed that the hearing process did not afford a person proposed to be subject to a CTO adequate opportunity to make representations and called for proposed subjects of CTOs to be granted more legal support before the MHRT. [643]

5.7 Others described the challenges in overturning a CTO, once imposed. For example, Mental Health Carers Network (MHCN) said that many consumers and carers are often unaware how to seek review of a CTO and an end to compulsory treatment:

> Our experiences with CTOs are not good. And even when we asked 'How do we get rid of this? How do we negotiate our own terms?' and nobody would tell us. I even rang the Mental Health Review Tribunal, and they wouldn't tell us anything … they refused to engage with either by phone or by email. So, it's a very opaque system..[644]

5.8 Similarly, ACON said that their clients had reported 'a lack of clear, affordable and accessible pathways' to overturn a CTO once imposed, referring to the review process "time-consuming and a significant administrative burden… typically requir[ing] a costly psychiatric review'. In their view, this had resulted in CTOs 'therefore often remain ongoing'.[645]

Length of community treatment orders

5.9 Under section 56(2) of the *Mental Health Act 2007*, a community treatment order ceases to have effect at the end of the period specified in the order or, if no period is specified, 12 months after the order is made.[646] Legal Aid NSW expressed the view that this 12-month period was too long, and that where an expiry date is not specified, the order should expire after six months in order to ensure consistency with the principle of 'least restrictive' care, as set out in section 68 of the Act:

> The imposition of a CTO for a longer period is not only an exception to the norm in practice, but also out of step with the legal framework for CTOs, given the statutory

640 See for example; Submission 147, Mental Health Commission of New South Wales, p 12; Submission 14, Name suppressed, p 7.

641 Submission 132, Mental Health Carers NSW (MHCN), pp 13-14.

642 Submission 132, Mental Health Carers NSW (MHCN), p 14.

643 Submission 21, Name suppressed, p 2.

644 Submission 132, Mental Health Carers NSW (MHCN), p 14.

645 Submission 41, ACON, p 12.

646 *Mental Health Act 2007*, s 56(2).

> presumption is in favour of the maximum period of time, which is inconsistent with the principle of least restrictive care throughout the Act.[647]

5.10 The Mental Health Review Tribunal explained that in determining the length of any order under section 53(7), consideration is given to the anticipated period of time needed for a person's condition to stabilise, or to establish or re-establish a therapeutic relationship with a case manager.[648]

The prevalence of community treatment orders

5.11 There was a clear consensus from stakeholders that the use of CTOs in NSW is increasing,[649] with many describing their 'overuse'.[650] Some stakeholders, such as Suicide Prevention Australia and Legal Aid New South Wales, noted that the use of CTOs in NSW was particularly high when compared to other jurisdictions.[651] The Australian Medical Association expressed particular concern around evidence of their disproportionate use within the CALD community.[652]

5.12 The Mental Health Coordinating Council (MHCC) identified a number of factors thought to be driving the use of CTOs, many linked to a lack of resources:

> Research with people with lived experience of CTOs generally points to the overuse of CTOs because of clinician risk aversion, systemic service deficiencies, lack of voluntary alternatives, legislative and policy shortcomings, and barriers to enacting criteria in the legislation.[653]

5.13 The MHCC and Australian Medical Association, along with a number of medical professional bodies asserted that the increased use of CTOs results from of a lack of capacity in the health and social justice system to support people through other means, resulting in a CTO being a necessary precondition to being able to access care in many cases.[654] Based on personal experiences shared with the committee, voluntary patients are not afforded the same level of support as those on CTOs.[655]

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647 Submission 108, Legal Aid New South Wales, p 9.

648 Submission 109, Mental Health Review Tribunal, p 5.

649 Submission 147, Mental Health Commission of New South Wales, p 12.

650 See for example; Submission 14, Name suppressed, p 8; Submission 20, Name suppressed, p 1; Submission 51, Justice Action, p 15; Submission 61, Suicide Prevention Australia, p 10; Submission 103, Australian Salaried Medical Officers' Federation NSW (ASMOF), p 4; Submission 105, Name suppressed, p 4; Submission 14, Name suppressed, p 7.

651 Submission 61, Suicide Prevention Australia, p 10; Submission 108, Legal Aid New South Wales, p 8.

652 Submission 80, Australian Medical Association, p 6.

653 Submission 39, Mental Health Coordinating Council, p 13.

654 See for example; Submission 80, Australian Medical Association, p 6; Submission 39, Mental Health Coordinating Council, p 14. See also Submission 26, Name suppressed, p 1; Submission 83, Graham Brereton, p 4; Submission 103, Australian Salaried Medical Officers' Federation NSW (ASMOF), p 4; Submission 146, New South Wales Nurses and Midwives' Association, p 10; Evidence, Ms Rachel Laidler, Policy Officer, Mental Health Carers NSW, 22 September 2023, pp 9-10.

655 Submission 26, Name suppressed, p 1. See also Submission 146, New South Wales Nurses and Midwives' Association, p 10.

5.14 The submission from Occupational Therapy Australia supported this view, stating that 'there is a focus on servicing patients with mandated community treatment orders', with similar views shared by the Official Visitors Program and Justice Reform Initiative. [656] The Mental Health Review Tribunal, the body responsible for making CTOs, also acknowledged that it was not 'an uncommon statement in Tribunal hearings by clinicians, consumers or carers, that CTOs help to guarantee services in an environment where service availability varies'.[657] Further to this point, the New South Wales Nurses and Midwives' Association, contended that the 'overuse' of CTOs was because there are not enough staff to provide the assertive case management for clients and that CTOs are being used as a guarantee of service rather than for the purpose they were originally intended.[658]

5.15 The committee also heard evidence that clinicians are too quick to apply CTOs and that one reason for their overuse is because of clinician risk aversion.[659] In this regard, Ms Corinne Henderson, Principal Policy Advisor, Mental Health Coordinating Council, referred to CTOs as a 'safety net', criticising their use in lieu of community services:

> CTOs can be extremely useful and a lot of people are greatly helped by them, but they are not a safety net in lieu of community services. Very often treatment teams become very risk averse because they've lost somebody to engagement in the past, and so a CTO is put in place as a safety net. That's not really what is envisaged under the Act, which is quite clear that it's about the least restrictive care that's safe and appropriate.[660]

5.16 One stakeholder suggested that CTOs were imposed out of a fear that a failure to do so could leave a doctor liable should anything happen:

> Often times doctors are frightened of not having an order continued because consumers will say they won't take their medications and they are worried about the consequences… We have set up a system that is now having health care being controlled by a legal framework. Doctors are not going to take the chance of being accused of negligence if a consumer harms themselves or someone else, therefore, most doctors will apply for a CTO.[661]

The effectiveness of community treatment orders

5.17 The perception of community treatment orders as an effective means of providing mental health support to people varied. Some stakeholders were supportive of their use, describing CTOs as 'empowering' and an effective way to allow people to return to living in the community rather

656 Submission 36, Occupational Therapy Australia, p 5; Submission 52, Official Visitors Program, p 7; Submission 76, Justice Reform Initiative, p 8.

657 Submission 109, Mental Health Review Tribunal, pp 7-8.

658 Submission 146, New South Wales Nurses and Midwives' Association, p 18,

659 See for example, Submission 39, Mental Health Coordinating Council (MHCC), p 13; Submission 61, Suicide Prevention Australia, p 10; Submission 98, Independent Community Living Australia (ICLA) p 4.

660 Evidence, Ms Corinne Henderson, Principal Policy Advisor, Mental Health Coordinating Council, 16 October 2023, p 38.

661 Submission 14, Name suppressed p 7.

than an institutional setting.[662] HealthWISE referred to them as 'a step in the right direction toward more person centred empowering mental health practices' and 'an important part of treatment in the community'.[663] The Mental Health Review Tribunal also noted that there had been many hearings where it had been presented with evidence of CTOs providing benefits to those to whom they apply.[664]

5.18 One Door Mental Health also noted that the perception of CTOs varied. On the benefits, the organization said that CTOs can provide more immediate access to mental health treatment and that some of the carers in their Reference Group 'felt reassured when the person they supported had a CTO in place, as it provided "guaranteed access to mental health services they need", preventing the 'revolving door' of inpatient admissions and treatment'.[665]

5.19 Others, such as Suicide Australia, were much more critical of CTOs, questioning both their appropriateness and efficacy:

> CTOs perpetuate mental ill-health stigma and restrict autonomy of treatment on the individual. There is a lack of evidence on the effectiveness of CTOs and a lack of clear understanding of their purpose.[666]

5.20 Legal Aid New South Wales also referred to the efficacy of CTOs as being 'the subject of debate', citing an international study which found that for people who were the subject of the equivalent of a CTO, there was 'no clear difference in service use, social functioning or quality of life compared with voluntary care or brief supervised discharge'.[667]

5.21 The Australian Clinical Psychology Association called for a reduction in their use, describing them as depriving individuals of 'choice and control', as well as emphasizing medication and hospitalization – often at significant expense.[668] The ACPA, along with a number of other stakeholders, stressed that CTOs must only ever be used as a last resort.[669]

5.22 The committee also heard evidence about the negative physical impact of treatment under CTOs, particularly the severe side effects of mandated medication.[670] Some stakeholders argued that CTO treatment plans do not provide adequate ways to address the negative side effects

662 Submission 98, Independent Community Living Australia (ICLA), p 4; Submission 20, Name suppressed, p 1; Submission 81, Patsy Fokes and Rosemary Brown, p 4.

663 Submission 68, HealthWISE, p 4.

664 Submission 109, Mental Health Review Tribunal, p 9.

665 Submission 60, One Door Mental Health, p 5.

666 Submission 61, Suicide Prevention Australia, p 10.

667 See for example, Submission 108, Legal Aid New South Wales, p 10; Evidence, Mr Todd Davis, Solicitor in Charge, Mental Health Advocacy Service, Legal Aid NSW, 15 February 2024, p 31.

668 Submission 75, Australian Clinical Psychology Association, pp 9-10.

669 Submission 75, Australian Clinical Psychology Association, p 9; Submission 77, Western Sydney Health Alliance, p 13; Submission 83, Graham Brereton, p 5.

670 See for example, Submission 61, Suicide Prevention Australia, p 10; Submission 98, Independent Community Living Australia (ICLA), p 4; Evidence, Mr Brett Collins, Coordinator, Justice Action, 15 February 2024, p 34.

that some medications can cause.[671] One stakeholder claimed that this shortcoming can lead people to breach their CTOs:

> Once again, he did not comply with his CTO – he advised me that the medication side effects were intolerable. To my knowledge, at no time did anyone try and review this with him, and he continued to evade.[672]

5.23 Other stakeholders added that people also experienced significant and 'traumatic' withdrawals when CTOs were stopped, which could impact their ability to maintain employment.[673] Mental Health Carers NSW described the personal experience of one consumer whose CTO ended, highlighting the challenges of not having appropriate planning and management:

> '(the consumer) was on two consecutive CTOs even before I'd stepped in. What had happened in each case was that…they were administered a really high dose of antipsychotic every single month… and then at the end of the CTO there was no tapering off, (the consumer) was just dumped. So (the consumer) went through a really high withdrawal and that led to, when I stepped in, that was like the direct cause of (the consumer) losing (their) job and then eventually reoffending because (the consumer) wasn't getting help.[674]

5.24 A number of stakeholders questioned the appropriateness of requiring people on CTOs to pay for their own compulsory medication, particularly given many such people are reliant on a Disability Support Pension. This concern was exacerbated by the fact that a failure to pay for their medication may place someone in breach of their CTO and potentially subject to police intervention and involuntary hospital admission.[675]

5.25 With regards to the effectiveness of CTOs, Magistrate Huntsman, President of the Mental Health Review Tribunal, explained that due to the Tribunal's database being 'ancient', de-identified data cannot be used for research purposes to further examine whether CTOs are effective in improving mental health outcomes.[676] Magistrate Huntsman noted that while the Tribunal has a huge repository of potential statistical evidence, they cannot access it and that the database is facing critical failure.[677]

5.26 Magistrate Huntsman explained that modernization of the Tribunal's systems – particularly the digitization of its processes – is needed and that doing so would save all parties time and cost, and improve service, allow healthcare agencies and hospitals to upload their documents easily

671 Submission 98, Independent Community Living Australia (ICLA), p 4.

672 Submission 18, Name Suppressed, p 1.

673 See for example, Submission 61, Suicide Prevention Australia, p 10; Submission 132, Mental Health Carers NSW, p 13.

674 Submission 132, Mental Health Carers NSW, p 13.

675 See for example, Submission 76, Justice Reform Initiative, p 8; Submission 31, Ms Donna Willdin, p 1.

676 Evidence, Magistrate Carolyn Huntsman, President, Mental Health Review Tribunal, 30 October 2023, p 20.

677 Evidence, Magistrate Carolyn Huntsman, President, Mental Health Review Tribunal, 30 October 2023, p 20.

onto the Tribunal website.[678] As an example of an effective, recent modernization, Magistrate Huntsman said that Queensland's Tribunal was now able to provide efficient audio-visual links at in person hearing, as well as digital orders.[679]

The enforcement of compliance with community treatment orders

5.27 A number of stakeholders raised concerns with the procedures used to enforce compliance with CTOs, particularly the potential for police involvement, which some described as escalating situations.[680] As noted above, a CTO is an enforceable treatment order, which may result in enforcement or compliance actions being taken if the order is breached. The procedures to be followed in the event of a breach are set out in sections 58-62 of the *Mental Health Act 2007*.

5.28 One stakeholder, a carer for someone on a CTO who refused to take his mandatory medication after experiencing side effects, said that the threat of police attendance to enforce his compliance was counterproductive and eroded trust in the system:

> At no time, to my knowledge, did any doctor discuss with him the reasons for refusing to comply or what modifications could be made to the medication to mitigate side effects. Rather, [two community mental health services] both threatened to send the police to enforce compliance. This meant that XX did not trust either of them and did not engage well. They consistently blamed him for lack of engagement.[681]

5.29 The Community Restorative Centre used a case study to illustrate the interaction between issues with medication and the attendance of police, noting that long wait times to see specialist psychiatrists can yield unnecessary police interventions and potentially negative outcomes on the clients:

> Jesse (29) is required to take medication as part of his CTO. The side effects from the medication are painful and cause aching muscles, migraines, and insomnia. Jesse would like to get his medication adjusted by a psychiatrist, however the wait time for Jesse to see a psychiatrist is several weeks. Jesse decides to stop taking his medication to reduce the side effects and is considered 'non-compliant' with his CTO. As a result, Jesse is scheduled under the Mental Health Act, with police attending and using force in order to transfer him to a mental health facility. This causes considerable trauma for Jesse.[682]

5.30 When asked about the appropriateness of police attendance at breaches of CTOs, representatives from the Police Association of New South Wales, Mr Kevin Morton, President, Police Association of New South Wales, told the committee that 'in a perfect world… it should be the doctor's decision as to whether they should activate either themselves, a mental health crisis team or some other resource other than a police officer'.[683] His fellow witness, Mr Tony

678 Evidence, Magistrate Carolyn Huntsman, President, Mental Health Review Tribunal, 30 October 2023, p 21.

679 Evidence, Magistrate Carolyn Huntsman, President, Mental Health Review Tribunal, 30 October 2023, p 21.

680 Submission 51, Justice Action, p 8; Submission 12, Mr Matthew Stonestreet, p 2.

681 Submission 18, Name suppressed, p 4.

682 Submission 135, Community Restorative Centre, pp 11-12.

683 Evidence, Mr Kevin Morton, President, Police Association of New South Wales, 30 October 2023, p 15.

Bear, Manager, Strategy and Relationships, Police Association of New South Wales, agreed that the enforcement of a CTO was 'a health matter', reflecting other stakeholders' views that the attendance of police is not appropriate in most cases.[684]

5.31 Others criticised the fact that while a consumer can be 'breached' for failing to meet their obligations under a CTO, there are no corresponding consequences for a community mental health service that fails to meet *its* obligations under an order. To remedy this, Mental Health Carers NSW (MHCN) called for amendments to the *Mental Health Act* to ensure that penalties apply to declared community mental health services which fail to meet their obligations under the CTO.[685]

The coercive nature of community treatment orders

5.32 Some stakeholders were critical of the 'coercive' nature of community treatment orders, particularly that they often result in the administration of medication without a person's consent. On this issue, Justice Action argued that there are 'serious concerns regarding ethical, legal and human rights violations' in requiring those subject to a CTO to accept 'forced treatment':

> In issuing Community Treatment Orders (CTO), mental health consumers are often forced to take medications against their expressed desires and without taking into consideration other less restrictive alternatives. This a violation of section 53 of the Mental Health Act 2007, and actively worsens the current problem.[686]

5.33 The Mental Health Commission also referred to the coercive nature of CTOs as having the potential to lessen a person's trust in other support services:

> The coercive nature of the orders can act as a barrier to people's autonomy, choice and independence. They emphasise pharmacological treatment and people can feel vulnerable or fearful of the threat of hospitalisation. In many circumstances, this can deemphasise the role of psychosocial supports and make it difficult for people to trust services, which are fundamental components of recovery.

5.34 UNSW Indigenous Health Education Unit (IHEU) and the Illawarra Aboriginal Medical Services (IAMS) were particularly concerned about the use of CTOs within Aboriginal and Torres Strait Islander communities, describing the use of these orders as 'highly traumatic':

> Coercive treatment of mental health consumers is within the usual scope of practice of a clinician. However, there are cultural complexities when an Aboriginal and Torres Strait Islander clinician is working with members of the Aboriginal and Torres Strait Islander community in which they live. Aboriginal and Torres Strait Islander communities have significant historical and contemporary trauma directly related to the police and justice systems. The use of these systems, especially when enacted by an

684 Evidence, Mr Tony Bear, Manager, Strategy and Relationships, Police Association of New South Wales, 30 October 2023, p 15.

685 Submission 132, Mental Health Carers NSW (MHCN), p 15.

686 Submission 51, Justice Action, p 9, 14.

> Aboriginal Mental Health Clinician when a consumer is in breach of their CTO, is highly traumatic for the clinician, the consumer, and, by extension, the local community.[687]

5.35 On the issue of trauma and the effect of CTOs, the Mental Health Commissioner, Ms Catherine Lourey, told the committee of work currently being undertaken by the Commission, looking at the lived experience of those subject to CTOs:

> That's one of the projects that the commission is currently doing on CTOs. A lot of the research is very much about compliance, medication, and risk and safety. We want to investigate more and to engage with people who have been on community treatment orders to understand the broader impacts it has upon them. If we are about having trauma-informed services and trauma-informed approaches, then being on a compulsory order isn't necessarily very trauma informed. In our piece of work that we are going to be finalising next year, they are the perspectives that we want to bring.[688]

Committee comment

5.36 The evidence received on community treatment orders (CTOs) and their use in New South Wales was some of the most alarming of the inquiry. In particular, to hear that New South Wales has the highest usage rate in Australia and that their usage is increasing to a point of 'overuse', was greatly concerning.

5.37 We acknowledge that evidence received showed that for some people, having a loved one subject to a CTO has been a positive experience, allowing the person to get the help they needed in the community. Hearing that people felt empowered and saw them as an important tool in allowing them to return to the community was a reminder that when used appropriately, CTOs can be a valuable tool.

5.38 However, these positive experiences were far outweighed by evidence that not only questioned their efficacy, but also their reasons for use. We were particularly concerned to hear that CTOs were being used in a risk averse sense and that some doctors are motivated more by fear of being liable should anything happen, rather than whether an CTO is in the best interests of the patient.

5.39 Tendency towards overuse and over caution was also said to be a result of the lack of availability of appropriate services within the community, with increased use of CTOs resulting from of a lack of capacity in the health and social justice system to support people through voluntary means. People's rights and liberties should not be so easily restricted as a way to cope with what is clearly a lack of appropriate community care and services. CTOs are being used to treat the symptom and not the cause – CTOs should not be a safety net for a failing mental health system. It is clear that in the context of an under-resourced community mental health system, community treatment orders have the capacity to be overused or misused to involuntarily facilitate engagement in care. Without a doubt, the adequate resourcing of community mental health services and implementation of recommendations 6, 10, 12, 19 will reduce community

687 Submission 164, UNSW Indigenous Health Education Unit (IHEU) and the Illawarra Aboriginal Medical Services (IAMS), p 1.

688 Evidence, Ms Catherine Lourey, Mental Health Commissioner, NSW Mental Health Commission, 17 November 2023, p 30.

treatment orders and support more people to have choice and autonomy over their mental health care.

Finding 16

In the context of an under-resourced community mental health system, community treatment orders have the capacity to be overused or misused to involuntarily facilitate engagement in care.

Finding 17

The adequate resourcing of community mental health services and implementation of Recommendations 6, 10, 12 and 19 will reduce community treatment orders and support more people to have choice and autonomy over their mental health care.

5.40 It was clear that some stakeholders felt that the process through which a CTO is granted does not empower people to advocate for themselves or provide enough support to people throughout the hearing process. To address this, the committee recommends that increased support be provided to patients and carers in the lead-up to Mental Health Review Tribunal hearings.

Recommendation 35

That NSW Health increase support to patients and carers in the lead up to hearings before the Mental Health Review Tribunal.

5.41 Similarly, once imposed, many stakeholders find it difficult to navigate pathways to overturn CTOs. This is concerning as CTOs should not be considered a life sentence. We ask that the NSW Government review the *Mental Health Act* 2007 with regard to community treatment orders and the overriding principal as least restrictive means of providing care.

Recommendation 36

That the NSW Government review the *Mental Health Act 2007* with regard to community treatment orders and the overriding principal as least restrictive means of providing care.

5.42 It is clear from evidence the committee received from the Mental Health Review Tribunal (MHRT), that the current MHRT database is significantly insufficient and outdated such that it is impossible to use any relevant data to inform research on the effectiveness of CTOs. To ensure the effectiveness of community treatment orders on mental health outcomes can be objectively and transparently assessed, the committee recommends that NSW Health adequately fund the digitisation of the records of the NSW Mental Health Review Tribunal to improve data access and analysis.

Recommendation 37

That NSW Health adequately fund the digitisation of the records of the NSW Mental Health Review Tribunal to improve data access and analysis.

5.43 On the benefit of digitisation, we were impressed by recent developments in Queensland, where the digitisation of administrative processes and the use of audio-visual links has improved the timeliness and cost efficiency of their services. Noting this success, we recommend that NSW Health investigate the feasibility of implementing similar processes in NSW to improve the administrative processes of the Mental Health Review Tribunal and mental health agencies, including the development of digital orders and a document portal.

Recommendation 38

That NSW Health investigate the feasibility of implementing similar processes in NSW to improve the administrative processes of the Mental Health Review Tribunal and mental health agencies, including the development of digital orders and a document portal.

5.44 The committee also notes evidence from stakeholders about the severe physical impacts some medications can have on people on CTOs, and the significant withdrawals experienced when treatment is abruptly stopped without appropriate planning.

5.45 Finally, with regards to enforcement, again the committee heard from both stakeholders and police that a health response rather than a law enforcement approach would be more appropriate. As examined in Chapter 4, police involvement in mental health crises and CTO enforcement often further escalates situations and can be traumatic for all those involved. The committee calls for NSW Health to adequately resource community mental health services to assertively follow up patients on community treatment orders without involving police, unless their attendance is deemed essential following an informed risk assessment performed on a case-by-case basis.

Recommendation 39

That NSW Health adequately resource community mental health services to assertively follow up patients on community treatment orders without involving police, unless their attendance is deemed essential following an informed risk assessment performed on a case-by-case basis.

Appendix 1 Submissions

No.	Author
1	Mr Grant Mistler
1a	Mr Grant Mistler
2	Mr Marc Lamond
2a	Mr Marc Lamond
3	Name suppressed
4	Mr Christopher Jaeger
5	Confidential
6	Mr Michael Daley
7	Name suppressed
8	Fulin Yan
9	Dr Cathy Francis
10	Name suppressed
11	Confidential
12	Mr Matthew Stonestreet
13	Name suppressed
14	Name suppressed
15	Name suppressed
15a	Name suppressed
15b	Name suppressed
16	Name suppressed
17	Name suppressed
18	Name suppressed
19	Name suppressed
20	Name suppressed
20a	Name suppressed
20b	Name suppressed
21	Name suppressed
22	Mrs Rachel O'Connell
23	Confidential
24	Confidential
25	Lifeline Australia
26	Name suppressed

No.	Author
27	Name suppressed
28	Name suppressed
29	Name suppressed
30	Name suppressed
31	Ms Donna Willdin
32	Confidential
33	Confidential
34	Mr Sam Woods
35	Australian Association of Psychologists Inc
36	Occupational Therapy Australia
37	Ingrid Berg
38	ReachOut
39	Mental Health Coordinating Council (MHCC)
40	Marathon Health
41	ACON
42	Name suppressed
43	Barnardos Australia
44	The Royal Australian College of General Practitioners (RACGP) Rural
45	SSI
46	Thadam
47	Doctors for the Environment Australia
48	PsychOrium Forensic and Clinical Psychology Services
49	Flourish Australia
50	NeuroAccess
51	Justice Action
52	Official Visitors Program
53	Confidential
54	Uniting NSW.ACT
55	Sydney Bi plus Network
56	Carers NSW
57	Local Government NSW
58	NSW ACT PHN Mental Health Network
59	The Society of Hospital Pharmacists of Australia (SHPA)
60	One Door Mental Health
61	Suicide Prevention Australia

No.	Author
62	NSW Council of Social Service (NCOSS)
63	North Coast Allied Health Association
64	The Royal Australian College of General Practitioners (RACGP) NSW and ACT
65	Confidential
66	Australasian College for Emergency Medicine
67	BEING - Mental Health Consumers
68	HealthWISE
69	Unbound Minds
70	Name suppressed
71	Confidential
72	Bega Valley Eurobodalla Suicide Prevention Collaborative
73	Confidential
74	Youth Action
75	The Australian Clinical Psychology Association (ACPA)
76	Justice Reform Initiative
77	Western Sydney Health Alliance
78	Gidget Foundation Australia
79	Endeavour Mental Health Recovery Clubhouse
80	Australian Medical Association (NSW) Ltd
81	Patsy Fokes and Rosemary Brown
82	Name suppressed
83	Graham Brereton
84	Sharon Grocott
85	Rachael Morris
86	Cooper Smeaton
87	Confidential
88	Amelia Klein
89	Miss Kasia Thoms
90	Name suppressed
91	Mr Simon Katterl
92	Ms Lynne Jennings
93	Ms Gail Mensinga
94	Ms Tabitha Merrell
95	FND Australia Support Services Inc
96	Department of Developmental Disability Neuropsychiatry, UNSW

No.	Author
97	Australian Association of Social Workers (AASW)
98	Independent Community Living Australia (ICLA)
99	Lived Experience Australia Ltd (LEA)
100	Dementia Law Network
101	Tresillian
102	Name suppressed
103	Australian Salaried Medical Officers' Federation NSW (ASMOF)
104	Australasian College of Paramedicine
105	Name suppressed
106	Dietitians Australia
107	Exercise and Sports Science Australia (ESSA)
108	Legal Aid New South Wales
109	Mental Health Review Tribunal
110	Name suppressed
111	Name suppressed
112	Name suppressed
113	Name suppressed
114	Name suppressed
115	Name suppressed
116	Confidential
117	Name suppressed
118	Name suppressed
119	Name suppressed
120	Name suppressed
121	Name suppressed
122	Name suppressed
123	Confidential
124	Confidential
125	Confidential
126	Confidential
127	Confidential
128	Multicultural Communities Council of Illawarra (MCCI)
129	Name suppressed
130	Dr Tim Senior
131	Mental Health Committee Members, The Y NSW Youth Parliament 2023

No.	Author
132	Mental Health Carers NSW (MHCN)
133	Office of the Advocate for Children and Young People (ACYP)
134	Health Services Union - NSW ACT QLD (HSU)
135	Community Restorative Centre
136	BrainStorm Mid North Coast
137	Confidential
138	Black Dog Institute
139	The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
140	Rural Doctors' Association of New South Wales (RDANSW)
141	Michael Strutt
142	headspace, National Youth Mental Health Foundation
143	Australian Psychological Society (APS)
144	Confidential
145	Confidential
146	New South Wales Nurses and Midwives' Association
147	Mental Health Commission of New South Wales
148	NSW Health
149	Australian Paramedics Association (NSW)
150	Name suppressed
151	Danial Khan
152	Public Interest Advocacy Centre (PIAC)
153	Name suppressed
154	Name suppressed
155	Full Stop Australia
156	Dr Karen Williams
157	Confidential
158	Redfern Legal Centre
159	Fay Jackson
160	Human Nature
161	Confidential
162	Confidential
163	Confidential
164	UNSW Indigenous Health Education Unit (IHEU) and the Illawarra Aboriginal Medical Services (IAMS)
165	Queer Family

Appendix 2 Witnesses at hearings

Date	Name	Position and Organisation
Friday 22 September 2023 **Macquarie Room** **Parliament House, Sydney**	Witness A	Individual with lived experience
	Witness B *(via videoconference)*	Individual with lived experience
	Witness C *(via videoconference)*	Individual with lived experience
	Witness D	Carer
	Witness E	Carer
	Witness F	Carer
	Ms Priscilla Brice	CEO, BEING: Mental Health Consumers
	Dr Peter Schmiedgen	Policy Lead, BEING: Mental Health Consumers
	Ms Katie Thorburn	Policy Manager, Mental Health Carers NSW
	Ms Rachael Laidler	Policy Officer, Mental Health Carers NSW
	Ms Annie Crowe *(via videoconference)*	Founder and consultant, NeuroAccess
	Dr Janelle Weise	Department of Developmental Disability Neuropsychiatry, UNSW
	Ms Gen Whitlam	Associate Director, Client Services, ACON
	Ms Siobhan Hannan	Team Leader, Counselling Services, ACON
	Mx Amber Loomis	President, Sydney Bi+ Network
	Mx Georgie Fischer	Board Member, Sydney Bi+ Network
	Ms Justine Harris	Clinical Psychologist, Head of Practice Management, Settlement Services International (SSI)
	Mr Ben Benazzouz	Provisional Psychologist, Mental Health Clinician, Settlement Services International (SSI)
	Ms Zoë Robinson	Advocate for Children and Young People

Date	Name	Position and Organisation
	Mr Kyzar Jing	Lived Experience Advisor, Office of the Advocate for Children and Young People
	Mr Ashley de Silva	CEO, ReachOut
	Mr Ben Bartlett	Director of Government Relations and Communications, ReachOut
Monday 16 October 2023 **Macquarie Room** **Parliament House, Sydney**	Mr Graham Brereton	Registered Nurse and Psychologist
	Dr Tim Senior	General Practitioner
	Dr Angelo Virgona	Chair, NSW Branch, The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
	Ms Helen Boardman	Registered Nurse, Clinical Nurse Consultant, NSW Nurses and Midwives Association
	Ms Victoria Norris	Registered Nurse, Perinatal and Infant Mental Health Service Nurse Manager, North Sydney Local Health District, NSW Nurses and Midwives Association
	Dr Vicki Mattiazzo	Deputy Chair, Royal Australian College of General Practitioners (RACGP) Rural Faculty
	Ms Kylie Coventry (*via videoconference*)	Head of Policy, Australian Psychological Society (APS)
	Ms Anita McGregor (*via videoconference*)	APS Member and Member of College of Forensic Psychologists, Australian Psychological Society (APS)
	Ms Sahra O'Doherty (*via videoconference*)	Acting President, Australian Association of Psychologists Inc
	Mrs Amanda Curran (*via videoconference*)	Chief Services Officer, Australian Association of Psychologists Inc
	Dr Evelyne Tadros	CEO, Mental Health Coordinating Council (MHCC)
	Ms Corinne Henderson	Principal Policy Advisor, Mental Health Coordinating Council (MHCC)
	Ms Deb Willcox	Deputy Secretary, Health System Strategy and patient Experience, NSW Ministry of Health
	Dr Brendan Flynn	Executive Director, Mental Health Branch, NSW Ministry of Health

Date	Name	Position and Organisation
	Dr Michael Bowden	A/Chief Psychiatrist, NSW Ministry of Health
	Mrs Marjorie Anderson	National Manager, 13Yarn
	Mr Shane Sturgiss	CEO, BlaQ Aboriginal Corporation
Monday 30 October 2023 Macquarie Room Parliament House, Sydney	Witness G	Individual with lived experience
	Mr Cooper Smeaton	Individual with lived experience
	Dr Fiona Kumfor	Associate Professor, School of Psychology, University of Sydney, Clinical Neuropsychologist and Co-Founder of the Dementia Law Network
	Mr Kevin Morton	President, Police Association of NSW
	Mr Tony Bear	Manager, Strategy and Relationships, Police Association of NSW
	Magistrate Carolyn Huntsman	President, Mental Health Review Tribunal
Friday 17 November 2023 Macquarie Room Parliament House, Sydney	Witness H	
	Witness I	
	Witness J	
	Witness K	
	Witness L	
	Witness M	
	Mr Paul Lemmer *(via videoconference)*	Executive Director, Metropolitan Operations – South Australia Ambulance
	Ms Katie McKenzie	Executive Director, Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS) Canberra Health Services, ACT Government
	Mr Lawrence Muskitta	Head of Government Relations, Black Dog Institute
	Ms Nicole Cockayne	Director, Policy & Research Operations, Black Dog Institute
	Mr Simon Dodd	Head of Workforce Development and Planning, headspace
	Ms Annie Hong	Youth National Reference Group Member, headspace
	Ms Nicola Rabbitte *(via videoconference)*	Wellness Health In-reach Nurse Coordinator Program

Date	Name	Position and Organisation
	Ms Catherine Lourey	Commissioner, Mental Health Commission of NSW
	Ms Lizz Reay	Chief Executive Officer, Nepean Blue Mountains Primary Health Network and Chair, NSW/ACT PHN CEO Network
	Mr Craig Parsons	General Manager, Partnerships & Innovation, Sydney North PHN and Chair, NSW/ACT Mental Health Network
	Mr Brett Simpson	President, Australian Paramedics Association (NSW), Intensive Care Paramedic
	Ms Jessica Whittaker	Delegate, Australian Paramedics Association (NSW) Paramedic
	Mr Jeffrey Andrew *(via videoconference)*	Delegate, Australian Paramedics Association (NSW), Critical Care Paramedic
Tuesday 13 February 2024 Function Room Lismore Heights Sports, Recreation and Community Club, Lismore	Witness N	
	Witness O	
	Witness P	
	Ms Kelly Bannister	CEO, Northern Rivers Women and Children's Services
	Ms Sonja Habenicht	Trauma Counsellor/Psychologists, Women's Outreach Trauma Health Service (WORTH), Northern Rivers and Children's Services
	Mr Andy Hamilton	Therapeutic Lead and Founder, Human Nature
	Ms Jennifer Parke	Head of Operations, Human Nature
	Ms Fay Jackson	Former Deputy Commissioner, Mental Health Commission of NSW & General Manager, Inclusion, Flourish Australia
	Mr Rob Curry	Executive Officer, North Coast Allied Health Association
	Mr Joel Orchard	Executive Director, WardellCORE

Date	Name	Position and Organisation
Thursday 15 February 2024 **Macquarie Room** **Parliament House, Sydney**	Witness R	Carer for child with lived experience
	Witness S	Carer for child with lived experience
	Witness T	Carer for child with lived experience
	Ms Tara Hunter	Director, Clinical and Client Services, Full Stop Australia
	Dr Karen Williams	Consultant Psychiatrist, Ramsay Clinic Thirroul
	Ms Sharon Grocott	CEO, WayAhead
	Mr William Campos	CEO, Independent Community Living Australia (ICLA)
	Dr Trevor Chan	Chair, NSW Faculty, Australasian College for Emergency Medicine
	Dr Clare Skinner	Immediate Past President & NSW Faculty Board Member, Australasian College for Emergency Medicine
	Dr Anna Brooks	Chief Research Officer, Lifeline Research Office – Government and Stakeholder Relations, Lifeline Australia
	Dr Tara Hunt	Deputy Chief Research Officer, Lifeline Research Office – Government and Stakeholder Relations, Lifeline Australia
	Mr Brett Collins	Coordinator, Justice Action
	Ms Lillie Mellin	Mental Health Spokesperson, Justice Action
	Mr Todd Davis	Solicitor in Charge, Mental Health Advocacy Service, Legal Aid New South Wales
	Mr Callum Hair	Senior Solicitor, Mental Health Advocacy Service, Legal Aid New South Wales
	Ms Cara Varian	CEO, NSW Council of Social Service (NCOSS)
	Ms Andrea Angeles	Policy Lead, NSW Council of Social Service (NCOSS)
	Ms Angela Scarfe *(via videoconference)*	Senior Policy Officer, Australian Association of Social Workers (AASW)
	Ms Kate O'Brien *(via videoconference)*	Member, Australian Association of Social Workers (AASW)

Date	Name	Position and Organisation
	Ms Anne Galloway	Mental Health Manager, HealthWISE New England North West
	Ms Louise Ingall	Manager if Strategy Research and Engagement, HealthWISE New England North West
	Mr Glen Cotter	Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative
	Ms Rebecca Grasso	Chair, Western Sydney Health Alliance
	Ms Deb Willcox AM	Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health
	Dr Brendan Flynn	Executive Director, Mental Health Branch, NSW Ministry of Health
	Dr Murray Wright	Chief Psychiatrist, NSW Ministry of Health

Appendix 3 Minutes

Minutes no. 2
Wednesday 12 July 2023
Portfolio Committee No. 2 – Health
Room 1043, Parliament House, Sydney at 2.01pm

1. Members present
Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Donnelly
Ms Faehrmann (via videoconference, until 2.32 pm)
Mr Murphy (substituting for Mr Buttigieg)
Ms Suvaal
Mrs Taylor (via videoconference)

2. Previous minutes
Resolved, on the motion of Mr Donnelly: That draft minutes no.1 be confirmed.

3. Correspondence
The committee noted the following items of correspondence:

Received

- 29 June 2023 – Letter from Hon Emily Suvaal MLC, Hon Greg Donnelly MLC and Hon Mark Buttigieg MLC requesting a meeting of Portfolio Committee No. 2 - Health to consider a proposed self-reference into the whole of government approach to community mental health in New South Wales
- 29 June 2023 – Letter from Dr Amanda Cohn MLC, Ms Cate Faehrmann MLC and Hon Bronnie Taylor MLC requesting a meeting of Portfolio Committee No. 2 - Health to consider a proposed self-reference into the whole of government approach to community mental health in New South Wales.

4. Consideration of two terms of reference
The Chair tabled two letters proposing the two self-references.

First terms of reference

That Portfolio Committee No. 2 – Health inquire into and report on the whole of government approach to community mental health in New South Wales, and in particular:

a. the social determinants of mental health,
b. current measures that exist for strengthening communities, and their efficacy,
c. current measures to integrate determinants, including, but not limited to, housing, law and justice, and their efficacy,
d. approach to treatment for those with low levels of distress/mild illness/early-stage illness, and its efficacy,
e. range and service scope of State and other community services including Commonwealth Medicare services and private services accessible for treatment of mental health, including in rural, regional and remote New South Wales,
f. capacity of state and other mental health services, including in rural, regional and remote New South Wales,
g. capacity of state and other community mental health services, specifically for youth aged up to 15 years, including in rural, regional and remote New South Wales,
h. navigation of community mental health services from a consumer and carer perspective,
i. capacity of primary care services to support mental health treatment in the community,
j. resources and capacity to respond to mental distress in the community,

k. any other related matter.

Mr Murphy moved: That the first terms of reference be adopted.

Question put.

The committee divided.

Ayes: Mr Donnelly, Ms Suvaal, Mr Murphy.

Noes: Mrs Carter, Dr Cohn, Ms Faehrmann, Mrs Taylor.

Question resolved in the negative.

Second terms of reference

That Portfolio Committee No. 2 – Health inquire into and report on outpatient mental health services in New South Wales, and in particular:

a. equity of access to outpatient mental health services,
b. navigation of outpatient mental health services from the perspectives of patients and carers,
c. capacity of State and other community mental health services, including in rural, regional and remote New South Wales,
d. integration between physical and mental health services, and between mental health services and providers,
e. appropriate and efficient allocation of mental health care workers, including psychiatrists, psychologists, GPs, councillors, social workers, allied health professionals and peer workers,
f. the use of Community Treatment Orders under the *Mental Health Act 2007*,
g. benefits and risks of online and telehealth services,
h. accessibility and cultural safety of mental health services for First Nations people, LGBTQIA+ people, young people, and people with disability,
i. alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER),
j. any other related matter.

Resolved, on the motion of Ms Faehrmann: That the terms of reference be amended by omitting 'outpatient mental health services in New South Wales' and inserting instead 'the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales'.

Resolved, on the motion of Mr Murphy: That:

a. paragraph b) of the terms of reference be amended by inserting the words 'and community' after 'navigation of outpatient',
b. paragraph e) of the terms of reference be amended by inserting the word 'nurses' after 'including psychiatrists',
c. paragraph h) of the terms of reference be amended by inserting the words 'culturally and linguistically diverse (CALD)' after the words 'First Nations People'.

Mr Murphy moved: That

a. paragraph i) of the terms of reference be amended by omitting the words 'alternatives to the police for' before 'emergency responses to people experiencing acute mental distress'
b. two new terms of reference be inserted after paragraph i):
   j) the social determinants of mental health,
   k) current measures to integrate determinants, including but not limited to, housing, law and justice, and their efficacy.

Question put.

The committee divided.

Ayes: Mr Donnelly, Mr Murphy, Ms Suvaal.

Noes: Mrs Carter, Dr Cohn, Ms Faehrmann, Mrs Taylor.

Question resolved in the negative.

Resolved, on the motion of Mr Donnelly: That the committee adopt the following terms of reference, as amended:

That Portfolio Committee No. 2 – Health inquire into and report on the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales, and in particular:

a. equity of access to outpatient mental health services,
b. navigation of outpatient and community mental health services from the perspectives of patients and carers,
c. capacity of State and other community mental health services, including in rural, regional and remote New South Wales,
d. integration between physical and mental health services, and between mental health services and providers,
e. appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, councillors, social workers, allied health professionals and peer workers,
f. the use of Community Treatment Orders under the *Mental Health Act 2007*,
g. benefits and risks of online and telehealth services,
h. accessibility and cultural safety of mental health services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability,
i. alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER),
j. any other related matter.

5. Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

5.1 Submissions

Resolved, on the motion of Ms Suvaal: That the closing date for submissions be Wednesday 6 September 2023.

5.2 Stakeholder list

Resolved, on the motion of Mr Murphy: That the secretariat circulate to members the Chairs' proposed list of stakeholders to provide them with the opportunity to amend the list or nominate additional stakeholders, and that the committee agree to the stakeholder list by email, unless a meeting of the committee is required to resolve any disagreement.

Ms Faehrmann left the meeting.

5.3 Approach to submissions

Resolved, on the motion of Ms Suvaal: That, to enable significant efficiencies for members and the secretariat while maintaining the integrity of how submissions are treated, in the event that 50 or more individual submissions are received, the committee may adopt the following approach to processing short submissions:

- All submissions from individuals 250 words or less in length will:
  - have an individual submission number, and be published with the author's name or as name suppressed, or kept confidential, according to the author's request
  - be reviewed by the secretariat for adverse mention and sensitive/identifying information, in accordance with practice
  - be channelled into one single document to be published on the inquiry website, with a searchable table of contents.
- All other submissions will be processed and published as normal.

5.4 Approach to proformas

Mr Murphy moved: That the committee not accept proformas or online questionnaires.

Question put.

The committee divided.

Ayes: Mrs Carter, Mr Donnelly, Mr Murphy, Ms Suvaal, Mrs Taylor.

Noes: Dr Cohn.

Question resolved in the affirmative.

5.5 Advertising

Resolved, on the motion of Mr Murphy: That in addition to the standard approach to advertising inquiries via social media, stakeholder emails and a media release distributed to all media outlets in New South Wales, the secretariat investigate options for advertising in publications relevant to particular stakeholders identified in the terms of reference, including but not limited to The Land.

5.6 Hearing dates and site visits

Resolved, on the motion of Mr Murphy: That the committee hold hearings and site visits in September/October/November, the dates of which are to be determined by the Chair after consultation with members regarding their availability.

6. Adjournment

The committee adjourned at 2.54 pm, *sine die*.

Laura Ismay
Committee Clerk

Minutes no. 3
Tuesday 25 July 2023
Portfolio Committee No. 2 - Health
Room 1043, Parliament House, Sydney at 2.32 pm

1. Members present

Dr Cohn, *Chair*
Mr Rath (substituting for Mrs Carter)
Dr Kaine (substituting for Mr Buttigieg)
Mr Donnelly
Ms Faehrmann
Ms Suvaal
Mr Fang (substituting for Mrs Taylor)

2. Acknowledgement of Country

3. Previous minutes

Resolved, on the motion of Ms Suvaal: That:

- item 5.4 of the draft minutes be amended to insert the words 'or online questionnaires' after the word 'proformas'
- draft minutes no. 2, as amended, be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 21 July 2023 – Letter from Dr Amanda Cohn MLC, Ms Cate Faehrmann MLC and Hon Emily Suvaal MLC requesting a meeting of Portfolio Committee No. 2 - Health to consider a proposed self-reference into current and potential future impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales

- 16 June 2023 – Email forwarded from Portfolio Committee No. 4 regarding correspondence received on 9 May 2023 from an individual raising concerns about Sydney Water
- 9 May 2023 – Email from an individual to committee, raising concerns about Sydney Water.

Resolved, on the motion of Mr Donnelly: That the email from an individual to the committee raising concerns about Sydney Water, dated 9 May 2023, be:

- forwarded to the Hon. Rose Jackson, MLC, Minister for Water for consideration
- kept confidential, as per the recommendation of the secretariat, as it contains identifying and/or sensitive information and is not related to an inquiry.

5. Consideration of terms of reference

The Chair tabled a letter proposing the following terms of reference:

1. That Portfolio Committee No. 2 inquire into and report on current and potential future impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales, in particular:
   a. the impact on the health of local residents and mine workers, including through biomagnification and bioaccumulation
   b. the impact on catchments and waterways, affecting both surface and groundwater destined for, local and town water supplies, including rainwater tanks, and on aquatic biodiversity
   c. the impact on land and soil, crops and livestock, including through biomagnification and bioaccumulation
   d. the adequacy of the response and any compliance action taken by the regulatory authorities in response to complaints and concerns from communities affected by mining activities
   e. the effectiveness of the current regulatory framework in terms of monitoring, compliance, risk management and harm reduction from mining activities
   f. the effectiveness of current decommissioning and rehabilitation practices in safeguarding human health and the environment
   g. the effectiveness of New South Wales Government agencies to regulate and improve outcomes including:
      i. the measurement, reporting and public awareness
      ii. the provision of various protective materials
      iii. the ability to ensure the health of at-risk groups
      iv. the suitability of work health and safety regulations, and
      v. the capacity to respond within existing resources
      vi. the adequacy of existing work, health and safety standards for workers
   h. whether the regulatory framework for heavy metals and critical minerals mining is fit for purpose and able to ensure that the positive and negative impacts of heavy metals and critical minerals mining on local communities, economies (including job creation) and the environment are appropriately balanced
   i. any other related matters.
2. The committee reports on its findings by 21 November 2023.

Resolved, on the motion of Ms Faehrmann: That:

- the terms of reference be amended by omitting the word 'future' from the first line of paragraph 1
- the committee adopt the terms of reference, as amended.

6. Conduct of inquiry into current and potential impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales

6.1 Closing date for submissions

Resolved, on the motion of Ms Faehrmann: That the closing date for submissions be Tuesday 5 September 2023.

6.2 Stakeholder list

Resolved, on the motion of Ms Faehrmann: That the secretariat circulate to members the Chairs' proposed list of stakeholders to provide them with the opportunity to amend the list or nominate additional stakeholders, and that the committee agree to the stakeholder list by email, unless a meeting of the committee is required to resolve any disagreement.

6.3 Approach to submissions

Resolved, on the motion of Ms Suvaal: That, to enable significant efficiencies for members and the secretariat while maintaining the integrity of how submissions are treated, in the event that 50 or more individual submissions are received, the committee adopt the following approach to processing short submissions:

- All submissions from individuals 250 words or less in length will:
  - have an individual submission number, and be published with the author's name or as name suppressed, or kept confidential, according to the author's request
  - be reviewed by the secretariat for adverse mention and sensitive/identifying information, in accordance with practice
  - be channelled into one single document to be published on the inquiry website
- All other submissions will be processed and published as normal.

6.4 Online questionnaire and proformas

Resolved, on the motion of Mr Donnelly: That the committee not accept proformas or online questionnaires.

6.5 Advertising

Resolved, on the motion of Ms Faehrmann: That, in addition to the standard approach to advertising inquiries via social media, stakeholder emails and a media release distributed to all media outlets in New South Wales, the secretariat investigate options for advertising in publications relevant to particular geographic locations.

The secretariat will circulate to members by the email the advertising budget for Legislative Council committees, for their information.

6.6 Hearing dates and site visits

Resolved, on the motion of Ms Faehrmann: That the committee hold a minimum of four hearings and site visits in locations including, but not limited to, Orange and Mudgee in September/October, the dates of which are to be determined by the Chair after consultation with members regarding their availability.

7. Adjournment

The committee adjourned at 2.57 pm, *sine die*.

Kate Mihaljek
Committee Clerk

Minutes no. 4
Monday 18 September 2023
Portfolio Committee No. 2 - Health
Macquarie Room, Parliament House, Sydney at 9.05 am

1. Members present

Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Buttigieg (via videoconference)
Mr Donnelly (from 9.00 am to 1.57 pm and from 3.15 pm to 4.15 pm)
Ms Faehrmann
Mr Fang (substituting for Mrs Taylor until 1.00 pm)

Ms Suvaal
Mrs Taylor (from 1.45 pm)

2. Acknowledgement of Country

3. Previous minutes
Resolved, on the motion of Ms Suvaal: That draft minutes no. 3 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 25 July 2023 – Email from Shannon Couper, Policy and Advocacy Adviser, Beyond Blue, advising Beyond Blue is unable to make a submission to the Mental Health inquiry, however they can share the invitation with their lived experience community on request
- 26 July 2023 – Email from an individual concerning terms of reference for mining impacts inquiry
- 27 July 2023 – Email from Ruth Das, Engagement and Partnerships Lead, Embrace Project - National Multicultural Mental Health Project, advising Embrace will not be making a submission to the Mental Health inquiry
- 5 August 2023 – Letter from Hon Rose Jackson MLC, Minister for Water, responding to Chair's letter dated 27 July 2023 which forwarded correspondence from an individual to committee raising concerns about Sydney Water, for consideration
- 17 August 2023 – Form letter from Clarence Catchment Alliance concerning mining in the Clarence Catchment, Northern Rivers, NSW
- 20 August 2023 – Email from Mr John Gerathy regarding Cadia Mine enclosing various correspondence to the EPA
- 20 August 2023 – Correspondence from Dr Peter Serov – Independent Desktop Review - Bowdens Silver Pty Ltd Environmental Impact Study Review for Lue Actions Group and Summary document
- 12 September 2023 – Email from Dr Elias Nasser, rural Generalist Trainee, Australian College of Rural and Remote Medicine to committee, enclosing correspondence to Health Minister regarding the transition to the Single Digital Patient Record and response from the Health Minister
- 14 September 2023 – Email from Mr Anthony McClure, Director, Bowdens Silver Pty Ltd, declining invitation to attend mining impacts inquiry hearing on 18 September 2023
- 14 September 2023 – Email from Regis Resources Limited, declining invitation to attend mining impacts inquiry hearing on 18 September 2023.

Sent

- 27 July 2023 – Letter to Hon Rose Jackson MLC, Minister for Water, forwarding correspondence from an individual to committee raising concerns about Sydney Water, for consideration
- 17 August 2023 – Letter to an individual conveying the substance of response to Chair from Hon Rose Jackson MLC, Minister for Water, dated 5 August 2023 about the individual's concerns about Sydney Water.

Resolved, on the motion of Ms Faehrmann: That the committee keep the following correspondence confidential as it contains identifying and/or sensitive information and is not related to an inquiry:

- 5 August 2023 – Letter from Hon Rose Jackson MLC, Minister for Water, responding to Chair's letter dated 27 July 2023 which forwarded correspondence from an individual to committee raising concerns about Sydney Water, for consideration
- 17 August 2023 – Letter to an individual conveying the substance of response to Chair from Hon Rose Jackson MLC, Minister for Water, dated 5 August 2023 about the individual's concerns about Sydney Water.

That the committee keep the following correspondence confidential as it is from an individual who has made a submission to the committee's mining impacts inquiry and the individual has asked that this submission be kept confidential:

- 26 July 2023 – Email from an individual concerning terms of reference for mining impacts inquiry.

5. Inquiry into current and potential future impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales

5.1 Public submissions

The Committee noted the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submissions nos: 1, 5, 6, 7, 10, 12, 13, 14, 15, 16, 17, 18, 20, 21, 24, 25, 26, 27, 28, 31, 32, 33, 34, 36, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 50, 52, 53, 57, 58, 59, 62, 63, 64, 64A, 65, 67, 68, 69, 70, 71, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85 and 106.

5.2 Partially confidential submissions

Resolved, on the motion of Ms Suvaal: That the committee keep the following information confidential, as per the request of the author: names in submissions no. 2, 4, 8, 9, 11, 19, 22, 49, 51, 56, and 66.

Resolved, on the motion of Ms Suvaal: That the committee authorise the publication of submissions no. 3, 29, 35, 48, 54, 55, 60, 61, 72 and 92 with the exception of sensitive or identifying material or potential adverse comments that have been highlighted by the secretariat.

5.3 Confidential submissions

Resolved, on the motion of Ms Suvaal: That the committee keep submissions no. 23, 30 and 37 confidential, as per the request of the authors.

5.4 Attachments to submissions

Resolved, on the motion of Mrs Carter: That the committee authorise the publication of attachments to submissions no 6, 18 and 77 as they contain material particularly pertinent to the inquiry.

5.5 Proforma submissions

The committee noted a series of hard copy pro forma submissions have been lodged and that the secretariat has not yet reviewed them as substantive submissions are being prioritised.

5.6 Transport – site visits and hearings in Orange and Mudgee

The committee noted that it had previously agreed via email to the use of a charter plane to facilitate site visits and hearings in Orange and Mudgee on 3 and 4 October 2023 at a cost of $19,140.

The booking was subsequently cancelled by the charter flight provider for maintenance reasons.

The committed noted that the secretariat sought alternative quotes with the most suitable option costing approximately $30,000.

Discussion ensued.

Resolved, on the motion of Mrs Carter: That consideration of the agenda item be deferred until later in the day, to allow the secretariat to obtain information about commercial flight and bus options.

5.7 Site visit and hearing itinerary – Orange and Mudgee

Resolved, on the motion of Ms Suvaal: That consideration of the itinerary for the committee's site visits in Orange and Mudgee on Tuesday 3 October 2023 and Wednesday 4 October 2023 also be deferred until later in the day.

5.8 Public hearing

Resolved, on the motion of Mrs Carter: That the timing and sequence of questions to be asked at the hearing on 18 September 2023 be left to the Chair to allocate between opposition, crossbench, and government members.

6. Inquiry into Budget Estimates 2023-2024 – procedural resolutions

The committee noted that the Budget Estimates timetable for 2023-2024 was agreed to by the House, with hearings generally commencing at 9.15 am and concluding by 5.30 pm. Below is a table of Portfolio Committee No. 2 hearings:

Date	Portfolio
Thursday 26 October 2023	Health, Regional Health, the Illawarra and the South Coast
Wednesday 1 November 2023	Water, Housing, Homelessness, Mental Health, Youth, the North Coast

6.1 Allocation of question time and total hearing time

The committee noted that under the Budget Estimates 2023-2024 resolution, each portfolio, except The Legislature, be examined concurrently by Opposition and Crossbench members only from 9.15 am to 10.45 am, 11.15 am to 12.45 pm, 2.00 pm to 3.30 pm and 3.45 pm to 5.15 pm, and, if required, by Government members only from 10.45 am to 11.00 am, 12.45 pm to 1.00 pm, and 5.15 pm to 5.30 pm.

6.2 Witness requests

Resolved, on the motion of Mr Fang: That:

- the secretariat write to the ministers of the relevant portfolios being examined by the committee to request that they nominate witnesses to appear at each hearing, for the committee's consideration
- upon receipt, the nominated witnesses be circulated to the committee
- members be given two days from when the nominated witnesses are circulated to make amendments or nominate additional witnesses
- the committee agree to the witness list by email, unless a meeting of the committee is required to resolve any disagreement.

Mr Fang moved: That the committee invite Dr Michael Holland MP, Parliamentary Secretary for Health and Parliamentary Secretary for Regional Health, to the hearing for the portfolios of Health, Regional Health, the Illawarra and the South Coast on Thursday 26 October 2023, from 9.15 am to 1.00 pm only.

Question put.

The committee divided.

Ayes: Mrs Carter, Dr Cohn, Ms Faehrmann, Mr Fang

Noes: Mr Buttigieg, Mr Donnelly, Ms Suvaal

Question resolved in the affirmative.

6.3 Witness appearance time

The committee noted that under the Budget Estimates 2023-2024 resolution Ministers are invited to appear for the morning sessions only, 9.15 am to 1.00 pm, unless requested by the committee to appear also for the afternoon session.

7. Inquiry into current and potential future impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales

7.1 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:
- Ms Beverley Smiles, President – Inland Rivers Network
- Mr Ross McDonnell, NPA Executive, National Parks Association
- Mr Warwick Pearse, NPA Landscape Conservation Forum, National Parks Association

Mr Pearse tendered a document entitled 'Examples of contaminated mine waste water discharge into waterways which flow into NSW national parks'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Sherry Duhe, Interim CEO, Newcrest Mining Limited
- Mr Michael Dewar, General Manager, Cadia Valley Operations, Newcrest Mining

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Gem Green, Chair, Cadia Community Sustainability Network
- Ms Frances Retallack, Vice Chair, Cadia Community Sustainability Network
- Dr Ian Wright, Associate Professor, Environmental Science, Western Sydney University

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Susannah White, Angus seedstock producer, Mudgee Region Action Group
- Ms Shireen Baguley, Environmental Consultant, Mudgee Region Action Group
- Mr Dan Sutton, President, Belubula Headwaters Protection Group
- Ms Rebecca Price, Vice President, Belubula Headwaters Protection Group

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mr Tony Chappel, CEO, NSW Environment Protection Authority
- Mr Stephen Beaman, Executive Director Regulatory Practice & Services, NSW Environment Protection Authority

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mr Stephen Galilee, CEO, NSW Minerals Council
- Ms Claire Doherty, Director, Policy, NSW Minerals Council

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Georgina Beattie, CEO, Mining Exploration and Geoscience, NSW Resources Regulator
- Mr Peter Day, Executive Director, NSW Resources Regulator

The evidence concluded and the witnesses withdrew.

Tendered documents

Resolved, on the motion of Mr Donnelly: That the committee accept and publish the following document tendered during the public hearing:
- Document entitled 'Examples of contaminated mine wastewater discharge into waterways which flow into NSW national parks' tendered 18 September 2023 by Mr Warwick Pearse, NPA Landscape Conservation Forum, National Parks Association.

7.2 Transport – site visits and hearings in Orange and Mudgee

The committee considered the following information provided by the secretariat about transport options for the committee's site visits and hearings in Orange and Mudgee:

- commercial flights from Sydney to Orange on Tuesday 3 October 2023 for the required number of members and staff (13) would cost approximately $5,000, and
- bus hire for Tuesday 3 and Wednesday 4 October 2023 to transport members and staff to hearings and site visits and back to Sydney would cost approximately $5,000.

Discussion ensued.

Resolved, on the motion of Ms Faehrmann: That for the purposes of its Orange and Mudgee hearings and site visits the committee:

- take a commercial flight from Sydney to Orange on Tuesday 3 October 2023, and
- hire a bus to travel to hearings and site visits on Tuesday 3 October and Wednesday 4 October 2023 and to return to Sydney on Wednesday 4 October 2023.

7.3 Site visit and hearing itinerary – Orange and Mudgee

The committee considered the itinerary for the site visits and hearings in Orange and Mudgee on Tuesday 3 October and Wednesday 4 October 2023.

Discussion ensued.

Resolved, on the motion of Ms Faehrmann: That the committee adopt the following itinerary for the site visits and hearings in Orange and Mudgee, noting that times may need to change to accommodate witness availability and logistical details:

Tuesday 3 October 2023:

- 6.50 am to 7.45 am: commercial flight Sydney to Orange
- 7.45 am to 8.15 am: bus travel to hearing venue, Orange
- 8.15 am to 9.30 am: hearing set up and deliberative meeting
- 9.30 am to 12.00 pm: hearing, Orange
- 12 noon to 12.30 pm: lunch
- 12.30 pm to 1.30 pm: hearing, Orange
- 1.30 pm to 2.00 pm: bus travel to Cadia Mine
- 2.00 pm to 5.30 pm: site visit, Cadia Mine
- 5.30 pm to 6.00 pm: bus travel to Orange, stay in Orange overnight.

Wednesday 4 October 2023:

- 6.00 am to 8.30 am: bus travel to Mudgee
- 8.30 am to 9.30 am: breakfast and hearing set up
- 9.30 am to 12.00 pm: hearing, Mudgee
- 12.00 pm to 12.30 pm: lunch
- 12.30 pm to 2.00 pm: hearing, Mudgee
- 2.00 pm to 2.30 pm: bus travel to Bowdens Silver Project, Lue
- 2.30 pm to 4.00 pm: Bowdens presentation and site tour
- 4.00 pm to 5.30 pm: Time with Mudgee Region Action Group and landholders
- 5.30 pm to 9.30 pm (incorporating half hour dinner break): Bus travel Mudgee to Sydney.

Resolved, on the motion of Mr Donnelly, That:

- Regis Resources Limited be invited to give evidence at the Orange hearing on Tuesday 3 October 2023 or at another hearing for the inquiry.
- Bowdens Silver Pty Ltd be invited to give evidence at the Mudgee hearing on Wednesday 4 October 2023 or at another hearing for the inquiry.
- Further discussions regarding witness selection for the Orange and Mudgee hearings take place via email.

8. Adjournment

The Committee adjourned at 4.15 pm until Friday 22 September 2023 (public hearing – inquiry into the Equity, accessibility and appropriate delivery of outpatient and community mental health in New South Wales).

Elspeth Dyer
Committee Clerk

Minutes no. 5
Friday, 22 September 2023
Portfolio Committee No. 2 - Health
Macquarie Room, Parliament House, Sydney at 9.02 am

1. Members present

Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Buttigieg
Mr Donnelly
Ms Faehrmann (via videoconference from 9.10 am)
Ms Suvaal
Mrs Taylor (until 10.45 am)

2. Previous minutes

Resolved, on the motion of Mrs Carter: That the draft minutes no. 4 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received

- 15 September 2023 – Email from an individual advising that they will not be appearing before the committee as a witness for the inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.
- 18 September 2023 – Email from Lo-Shu Wen, Policy Officer, STARTTS Community Services, advising that STARTTS Community Services are unable to appear before the committee as witnesses for the inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales on 22 September but would be available at another time.
- 18 September 2023 – Correspondence from Mr Chris Pavich attaching submission to Independent Planning Commission regarding Bowdens Mine.
- 19 September 2023 – Email from Kate Munro, CEO, Youth Action, advising that Youth Action are unable to appear before the committee as witnesses for the inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales on 22 September 2023 but would be available at another time.
- 19 September 2023 – Email from an individual declining to appear at the hearing for the inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales on 22 September, as they are unavailable, and advising that another individual has made a submission about the same individual and is willing to appear.
- 19 September 2023 – Email from an individual advising she has been contacted by an invited witness, an individual, who is unable to attend the hearing for the inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales on 22 September 2023, offering to attend in their place as her submission is about the same individual.
- 20 September 2023 – Email from Corinne Henderson, Principal Policy Advisor, Mental Health Coordinating Council to secretariat, advising that representatives of their organisation are unable to

attend the hearing of the Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales on 22 September 2023 but would be keen to participate in future hearings.

4. Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

4.1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 1, 2, 6, 9, 12, 22, 25, 31, 34 - 41, 44 - 52, 54 - 64, 66 - 69, 72, 74 - 80, 83, 86, 89, 91 - 93, 95 - 101, 103, 104, 106 - 109, 132 and 133.

4.2 Partially confidential submissions

Resolved, on the motion of Mrs Carter: That the committee keep the following information confidential, as per the request of the author: names in submissions nos. 3, 4, 7, 10, 13 - 21, 26 - 30, 110 and 113.

Resolved, on the motion of Mrs Carter**:** That the committee authorise the publication of submissions nos: 8, 42 and 45, 88 with the exception of sensitive or identifying material or potential adverse mention, which is to remain confidential, as per the recommendation of the secretariat.

4.3 Confidential submissions

Resolved, on the motion of Mrs Carter: That the committee keep submissions no: 5, 11, 23, 24, 32, 33, 53, 65, 71, 73, 116, 123 -127 confidential, as per the request of the authors.

4.4 Sequence of questions

Resolved, on the motion of Mrs Carter: That the allocation of questions to be asked at the hearing be left in the hands of the Chair.

4.5 *In camera* hearing

The committee previously agreed to take *in camera* evidence from individual submission authors.

The committee proceeded to take *in camera* evidence.

Persons present other than the committee: Rhia Victorino, Sarah Newlands, Gerard Rajakariar, Andrew Ratchford, Kirsty Simpson, Ryan Percy, Cameron McEwan, Natalie Tipping, and Yajun Ma.

Session 1

Witnesses were admitted.

The Chair made an opening statement regarding the proceedings and other matters.

The following witness was sworn and examined:

- Witness A, individual with lived experience
- Witness B (via videoconference), individual with lived experience
- Witness C (via videoconference), individual with lived experience

The evidence concluded and the witnesses withdrew.

Session 2

Witnesses were admitted.

The Chair made an opening statement regarding the proceedings and other matters.

The following witnesses were sworn and examined:

- Witness D, carer
- Witness E, carer
- Witness F, carer

The evidence concluded and the witnesses withdrew.

4.6 Public hearing

Witnesses, the public and the media were admitted at 11.00 am.

The Chair made an opening statement regarding the broadcasting of the proceedings and other matters.

The following witnesses were sworn and examined:

- Ms Priscilla Brice, CEO, BEING: Mental Health Consumers
- Dr Peter Schmiedgen, Policy Lead, BEING: Mental Health Consumers
- Ms Katie Thorburn, Policy Manager, Mental Health Carers NSW
- Ms Rachael Laidler, Policy Officer, Mental Health Carers NSW

The evidence concluded and the witnesses withdrew.

Mr Buttigieg and Ms Suvaal left the meeting.

The following witnesses were sworn and examined:

- Ms Annie Crowe (via videoconference), Founder and consultant, NeuroAccess
- Dr Janelle Weise, Department of Developmental Disability Neuropsychiatry, UNSW

The evidence concluded and the witnesses withdrew.

Mr Buttigieg and Ms Suvaal re-joined the meeting.

The following witnesses were sworn and examined:

- Ms Gen Whitlam, Associate Director, Client Services, ACON
- Ms Siobhan Hannan, Team Leader, Counselling Services, ACON
- Mx Amber Loomis, President, Sydney Bi+ Network
- Mx Georgie Fischer, Board Member, Sydney Bi+ Network.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Justine Harris, Clinical Psychologist, Head of Practice Management, Settlement Services International (SSI)
- Mr Ben Benazzouz, Provisional Psychologist, Mental Health Clinician, Settlement Services International (SSI)

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Zoë Robinson, Advocate for Children and Young People
- Mr Kyzar Jing, Lived Experience Advisor, Office of the Advocate for Children and Young People
- Mr Ashley de Silva, CEO, ReachOut
- Mr Ben Bartlett, Director of Government Relations and Communications, ReachOut

The evidence concluded and the witnesses withdrew.

5. Adjournment

The committee adjourned at 4.30 pm until Tuesday 3 October 2023 (site visit and public hearing – inquiry into current and potential future impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales).

Sarah Newlands
Committee Clerk

Minutes no. 6
Tuesday 3 October 2023
Portfolio Committee No. 2 - Health
Coral Sea Room, Orange Ex-Services Club, Orange at 9.05 am

1. Members present
Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Buttigieg (via videoconference)
Mr Donnelly
Ms Faehrmann
Ms Suvaal (via videoconference)
Mrs Taylor (via videoconference)

2. Acknowledgement of Country

3. Previous minutes
Resolved, on the motion of Mrs Carter: That draft minutes no. 5 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 5 September 2023 – Correspondence from Mr Mark Tutton concerning McPhillamys Gold Mine
- 5 September 2023 – Correspondence from Ms Michelle Seagrott concerning McPhillamys Gold Mine
- 5 September 2023 – Email from an individual attaching PowerPoint presentation by Dr Haydn Washington concerning Bowdens Mine and the problems of acid mine drainage
- 22 September 2023 – Email from Luke Pidgeon, BlaQ Aboriginal Corporation, to the secretariat, advising BlaQ is unable to send representatives to the Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales, but would be willing to appear on another date
- 25 September 2023 – Email from Ms Sue Varcoe, Managing Director SEC Newgate Research raising concerns regarding evidence given to the committee at its mining impacts inquiry hearing on 18 September 2023 by Belubula Headwaters Protection Group
- 25 September 2023 – Letter from Captains Flat Community Association Inc seeking an extension to 24 October 2023 to make a submission to the mining impacts inquiry and inviting the committee to conduct a site visit at Captains Flat
- 26 September 2023 – Email from Mr John Gerathy, Chair, Cadia District Protection Group, declining invitation to attend mining impacts inquiry hearing on 3 October 2023
- 26 September 2023 - Email from Marianne Kearney, Senior Policy Advisor, Office of the Advocate for Children and Young People, advising that Mr Kyzar Jing, who appeared before the committee as a witness for the inquiry into the equity, accessibility and appropriate delivery of outpatient community mental health care in New South Wales wished to make an additional point in response to one of the questions asked at the hearing
- 27 September 2023 – Email from Bowdens Silver Pty Ltd, declining invitation for Mr Anthony McClure, Director, to attend mining impacts inquiry hearing on 4 October 2023
- 27 September 2023 – Email from Blayney Shire Council declining invitation to attend mining impacts inquiry hearing on 3 October 2023
- 28 September 2023 – Email from CFMEU, Mining Division declining invitation to attend mining impacts inquiry hearings on 3 and 4 October 2023
- 28 September 2023 – Email from Australian Workers' Union, NSW Branch declining invitation to attend mining impacts inquiry hearing on 3 October 2023

- 29 September 2023 – Email from Healthy Rivers Dubbo declining invitation to attend mining impacts inquiry hearing on 4 October 2023.

Sent:

- 26 September 2023 – Letter from Chair to Mr Phil Donato MP, Member for Orange, advising of the committee's visit to Orange on 3 October 2023 for its mining impacts inquiry
- 26 September 2023 – Letter from Chair to Mr Dugald Saunders MP, Member for Dubbo, advising of the committee's visit to Mudgee on 4 October 2023 for its mining impacts inquiry.

Resolved, on the motion of Ms Faehrmann: That Captains Flat Community Association Inc. be granted an extension for lodgement of the Captains Flat Community Association Inc. submission to the mining impacts inquiry until 24 October 2023.

5. Inquiry into current and potential impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales

5.1 Public submissions

The Committee noted the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submissions nos: 86, 87, 89, 90, 108, 123, 124, 125, 134, 135, 136, 137, 138, 142, 143, 144, 145, 147, 151, 153, 156, 158, 159, 161, 163, 166, 168, 172, 173, 174, 175, 176, 178, 179 and 181.

5.2 Partially confidential submissions

The committee considered partially confidential submissions to the inquiry.

Discussion ensued.

Resolved, on the motion of Mrs Carter: That the committee keep the following information confidential, as per the request of the author: names in submissions no. 120, 126, 129, 131, 133, 146, 150, 152, 164 and 180.

Resolved, on the motion of Mrs Carter: That the committee authorise the publication of submissions no. 88, 91, 95, 109, 117, 122, 127, 128, 140, 148, 154, 155, 160, 162, 165, 166A, 167, 169, 170, 177 and 182 with the exception of sensitive or identifying material or potential adverse comments.

5.3 Confidential submissions

Resolved, on the motion of Mrs Carter: That the committee keep submissions no. 108A, 121, 132, 139, 141, 149 and 171 confidential, as per the request of the authors.

5.4 Orange and Mudgee visits

The committee noted it would conduct a site visit to Cadia Mine, Orange on 3 October 2023 from approximately 1.30 pm to 6.30 pm including induction and travel time.

In addition, the committee noted that it would conduct a site visit to the property of Mr Tom Harris and Ms Sue Barry to the south of the Cadia mine site on 3 October 2023 following its site visit to Cadia Mine.

The committee also noted it would conduct the following site visits in Lue, just outside Mudgee, on 4 October 2023:

- Bowdens Silver Project, Lue, from approximately 2.30 pm to 4.00 pm.
- Consultation with Mudgee Region Action Group and local landholders from approximately 4.00 pm to 5.30 pm.

5.5 Further possible site visits and inquiry timetable

The Chair raised the possibility of a site visit to Captains Flat, NSW for the inquiry and a possible revised timetable for the inquiry to incorporate this site visit.

Discussion ensued.

The committee agreed that the secretariat would prepare for its consideration a possible revised timetable for the inquiry and that possible further site visits and a revised inquiry timetable would be discussed at the committee's next meeting on Wednesday 4 October 2023.

5.6 Sequence of questions

Resolved, on the motion of Ms Faehrmann: That the timing and sequence of questions to be asked at the hearing on 3 October 2023 be left to the Chair to allocate between opposition, crossbench, and government members, with the group of members to start the questioning to be alternated.

5.7 Public hearing – 3 October 2023, Ex Serviceman's Club Orange

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

Mrs Claire Bennett, Operations Manager, Goldfields Honey Group, was sworn and examined.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Lisa Paton, local resident
- Mr Tony Newman, local resident.

Mr Newman tendered the following documents:

- Document entitled 'Figure 15 Preliminary Aboriginal Heritage Sites'
- Lisa Paton, 'Additional Evidence for the State heritage Application for the Kings Plains Cultural Landscape', 28 June 2023
- Dr Michael Davies, 'Filtered Dry Stacked Tailings – The Fundamentals' (paper presented at Tailings and Mine Waste Conference, Vancouver, November 6 to 9, 2011)
- Biodynamic Association, 'Biodynamic Principles & Practices'
- Tony Newman, 'Submission to DPIE'.

The evidence concluded and the witnesses withdrew.

Mr David Waddell, Chief Executive Officer, Orange City Council was sworn and examined.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Catherine Sullivan, local resident
- Mr Craig Day, local resident.

Ms Sullivan tendered a document entitled 'Memorandum of Understanding Broula King Tailings Storage Facility'.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Ian Pearce, PFT Agriculture
- Mr Bruce Reynolds, local resident.

The evidence concluded and the witnesses withdrew.

5.8 Cadia Mine, Orange site visit

The committee visited Cadia Mine, Orange led by Mr Simon Troeth, Manager Government and Industry Relations, Newcrest Mining Ltd; and Mr Michael Dewar, General Manager, Cadia Valley Operations, Newcrest Mining Limited; and undertook a conducted tour.

5.9 Site visit to property of private landholder

The committee visited the property of Mr Tom Harris and Ms Sue Barry to the south of the Cadia mine site and consulted with the landholders and Ms Gem Green, Chair, Cadia Community Sustainability Network; Ms Frances Retallack, Vice-Chair, Cadia Community Sustainability Network; and local residents.

6. Adjournment

The Committee adjourned at 7.30 pm until Wednesday 4 October 2023 (public hearing and site visits – inquiry into current and potential impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales).

Elspeth Dyer
Committee Clerk

Minutes no. 8
Monday 16 October 2023
Portfolio Committee No. 2 - Health
Macquarie Room, Parliament House, Sydney at 9.01 am

1. Members present

Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Buttigieg (via videoconference)
Mr Donnelly
Ms Faehrmann
Mr Fang (substituting for Mrs Taylor)
Ms Suvaal

2. Acknowledgement of Country

3. Previous minutes

Resolved, on the motion of Ms Suvaal: That draft minutes nos. 6 and 7 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received:

- 26 September 2023 – Email from Marianne Kearney, Senior Policy Advisor, Office of the Advocate for Children and Young People, to the committee, providing additional information following the public hearing for the inquiry into mental health on Friday 22 September 2023.
- 29 September 2023 – Email from Office of Mrs Bronnie Taylor, to the secretariat, providing a report entitled 'Wellbeing and Health In-Reach Nurse (WHIN) Coordinator Model Pilot Evaluation Report' for the inquiry into mental health.
- 30 September 2023 – Email from Dr Peter Roberts, declining the invitation to appear at the public hearing into the impacts of mining on Wednesday 4 October 2023.
- September and October 2023 – Emails between Bowdens Silver and committee secretariat concerning Bowdens Silver appearing at a hearing of the impacts of mining inquiry to give evidence.
- 4 October 2023 – Email from Mr Simon Troeth, Manger Government and Industry Relations, Newcrest Mining Limited, to the committee, regarding EPA report into metal in soil around Cadia for the impacts of mining inquiry.
- 4 October 2023 – Email from Ms Gem Green, Chair, Cadia Community Sustainability Network, to the committee, providing information concerning Cadia Mine for the impacts of mining inquiry.
- 5 October 2023 – Email from Ms Sallie Bennett, Executive Assistant to CEO, Relationships Australia NSW, to the secretariat, declining the invitation to make a submission to the mental health inquiry.

Sent:

- 10 October 2023 – Letter to Mr Anthony McClure, Bowdens Silver, inviting him to give evidence at a public hearing for the impacts of mining inquiry on 27 October 2023.

5. Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

5.1 Public Submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submissions nos 4, 43, 52, 128, 134–136, 138–140, 142, 143 and 146–149.

5.2 Partially confidential submissions

Resolved, on the motion of Mr Fang: That the committee keep the following information confidential, as per the request of the author: names in submissions nos: 70, 105, 111, 115, 117–122 and 129.

Resolved, on the motion of Ms Suvaal: That the committee authorise the publication of submissions nos: 81 and 131 with the exemption of sensitive or identifying material or potential adverse mention that have been highlighted by the secretariat.

Resolved, on the motion of Ms Carter: That the committee authorise the publication of submission 130, with the exception of identifying information, as identified by the submission author.

5.3 Confidential submissions

Resolved, on the motion of Mr Fang: That the committee keep submissions nos: 137, 144 and 145 confidential, as per the request of the authors.

5.4 Sequence of questions

Resolved, on the motion of Mr Fang: That the allocation of questions to be asked at the hearing be left in the hands of the Chair.

5.5 Public Hearing

Witnesses, the public and the media were admitted at 9.17 am.

The Chair made an opening statement regarding the broadcasting of the proceedings and other matters.

The following witnesses were sworn and examined:

- Mr Graham Brereton, Registered Nurse and Psychologist
- Dr Tim Senior, General Practitioner.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Dr Angelo Virgona, Chair, NSW Branch, The Royal Australian and New Zealand College of Psychiatrists (RANZCP).

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Helen Boardman, Registered Nurse, Clinical Nurse Consultant, NSW Nurses and Midwives Association
- Ms Victoria Norris, Registered Nurse, Perinatal and Infant Mental Health Service Nurse Manager, North Sydney Local Health District, NSW Nurses and Midwives Association.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Dr Vicki Mattiazzo, Deputy Chair, Royal Australian College of General Practitioners (RACGP) Rural Faculty.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Kylie Coventry (via videoconference), Head of Policy, Australian Psychological Society (APS)
- Ms Anita McGregor (via videoconference), APS Member and Member of College of Forensic Psychologists, Australian Psychological Society (APS)
- Ms Sahra O'Doherty (via videoconference), Acting President, Australian Association of Psychologists Inc
- Mrs Amanda Curran (via videoconference), Chief Services Officer, Australian Association of Psychologists Inc.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Evelyne Tadros, CEO, Mental Health Coordinating Council (MHCC)
- Ms Corinne Henderson, Principal Policy Advisor, Mental Health Coordinating Council (MHCC).

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Deb Willcox, Deputy Secretary, Health System Strategy and patient Experience, NSW Ministry of Health
- Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health
- Dr Michael Bowden, A/Chief Psychiatrist, NSW Ministry of Health.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mrs Marjorie Anderson, National Manager, 13Yarn
- Mr Shane Sturgiss, CEO, BlaQ Aboriginal Corporation.

The evidence concluded and the witnesses withdrew.

6. Adjournment

The committee adjourned at 4.44 pm until Thursday 19 October 2023 (committee meeting – inquiry into current and potential future impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales)

Holly Rivas Perdomo
Committee Clerk

Minutes no. 9
Thursday 19 October 2023
Portfolio Committee No. 2 - Health
Room 1254, Parliament House, Sydney at 6.48 pm

1. Members present

Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Buttigieg
Mr Donnelly
Ms Faehrmann
Ms Suvaal
Mr Fang (substituting for Mrs Taylor)

2. Acknowledgement of Country

3. Inquiry into current and potential impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales

3.1 Witness schedule

The committee considered:

- the Chair's proposed witness schedule for the mining impacts inquiry public hearing on 27 October; and
- changes to the Chair's proposed witness schedule proposed by Ms Faehrmann.

Mr Donnelly tabled an amended proposed witness schedule.

Mr Donnelly moved: That his amended proposed witness schedule be endorsed and adopted.

Discussion ensued.

Ms Faehrmann moved: That the motion be amended as follows:

- Professor Deborah Yates and Professor Mark Taylor to give evidence at 2.15 pm
- The Country Mayors Association and Local Business Chambers to give evidence together at 5.15 pm.

Question put: That the amendment of Ms Faehrmann be agreed to.

The Committee divided.

Ayes: Dr Cohn and Ms Faehrmann.
Noes: Mrs Carter, Mr Buttigieg, Mr Donnelly, Ms Suvaal and Mr Fang.

Question resolved in the negative.

Question put: That the original motion be agreed to.

The committee divided.

Ayes: Mrs Carter, Mr Buttigieg, Mr Donnelly, Ms Suvaal and Mr Fang.
Noes: Dr Cohn and Ms Faehrmann.

Question resolved in the affirmative.

3.2 Other business/any related matters

Mr Donnelly moved, That:

- the committee hold no further hearings as part of this inquiry, after the hearing on 27 October 2023, and that the committee chair prepare a draft report in accordance with Standing Order 234
- furthermore, the Chair's draft report be submitted to committee members at least 14 days prior to the date scheduled for the report deliberative meeting.

Question put: That the motion be agreed to.

The committee divided.

Ayes: Mrs Carter, Mr Buttigieg, Mr Donnelly, Ms Suvaal and Mr Fang.
Noes: Dr Cohn and Ms Faehrmann.

Question resolved in the affirmative.

Resolved, on the motion of Mrs Carter: That the report deliberative meeting be held on 7 December 2023.

4. Other business

Resolved, on the motion of Ms Faehrmann, That:

- 15-17 November 2023, which were being held for the committee's mining impacts inquiry, be made available instead for the committee's mental health inquiry
- 1 December 2023, which was being held for the committee's mental health inquiry, be vacated.

5. Adjournment

The committee adjourned at 7.10 pm until Thursday 26 October 2023 – Budget Estimates 2023-2024 hearing – Health, Regional Health, the Illawarra and the South Coast (Park).

Elspeth Dyer
Committee Clerk

Minutes no. 10
Wednesday 25 October 2023
Portfolio Committee No. 2 - Health
Room 1043, Parliament House, Sydney at 5.31 pm

1. Members present
Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Buttigieg
Mr Donnelly
Ms Higginson (substituting for Ms Faehrmann)
Ms Suvaal (via videoconference)
Mrs Taylor

2. Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

2.1 Witness list
The committee considered advice from the Clerk of the Parliaments regarding the sub judice convention in relation to the appearance of a proposed witness.

Mr Donnelly moved: That the committee await the witness' written submission, consider it carefully and potentially seek further information from relevant authorities about current, expected or potential legal proceedings and on the basis of that information, consider inviting the witness, to give evidence in public or *in camera* at a future subsequent hearing.

Question put.

The committee divided.

Ayes: Mr Buttigieg, Mr Donnelly, Ms Suvaal
Noes: Mrs Carter, Dr Cohn, Ms Higginson and Mrs Taylor.

Question resolved in the negative.

Mrs Carter moved: That:
- the committee proceed to invite the witness to appear *in camera*, with the secretariat to brief them on avoiding adverse reflection, and
- the witness' evidence remain confidential.

Question put.

The committee divided.

Ayes: Mrs Carter, Dr Cohn, Ms Higginson and Mrs Taylor.
Noes: Mr Buttigieg, Mr Donnelly and Ms Suvaal

Question resolved in the affirmative.

Mr Donnelly moved: That the following witnesses not be invited to give evidence at the hearing on Monday 30 October 2023:
- Justice Reform Initiative

- Justice Action
- Community Restorative Centre
- Official Visitors Program.

Question put.

The committee divided.

Ayes: Mr Buttigieg, Mrs Carter, Mr Donnelly, Ms Suvaal and Mrs Taylor.
Noes: Dr Cohn and Ms Higginson

Question resolved in the affirmative.

3. Adjournment
The committee adjourned at 6.01 pm until Thursday 26 October 2023 – Budget Estimates 2023-2024 hearing – Health, Regional Health, the Illawarra and the South Coast (Park).

Holly Rivas Perdomo
Committee Clerk

Minutes no. 13
Monday 30 October 2023
Portfolio Committee No. 2 – Health
Macquarie Room, Parliament House, Sydney at 9.01 am

1. Members present
Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Murphy (substituting for Mr Buttigieg until 9.34 am)
Mr Donnelly
Ms Suvaal
Mr Fang (via videoconference from 9.00 am until 9.07 am) (from 9.31 am) (substituting for Mrs Taylor)

2. Apologies
Ms Higginson (substituting for Ms Faehrmann)

3. Previous minutes
Resolved, on the motion of Mr Donnelly: That draft minutes nos. 8 and 10 be confirmed.

4. Correspondence
The committee noted the following items of correspondence:

Received

- 6 October 2023 - Email from submission author 154, to the committee, providing a copy a complaint regarding Royal Prince Alfred Hospital, in relation to the mental health inquiry.
- 12 October 2023 - Email from Ms Naiomi Levack, Faculty Officer, The Royal Australian College of General Practitioners (RACGP) NSW & ACT, to the secretariat, declining the invitation to appear at public hearing for the mental health inquiry on 16 October 2023.
- 18 October 2023 - Email from Ms Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc, to the committee, providing a document entitled 'ANU Psychology Workforce Preliminary Report' and accompanying media release, in relation to the mental health inquiry.
- 25 October 2023 - Email from Mr Jaspar McCahon-Boersma, Australian Paramedics Association NSW, to the secretariat, declining the invitation to appear at public hearing for the mental health inquiry on 30 October 2023.

- 25 October 2023 - Email from Mr Brian Diplock, ACT Policing, declining the invitation to appear at public hearing for the mental health inquiry on 30 October 2023 and providing a document entitled 'PACER Evaluation FINAL Evaluation Report'.
- 25 October 2023 - Email from Mr Paul Lemmer ASM, SA Ambulance Service, declining the invitation to appear at public hearing for the mental health inquiry on 30 October 2023.
- 26 October 2023 - Email from Ms Katie McKenzie, Canberra Health Services, ACT Government, declining the invitation to appear at public hearing for the mental health inquiry on 30 October 2023.
- 26 October 2023 - Email from Ms Catherine Sullivan attaching correspondence from Mr Tony Chappel, Chief Executive Officer, NSW Environment Protection Authority regarding Broula King Gold Mine for the impacts of mining inquiry.

Resolved, on the motion of Mr Donnelly, that the email from submission author 154, dated 6 October 2023, be kept confidential.

5. Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

5.1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submissions nos. 94, 141, 151-152, 155 and 156.

Resolved, on the resolution of Mr Murphy, that submission no. 158 be published.

5.2 Partially confidential submissions

The committee noted that the following submissions were partially published by the committee clerk under the authorisation appointing the committee: submissions nos. 82, 102, 153 and 154.

Resolved, on the motion of Mr Murphy, that the committee keep the following information confidential, as per the request of the author: names in submissions nos. 82, 102, 153 and 154.

Resolved, on the motion of Mr Murphy, that the committee authorise the publication of submissions nos. 84, 85, 90, 112, 114 and 150 with the exception of sensitive or identifying material or identifying material or potential adverse mention that have been highlighted by the secretariat.

5.3 Confidential submissions

Resolved, on the motion of Mr Murphy, that the committee keep submissions nos. 87 and 157 confidential, as per the request of the author.

5.4 Update on publication of submission no. 144

The secretariat provided an update to the committee on the publication status of submission no. 144.

5.5 Public Hearing

Sequence of questions

Resolved, on the motion of Mrs Carter: That the allocation of questions to be asked at the hearing be left in the hand of the Chair.

5.6 *In camera* hearing

The committee previously agreed to take *in camera* evidence from Witness G.

The committee proceeded to take *in camera* evidence.

Persons present other than the committee: Alex Stedman, Holly Rivas, Gerard Rajakariar, Tina Mrozowska, Jaelyn Lyas, Paul Hoad, Julia Drake-Broadman and Janice Herne.

Session 1

The witness was admitted.

The Chair made an opening statement regarding the proceedings and other matters.

The following witness was sworn and examined:

- Witness G - individual with lived experience.

The evidence concluded and the witness withdrew.

5.7 Public Hearing

Witnesses, the public and the media were admitted at 10.06 am.

The Chair made an opening statement regarding the broadcasting of the proceedings and other matters.

The following witness was sworn and examined:

- Mr Cooper Smeaton, individual with lived experience.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Dr Fiona Kumfor, Associate Professor, School of Psychology, University of Sydney, Clinical Neuropsychologist and Co-Founder of the Dementia Law Network

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mr Kevin Morton, President, Police Association of NSW
- Mr Tony Bear, Manager, Strategy and Relationships, Police Association of NSW

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Magistrate Carolyn Huntsman, President, Mental Health Review Tribunal

The evidence concluded and the witness withdrew.

6. Inquiry into current and potential impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales

6.1 Public submissions

The committee noted that submission no. 183 was published by the committee clerk under the authorisation of the resolution appointing the committee.

6.2 Partially confidential submissions

Resolved, on the motion of Mr Donnelly, that the committee authorise the publication of submission no. 184 with the exception of sensitive or identifying information or potential adverse comments.

7. Adjournment

The committee adjourned at 12.31 pm until Wednesday 1 November 2023 (Budget Estimates 2023 – 2024 hearing – Water, Housing, Homelessness, Mental Health, Youth, the North Coast).

Holly Rivas
Committee Clerk

Minutes no. 15
Friday 17 November 2023
Portfolio Committee No. 2 - Health
Macquarie Room, Parliament House, Sydney at 9.02 am

1. Members present

Dr Cohn, *Chair*
Ms Suvaal (*Deputy Chair* until 1:30 pm)
Mrs Carter, *Deputy Chair* (from 1.30 pm until 4.30 pm)
Mr Buttigieg (via videoconference)

Mr Donnelly, until 9.15 am
Ms Faehrmann (via videoconference)
Mr Farlow (substituting for Mrs Carter, from 9.00 am until 12.30 pm)
Mrs Taylor (via videoconference from 2:00 pm until 2.30 pm)

2. Apologies
Mrs Taylor, until 2.00 pm

3. Acknowledgement of Country

4. Election of Deputy Chair
The Chair called for nominations for the Deputy Chair for the morning session, noting Mrs Carter's absence.

Mr Farlow moved: That Ms Suvaal be elected Chair of the committee.

There being no further nominations, the Chair declared Ms Suvaal elected Deputy Chair from 9.00 am until 12.30 pm.

5. Previous minutes
Resolved, on the motion of Mr Donnelly: That the draft minutes nos. 13 and 14 be confirmed.

6. Correspondence
The committee noted the following items of correspondence:

Received

- 26 October 2023 - Email from Mr Howard Wren, ACT Ambulance Service, declining the invitation to appear at a public hearing for the mental health inquiry on 30 October 2023
- 27 October 2023 – Email from Ms Catherine Sullivan attaching correspondence regarding Broula King Gold Mine
- 1 November 2023 – Email from Dr Peter Bentivoglio attaching additional information following his appearance at the committee's mining impacts inquiry hearing on 4 October 2023; a Department of Planning study on environmental lead risks; and a study by Mark P. Taylor on environmental lead risks
- 2 November 2023 – Email from Ms Maree O'Connell providing additional information following her appearance at the committee's mining impacts inquiry hearing on 4 October 2023 and attaching a study by Mark P. Taylor concerning environmental lead risks
- 2 November 2023 – Email from Ms Jade Miskle providing additional information following her appearance at the committee's mining impacts inquiry hearing on 4 October 2023 and attaching a study by Mark P. Taylor concerning environmental lead risks
- 3 November 2023 – Email from Cadia Community Sustainability Network attaching minutes of a Cadia Community Consultative Committee meeting, August 2023
- 10 November 2023 – Email from Mr Brian Diplock, ACT Policing, declining the invitation to appear at public hearing for the mental health inquiry on 17 November 2023
- 10 November 2023 - Email from Mr Howard Wren, ACT Ambulance Service, declining the invitation to appear at a public hearing for the mental health inquiry on 17 November 2023
- 13 November 2023 – Email from Dr Anna Brooks, Lifeline, declining the invitation to appear at public hearing for the mental health inquiry on 17 November 2023
- 13 November 2023 - Email from Mr Brian Diplock, ACT Policing, advising that a document entitled 'PACER Evaluation FINAL Evaluation REPORT' is authorised to be published for the purposes of the mental health inquiry.

7. Inquiry into current and potential impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales

7.1 Answers to questions on notice – public

The following answers to questions on notice were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Answer to question on notice from Ms Lucy White received 3 November 2023.
- Answer to question on notice from NSW Resources Regulator, Mining Exploration and Geoscience, Department of Regional NSW received 10 November 2023.
- Answers to questions on notice from Mr Tony Chappel, CEO, NSW Environment Protection Authority received 13 November 2023.
- Answers to questions on notice from Mr Stephen Beaman, Executive Director, Regulatory Practice and Services, NSW Environment Protection Authority.
- Answers to questions on notice from the NSW Independent Planning Commission received 13 November 2023.
- Answers to questions on notice from Mr Anthony McClure, Managing Director, Bowdens Silver received 13 November 2023.

7.2 Answers to questions on notice – partially confidential

Resolved, on the motion of Ms Faehrmann: that the committee authorise the publication of the answers to questions on notice from Ms Lisa Paton and Mr Tony Newman with the exception of sensitive or identifying information.

7.3 Answers to questions on notice – confidential

Resolved, on the motion of Ms Faehrmann: That the answers to questions on notice from Mr Bruce Reynolds be kept confidential at the request of the witness.

Resolved, on the motion of Ms Faehrmann: That the answer to a question on notice from Mrs Claire Bennett – document entitled 'Report – Goldfields Honey – Final – 20 December 2022' be kept confidential as per the request of the witness.

7.4 Public submission

The following submission was published by the committee clerk under the authorisation of the resolution appointing the committee: submission no. 77A.

8. Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

8.1 Public submissions

The following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 159 and 160.

8.2 Confidential submissions

Resolved, on the motion of Ms Faehrmann: That submission no. 162 be kept confidential, as per the request of the author.

8.3 Consideration of submission no. 161

The secretariat updated the committee on discussions with the author, with the committee to consider publication at a subsequent meeting.

8.4 Answers to questions on notice and supplementary questions – public

The following answers to questions on notice and supplementary questions were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Answers to questions on notice and supplementary questions from Dr Janelle Weise, UNSW Department of Developmental Disability Neuropsychiatry, received 23 October 2023
- Answers to supplementary questions from BEING: Mental Health Consumers, received 25 October 2023

- Answers to questions on notice and supplementary questions from SSI received on 26 October 2023
- Answers to supplementary questions from Sydney Bi+ Network, received 27 October 2023
- Answers to questions on notice and supplementary questions from ACON, received 27 October 2023
- Answers to supplementary questions from ReachOut, received on 30 October 2023
- Answers to supplementary questions from Mental Health Carers NSW, received on 31 October 2023
- Answers to supplementary questions from the Office of the Advocate for Children and Young People, received 2 November 2023.

8.5 Answers to questions on notice and supplementary questions – confidential

Resolved, on the motion of Mr Donnelly: That the following answers to questions on notice and supplementary questions be kept confidential:

- Answers to questions on notice and supplementary questions from Witness B, received 6 October 2023
- Answers to supplementary questions from Witness A, received 22 October 2023
- Answers to supplementary questions from Witness E, received 19 October 2023
- Answers to supplementary questions from Witness F, received 15 October 2023
- Answers to supplementary questions from Witness C, received 7 November 2023.

8.6 Consideration of committee activity in 2024

Committee activity for the mental health inquiry in early 2024 was confirmed for**:**

- Tuesday 13 February 2024
- Wednesday 14 February 2024
- Thursday 15 February 2024.

8.7 Public hearing

Sequence of questions

Resolved, on the motion of Ms Suvaal: That the sequence of questions to be asked at the hearing be left in the hands of the Chair.

8.8 Publication of PACER Evaluation FINAL Evaluation Report from ACT Policing

Resolved, on the motion of Mr Donnelly, that the committee authorise the publication of document entitled 'PACER Evaluation FINAL Evaluation Report'.

8.9 *In camera* hearing

The committee previously agreed to take *in camera* evidence from individual submissions authors.

The committee proceeded to take *in camera* evidence.

Persons present other than the committee: Laura Ismay, Holly Rivas, Gerard Rajakariar, Reeti Pandharipande, Andrew Ratchford, Claire Morgan, Jaymie Pope and Jaelyn Lyas.

Session 1

Witnesses were admitted.

The Chair made an opening statement regarding the proceedings and other matters.

The following witness was sworn and examined:

- Witness H
- Witness I
- Witness J
- Witness K

The evidence concluded and the witnesses withdrew.

Session 2

Witnesses were admitted.

The Chair made an opening statement regarding the proceedings and other matters.

The following witnesses were sworn and examined:
- Witness L
- Witness M

The evidence concluded and the witnesses withdrew.

8.10 Public hearing

Witnesses, the public and the media were admitted at 11.00 am.

The Chair made an opening statement regarding the broadcasting of the proceedings and other matters.

The following witness was sworn and examined:
- Mr Paul Lemmer (*via videoconference*), Executive Director, Metropolitan Operations – South Australia Ambulance.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:
- Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS) Canberra Health Services, ACT Government.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mr Lawrence Muskitta, Head of Government Relations, Black Dog Institute
- Ms Nicole Cockayne, Director, Policy & Research Operations, Black Dog Institute.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mr Simon Dodd, Head of Workforce Development and Planning, headspace
- Ms Annie Hong, Youth National Reference Group Member, headspace.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:
- Ms Nicola Rabbitte (*via videoconference*), Wellness Health In-reach Nurse Coordinator Program.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:
- Ms Catherine Lourey, Commissioner, Mental Health Commission of NSW.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:
- Ms Lizz Reay, Chief Executive Officer, Nepean Blue Mountains Primary Health Network and Chair, NSW/ACT PHN CEO Network.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:
- Mr Craig Parsons, General Manager, Partnerships & Innovation, Sydney North PHN and Chair, NSW/ACT Mental Health Network.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mr Brett Simpson, President, Australian Paramedics Association (NSW), Intensive Care Paramedic
- Ms Jessica Whittaker, Delegate, Australian Paramedics Association (NSW) Paramedic
- Mr Jeffrey Andrew (*via videoconference*), Delegate, Australian Paramedics Association (NSW), Critical Care Paramedic.

The evidence concluded and the witnesses withdrew.

9. Post-hearing deliberative

Resolved, on the motion of Ms Suvaal: That the Chair write to Mr Brian Diplock, ACT Policing, on behalf of the committee, requesting responses to questions directed in the hearing to Ms Katie McKenzie, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services.

10. Adjournment

The committee adjourned at 4.32 pm until 7 December 2023 (Mining Impacts Inquiry – Report Deliberative).

Holly Rivas
Committee Clerk

Minutes no. 18
Tuesday 13 February 2024
Portfolio Committee No. 2 - Health
Function Room, Lismore Heights Sports, Recreation and Community Club, Lismore at 10.47 am

1. Members present

Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Buttigieg (via videoconference until 11.05 am)
Mr Donnelly (via videoconference)
Ms Higginson (substituting for Ms Faehrmann)
Ms Suvaal

2. Apologies

Mrs Taylor

3. Acknowledgment of Country

4. Correspondence

The committee noted the following items of correspondence:

Received

- 16 November 2023 - Email from Ms Nicola Rabbitte, Wellbeing and Health In Reach Nurse (WHIN) Coordinator, providing WHIN program video links for the mental health inquiry hearing on 17 November 2023
- 19 November 2023 - Email from Mr Grant Mistler providing additional information to the committee in relation to the mental health inquiry
- 20 November 2023 - Email from Jonathan Harms, Mental Health Carers NSW (MHCN), providing a copy of MHCN's submission to the Special Commission of Inquiry into Healthcare Funding, to the committee in relation to the mental health inquiry
- 21 November 2023 - Email from Mr Cooper Smeaton to secretariat, requesting corrections to transcript for the mental health inquiry public hearing on 30 October 2023
- 23 November 2023 - Email from Mr Grant Mistler providing additional information to the committee in relation to the mental health inquiry
- 24 November 2023 - Email from Mr Jonathan Harms, Mental Health Carers NSW (MHCN), providing a document entitled 'Insights Report - The role of Peer Navigators - August 2023' to the committee in relation to the mental health inquiry

- 1 December 2023 – Multiple emails from Mr Brett Collins, Justice Action, to secretariat requesting to give evidence at a hearing for the mental health inquiry
- 25 January 2024 – Email from Mr Pat Stevenson, South Australia Ambulance Service, providing a document entitled 'SA Ambulance Service Interim Procedure Solo Responder Safety', responding to questions taken on notice at the hearing on 17 November 2023
- 31 January 2024 – Email from Mr Harry Grant, Black Dog Institute, requesting corrections to transcript and clarifying answers the questions on notice from mental health hearing 17 November 2023
- 5 February 2024 - Email from the Mental Health Coordinating Council providing further information to the committee in relation to the mental health inquiry.

Sent

- 28 November 2023 - Letter from Dr Amanda Cohn MLC, Committee Chair, to Mr Brian Diplock, ACT Policing, providing supplementary questions regarding the mental health inquiry
- 25 January 2024 – Letter from Dr Amanda Cohn MLC, Committee Chair, to Ms Janelle Saffin, MP, regarding details of the Committee's regional hearing in Lismore on 13 February 2024.

5. Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

5.1 Confidential submissions

Resolved, on the motion of Mr Donnelly: That the committee keep submission no 161 confidential, as per the request of the author.

5.2 Answers to questions on notice and supplementary questions – public

The committee noted that the following answers to questions on notice and supplementary questions were published by the committee clerk under the authorisation of the resolution appointing the committee:

- The Mental Health Coordinating Council, received 15 November 2023
- The Royal Australian College of General Practitioners Rural, received 17 November 2023
- The Australian Association of Psychologists Inc, received 18 October 2023
- The Australian Psychological Society, received 20 November 2023
- The NSW Ministry of Health, received 23 November 2023
- The NSW Nurses and Midwives Association, received 27 November 2023
- Additional information from Mr Graham Brereton, received 29 November 2023
- The Royal Australian and New Zealand College of Psychiatrists, received 29 November 2023
- Ms Annie Crowe, NeuroAccess, received 30 November 2023
- headspace, received 14 December 2023
- Primary Health Network NSW/ACT Mental Health Network, received 18 December 2023
- Australian Paramedics Association NSW, received 19 December 2023
- The Mental Health Commission of NSW, received 19 December 2023
- Ms Nicola Rabbitte, received 20 December 2023

Resolved, on the motion of Ms Suvaal: That the committee publish the correspondence from Doug Boudy, Deputy Chief Officer, ACT Policing, received 22 December 2023.

Resolved, on the motion of Ms Suvaal: That the committee authorise the publication of answers to questions on notice and supplementary questions from Black Dog Institute and South Australia Ambulance Service.

5.3 Answers to questions on notice – confidential

Resolved, on the motion of Ms Suvaal: That the committee keep the answers to questions on notice from Witnesses H, I, J, K, L, M confidential, as evidence was provided *in camera*.

5.4 Transcript corrections

Resolved, on the motion of Mr Donnelly: That the committee authorise the publication of correspondence from Mr Cooper Smeaton to the committee providing transcript corrections, received 21 November 2023, and the secretariat insert a footnote on the transcript from the 30 October 2023 hearing, clarifying the evidence of Mr Smeaton, as per the correspondence received 21 November 2023.

and that

the committee authorise the publication of correspondence from Mr Harry Grant to the committee providing transcript corrections, received 19 January 2024, and the secretariat insert a footnote on the transcript from the 17 November 2023 hearing, clarifying the evidence of Mr Lawrence Muskitta, as per the correspondence received 19 January 2024.

5.5 *In camera* hearing

Sequence of questions
Resolved, on the motion of Ms Suvaal: That the allocation of questions to be asked at the hearing be left in the hand of the Chair.

Witness request to provide *in camera* evidence
Resolved, on the motion of Mrs Carter: That the committee proceed to take evidence from Witness P, *in camera*.

5.6 *In camera* hearing

The committee proceeded to take in *in camera* evidence.

Persons present other than the committee: Laura Ismay, Holly Rivas, Gerard Rajakariar, Andrew Ratchford, James McLeod, Amy Park, Harley Jones, David Burke.

Session 1
The witnesses were admitted.

The Chair made an opening statement regarding the proceedings and other matters.

The following witness was sworn and examined:
- Witness N
- Witness O

The evidence concluded and the witnesses withdrew.

Session 2
The witness was admitted.

The Chair made an opening statement regarding the proceedings and other matters.

The following witness was sworn and examined:
- Witness P

The evidence concluded and the witness withdrew.

5.7 Public hearing

Witnesses, the public and the media were admitted at 12.15 pm

The Chair made an opening statement regarding the proceedings and other matters.

The following witnesses were sworn and examined:
- Ms Kelly Bannister, CEO, Northern Rivers Women and Children's Services.
- Ms Sonja Habenicht, Trauma Counsellor/Psychologists, Women's Outreach Trauma Health Service (WORTH), Northern Rivers and Children's Services.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:
- Mr Andy Hamilton, Therapeutic Lead and Founder, Human Nature.

- Ms Jennifer Parke, Head of Operations, Human Nature.

Mr Andy Hamilton tendered the following document: 2023 Impact Report – Human Nature.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Ms Fay Jackson, Former Deputy Commissioner, Mental Health Commission of NSW & General Manager, Inclusion, Flourish Australia.

Ms Fay Jackson tendered the following document: Consumer Perspective, Lived Experience Expertise Peer Operated Services, Multi-disciplinary Teams Climate Emergency Prevention.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Mr Rob Curry, Executive Officer, North Coast Allied Health Association.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Mr Joel Orchard, Executive Director, WardellCORE.

The evidence concluded and the witness withdrew.

The public hearing concluded at 3:31 pm. The public and the media withdrew.

5.8 Tendered documents

Resolved, on the motion of Ms Suvaal: That the committee accept and publish the following documents tendered:

- Consumer Perspective, Lived Experience Expertise Peer Operated Services, Multi-disciplinary Teams Climate Emergency Prevention.
- 2023 Impact Report – Human Nature.

5.9 Site visit to Lismore Safe Haven

The committee visited Lismore Safe Haven to meet and discuss with staff:

- Leone Crayden, CEO
- Frances Pidcock, Clinical Operations Manager
- Fiona Lynch, Senior Clinician.

6. Other business

The committee noted correspondence regarding the attendance of Witness Q to appear at the regional public hearing in Lismore on the 13 February 2024.

Resolved, on the motion of Mrs Carter: That the committee write to Witness Q inviting them to provide evidence in camera at a future hearing, or to provide a confidential written submission.

Resolved, on the motion of Ms Suvaal: That Witness R be permitted to bring support persons whilst providing in camera evidence to the committee on 15 February 2024.

7. Adjournment

The committee adjourned at 5.01 pm until Wednesday 14 February 2024.

Holly Rivas
Committee Clerk

Minutes no. 19
Wednesday 14 February 2024

Portfolio Committee No. 2 – Health
Uniting Housing and Accommodation Support Initiative Plus (HASI+) Western Sydney at 10.50 am

1. Members present

Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Ms Suvaal

2. Apologies

Mr Buttigieg
Mr Donnelly
Ms Faerhmann
Mrs Taylor

3. Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

3.1 Site visit to Uniting Housing and Accommodation Support Initiative Plus (HASI+) Western Sydney

The committee visited the Uniting HASI+ Western Sydney and met with staff from Uniting and Western Sydney Local Health District, and consumers, including:

- Mr Antoni Yesudoss, Adult Community Mental Health Services Manager, Western Sydney Local Health District
- Mr Jason Sevil, General Manager, Mental Health Service, Western Sydney Local Health District
- Ms Daria Korobanova, Director Community, Mental Health Service, Western Sydney Local Health District
- Ms Chelsea Miller, Western Sydney Local Health District HASI+ Senior Clinician
- Ms Chantal Nagib Duffy, Head of Uniting Recovery, Uniting
- Ms Nirajah Mahendra, General Manager, Mental Health and Community Services, Uniting
- Dr Paul Phung, Clinical Director, Uniting
- Ms Mallika Ghandi, HASI+ Operations Manager
- Mr Aaron Buyers, HASI+ Clinician (CNC), Uniting
- MsLozza Devereuxx, Peer Support Worker, HASI+, Uniting.
- Resident.

4. Post-site visit deliberative

Resolved, on the motion of Mrs Carter: That the committee write and thank the resident for meeting with the committee.

5. Adjournment

The committee adjourned at 10.54 am until 15 February 2024.

Holly Rivas
Committee Clerk

Minutes no. 20
Thursday 15 February 2024
Portfolio Committee No. 2 - Health
Macquarie Room, Parliament House, Sydney at 8.46 am

1. Members present

Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Buttigieg (from 8.46 am until 10.40 am)
Mr Donnelly
Ms Faehrmann (from 9.45 am until 10.40 am) (from 11.06 am until 1.30 pm) (from 3.30 pm until 5.04 pm)
Ms Suvaal (from 9.00 am until 9.55 am) (from 10.50 am until 3.30 pm) (from 4.30 pm until 5.04 pm)

2. Apologies
Mrs Taylor

3. Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

3.1 Sequence of questions
Resolved, on the motion of Ms Suvaal: That the allocation of questions to be asked at the hearing be left in the hand of the Chair.

3.2 *In camera* hearing

The committee noted that it had previously agreed via email to take evidence in camera from the following witnesses:
- Witness R
- Witness S
- Witness T

The committee proceeded to take *in camera* evidence.

Persons present other than the committee: Emma Rogerson, Holly Rivas, Gerard Rajakariar, Andrew Ratchford, Cameron McEwan, Jaymie Pope, Shyamalika Heffernan.

Session 1
The witnesses were admitted.

The Chair made an opening statement regarding the proceedings and other matters.

The following witnesses were sworn and examined:
- Witness R
- Witness S
- Witness T

Witness T tendered a document.

The evidence concluded and the witnesses withdrew.

3.3 Public hearing
Witnesses, the public and the media were admitted at 9.55 am.

The following witnesses were sworn and examined:
- Ms Tara Hunter, Director, Clinical and Client Services, Full Stop Australia.
- Dr Karen Williams, Consultant Psychiatrist, Ramsay Clinic Thirroul.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:
- Ms Sharon Grocott, CEO, WayAhead.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:
- Mr William Campos, CEO, Independent Community Living Australia (ICLA).

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:
- Dr Trevor Chan, Chair, NSW Faculty, Australasian College for Emergency Medicine.
- Dr Clare Skinner, Immediate Past President & NSW Faculty Board Member, Australasian College for Emergency Medicine.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Dr Anna Brooks, Chief Research Officer, Lifeline Research Office – Government and Stakeholder Relations, Lifeline Australia.
- Dr Tara Hunt, Deputy Chief Research Officer, Lifeline Research Office – Government and Stakeholder Relations, Lifeline Australia.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mr Brett Collins, Coordinator, Justice Action.
- Ms Lillie Mellin, Mental Health Spokesperson, Justice Action.
- Mr Todd Davis, Solicitor in Charge, Mental Health Advocacy Service, Legal Aid New South Wales.
- Mr Callum Hair, Senior Solicitor, Mental Health Advocacy Service, Legal Aid New South Wales.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Cara Varian, CEO, NSW Council of Social Service (NCOSS)
- Ms Andrea Angeles, Policy Lead, NSW Council of Social Service (NCOSS).

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Angela Scarfe (via videoconference) Senior Policy Officer, Australian Association of Social Workers (AASW).
- Ms Kate O'Brien (via videoconference) Member, Australian Association of Social Workers (AASW).

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Anne Galloway, Mental Health Manager, HealthWISE New England North West.
- Ms Louise Ingall, Manager if Strategy Research and Engagement, HealthWISE New England North West.
- Mr Glen Cotter, Steering Group Member, Bega Valley Eurobodalla Suicide Prevention Collaborative.
- Ms Rebecca Grasso, Chair, Western Sydney Health Alliance.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Ms Deb Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Ministry of Health.
- Dr Brendan Flynn, Executive Director, Mental Health Branch, NSW Ministry of Health.
- Dr Murray Wright, Chief Psychiatrist, NSW Ministry of Health.

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 5.00 pm. The public and the media withdrew.

The Chair tendered the following document: Transcript – Portfolio Committee No. 2 – Health – Water, Housing, Homelessness, Mental Health, Youth, The North Coast, Wednesday 1 November 2023.

3.4 Tendered documents

Resolved, on the motion of Ms Suvaal: That the committee keep the document tendered by Witness T confidential.

Resolved, on the motion of Ms Faerhmann: That the committee accept the following document tendered: Transcript – Portfolio Committee No. 2 – Health – Water, Housing, Homelessness, Mental Health, Youth, The North Coast, Wednesday 1 November 2023.

4. Other business

Resolved, on the motion of Ms Suvaal: That:

- Correspondence between the committee and Witness Q, dated 13 February 2024, be kept confidential,
- The secretariat canvass dates in May 2024 for potential report deliberative dates, and
- The Chair's draft report be circulated to the committee two weeks prior to the report deliberative.

5. Adjournment

The committee adjourned at 5.04 pm until Thursday 23 February 2024 (Budget Estimates 2023 – 2024 hearing - Health, Regional Health, the Illawarra and the South Coast).

Holly Rivas
Committee Clerk

Draft minutes no. 23
Tuesday 28 May 2024
Portfolio Committee No. 2 - Health
Room 1136, Parliament House, Sydney, 10.02 am

1. Members present

Dr Cohn, *Chair*
Mrs Carter, *Deputy Chair*
Mr Buttigieg
Mr Donnelly
Ms Faehrmann – *via webex*
Ms Suvaal
Mrs Taylor – *via webex*

2. Acknowledgment of Country

3. Previous minutes

Resolved on the motion of Mr Buttigieg: That draft minutes no. 18, 19 and 20 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 15 September 2023 – Email from an individual, advising that they are unable to attend the mental health inquiry hearing on 22 September 2023.
- 19 September 2023 – Email from an individual, advising that they are unable to attend the mental health inquiry hearing on 22 September 2023 and suggesting witness D attend.
- 19 September 2023 – Email from Witness D, advising they are able to attend the mental health inquiry hearing on 22 September 2023.
- 12 February 2024 - Email from an individual, advising that Witness Q will not be appearing at the Lismore hearing for the Mental Health Inquiry on 13 February 2024.

- 12 February 2024 - Email from Witness T providing additional information to the committee in relation to the mental health inquiry.
- 13 February 2024 - Email from Witness P, providing additional information to the committee.
- 14 February 2024 - Email from Justice Action Mental Health Team, providing additional information to the committee ahead of their appearance at the mental health inquiry hearing on 15 February 2024.
- 14 February 2024 - Email from Dr Daria Korobanova, Director, Community Mental Health, providing a link to a document entitled 'HASI Evaluation' for the committee's information.
- 14 February 2024 - Email from Antoni Yesudoss, Uniting HASI+, providing additional information to the committee regarding its inquiry into mental health.
- 20 February 2024 - Email from Mr Luke Pidgeon, BlaQ, providing an update on the status of an answer to a question taken on notice on 17 November 2023.
- 20 February 2024 – Email from Witness P providing additional information and a transcript correction to the committee.
- 1 March 2024 - Email from Antoni Yesudoss, Western Sydney LHD thanking the committee for visiting Uniting HASI Plus as part of the mental health inquiry.
- 7 March 2024 - Email from Ms Louise Ingall, HealthWise New England North West, providing corrections to transcript from the mental health inquiry hearing on 15 February 2024.
- 13 March 2024 - Email from Witness T requesting transcript corrections in relation to the mental health inquiry.
- 13 March 2024 - Email from Ms Anne Galloway, Mental Health Manager, HealthWISE New England North West to committee, requesting transcript corrections for the 15 February 2024 hearing.
- 14 March 2024 - Government response to 'Report no. 63 Current and potential impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales'.
- 14 March 2024 - Email from Dr Tara Hunt, Lifeline, requesting transcript corrections for the mental health inquiry hearing on 15 February 2024.
- 17 March 2024 - Email from Witness R, providing additional information to the committee in relation to the hearing on 15 February 2024.
- 19 March 2024 - Email from Witness S, requesting a transcript correction in relation to the hearing on 15 February 2024.
- 19 March 2024 - Email from Ms Sandra Cappuccio, Australasian College for Emergency Medicine, requesting transcript corrections in relation to the mental health inquiry hearing on 15 February 2024.
- 27 March 2024 – Email from Witness R, providing additional information to the committee in relation to the hearing on 15 February 2024.
- 27 March 2024 – Email from Witness S providing additional information to the committee in relation to the hearing on 15 February 2024.
- 2 April 2024 - Email from Witness R, requesting transcript corrections from hearing on 15 February 2024.
- 4 April 2024 - Email from Ms Anne Galloway, Mental Health Manager, HealthWISE New England North West to the secretariat, advising of her wish to not proceed with transcript corrections after conversation with secretariat.
- 5 April 2024 - Email from Dr Evelyne Tadros, Chief Executive Officer, Mental Health Coordinating Council, to the secretariat, advising of the release of a paper entitled 'Mental Health Workforce Solutions: Towards a strategy for community-managed mental health in NSW' identifying recommendations.
- 7 April 2024 - Email from Ms Sharon Grocott, CEO, WayAhead, requesting transcript corrections for the 15 February 2024 hearing.
- 12 April 2024 - Email from Ms Bethany Bourke, Solicitor, on behalf of Broula King Enterprises alleging false and misleading statements were made at the 3 October 2023 hearing for the committee's inquiry into current and potential impacts of gold, silver, lead and zinc mining on human health, land, air and water quality in New South Wales.
- 14 April 2024 - Email from Mr Grant Mistler, to the committee, requesting that the scope of the mental health inquiry be expanded.

- 11 April 2024 - Email from Mr Brett Collins, Coordinator, Mental Health Team, Justice Action, to committee, advising of the release of a Justice Action report regarding the Mental Health Inquiry.
- 19 April 2024 - Email from Alice Batchelor, Systemic Advocacy and Engagement Officer, Physical Disability Council of NSW, to the committee introducing the Physical Disability Council of NSW.
- 29 April 2024 - Email from Dr Amanda Cohn MLC, Committee Chair, to the secretariat, forwarding correspondence from Ms Sharon Grocott, CEO, WayAhead.

Sent

- 1 March 2024 - Letter from Dr Amanda Cohn MLC, Committee Chair to Lismore Safe Haven thanking the organisation for hosting the committee on a site visit on 13 February 2024 as part of the mental health inquiry.
- 1 March 2024 - Letter from Dr Amanda Cohn MLC, Committee Chair to Uniting HASI Plus and an individual thanking the organisation for hosting the committee on a site visit on 14 February 2024 as part of the mental health inquiry.

Resolved, on the motion of Ms Suvaal: That the committee keep the following correspondence confidential, as per the recommendation of the secretariat, as it contains identifying and/or sensitive information:

- from an individual, advising that they are unable to attend the mental health inquiry hearing on 22 September 2023, dated 15 September 2023.
- from an individual, advising that they are unable to attend the mental health inquiry hearing on 22 September 2023 and suggesting witness D attend, dated 19 September 2023.
- from Witness D, advising they are able to attend the mental health inquiry hearing on 22 September 2023, dated 19 September 2023.
- from an individual, advising that Witness Q will not be appearing at the Lismore hearing for the Mental Health Inquiry on 13 February 2024, dated 12 February 2024.
- from Witness T providing additional information to the committee in relation to the mental health inquiry, dated 12 February 2024.
- from Witness P, providing additional information to the committee, dated 13 February 2024.
- from Witness P providing additional information and a transcript correction to the committee, dated 20 February 2024.
- from Antoni Yesudoss, Western Sydney LHD thanking the committee for visiting Uniting HASI Plus as part of the mental health inquiry, dated 1 March 2024.
- from Witness T requesting transcript corrections in relation to the mental health inquiry dated, 13 March 2024.
- from Witness R, providing additional information to the committee in relation to the hearing on 15 February 2024, dated 17 March 2024.
- from Witness S, requesting a transcript correction in relation to the hearing on 15 February 2024, dated 19 March 2024.
- from Witness R, providing additional information to the committee in relation to the hearing on 15 February 2024, dated 27 March 2024.
- from Witness S providing additional information to the committee in relation to the hearing on 15 February 2024, dated 27 March 2024.
- from Witness R, requesting transcript corrections from hearing on 15 February 2024, dated 2 April 2024.
- from Dr Amanda Cohn MLC, Committee Chair to Uniting HASI Plus and an individual thanking the organisation for hosting the committee on a site visit on 14 February 2024 as part of the mental health inquiry, dated 1 March 2024.

5. Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

5.1 Answers to questions on notice and supplementary questions – public

The committee noted that the following answers to questions on notice, supplementary questions and additional were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Mr Andy Hamilton, Therapeutic Lead and Founder, Human Nature, received 21 March 2024.
- Mr Joel Orchard, Executive Director, Wardell Core, received 21 March 2024.
- Ms Sonja Habenicht, Trauma Counsellor, Psychologist, Northern Rivers Women and Children's Services Inc, received 27 February 2024.
- Dr Tara Hunt, Deputy Chief Research Officer, Lifeline, received 13 March 2024.
- Mr Brett Collins, Coordinator, Justice Action, received 17 March 2024.
- Mr Peter List, Senior Business Partner, NSW Health received 18 March 2024.
- Ms Ally Dench, Program Manager, Western Sydney Health Alliance, received 18 March 2024.
- Ms Sandra Cappuccio, Policy Officer, Australasian College for Emergency Medicine, received 19 March 2024.
- Mr Callum Hair, Senior Solicitor, Mental Health Advocacy Service, Legal Aid, received 19 March 2024.
- Ms Angela Scarfe, Senior Policy Officer, Australian Association of Social Workers, received 21 and 25 March 2024.
- Ms Kelly Bannister, CEO Northern Rivers Women and Childrens Services, received 11 April 2024.
- Ms Sharon Grocott, WayAhead received 1 May 2024.

5.2 List of witnesses

Resolved, on the motion of Mrs Carter: That the committee keep the list of witnesses who provided in camera evidence confidential, as per the recommendation of the secretariat, as it contains sensitive/or identifying information.

5.3 Consideration of Chair's draft report

The Chair submitted her draft report entitled *'Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales* which, having been previously circulated, was taken as having been read.

Resolved, on the motion of Mrs Carter: That paragraph 1.2 be amended by inserting 'some' before 'psychosocial disabilities through the National Disability Insurance Scheme (NDIS)'.

Resolved, on the motion of Mrs Carter: That paragraph 2.5 be amended by omitting 'On the issue of climate change,' before 'the committee heard in depth about the increasing impact of natural disasters particularly the recent bushfires and floods, on mental health'.

Mrs Carter moved: That Finding 1 be amended by omitting 'and climate change' and inserting instead 'climate change anxiety and the impact of natural disasters'.

Question put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Mr Buttigieg, Mr Donnelly, Ms Faehrmann, Ms Suvaal.

Question resolved in the negative.

Resolved, on the motion of Ms Suvaal: That Finding 1 be omitted: 'Reform of the mental health system will require a whole-of-government approach which addresses social and environmental determinants of health including housing, cost of living, transport, education, employment and climate change', and the following new Recommendation be inserted instead:

> 'That the NSW Government undertake a whole of government reform approach to the mental health system, which addresses social and environmental determinants of health including housing, cost of living, transport, education, employment, climate change and impact of natural disasters.'

Ms Suvaal moved: That Recommendation 1 be amended by omitting 'make' before 'representations to the Australian Government' and inserting instead 'explore making'.

Question put.

The committee divided.

Ayes: Mr Buttigieg, Mr Donnelly, Ms Suvaal.

Noes: Dr Cohn, Mrs Carter, Ms Faehrmann, Mrs Taylor.

Question resolved in the negative.

Ms Suvaal moved: That Finding 2 be amended by omitting 'are' before 'significant barriers' and inserting instead 'can be'.

Question put.

The committee divided.

Ayes: Mr Buttigieg, Mr Donnelly, Ms Suvaal, Mrs Carter, Mrs Taylor.,

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Resolved, on the motion of Mrs Carter: That the following new Recommendation be inserted after paragraph 2.122:

'That the NSW Government look to initiatives that provide mental health care outside of traditional clinical settings, such as the Wellbeing and Health In-reach (WHIN) program which assist target populations to access appropriate mental health services'.

Resolved, on the motion of Mrs Carter: That Finding 3 be omitted 'The fragmentation of mental health funding and care in NSW through short-term grants and program funding has led to extraordinary difficulty for people and their carers to navigate and access appropriate care and exacerbated their distress, as well as contributing to inefficient use of limited resources' and the following two new findings be inserted instead:

'Finding x

The fragmentation of mental health services in NSW leads to extraordinary difficulties for mentally ill people and their carers to navigate and access appropriate services and care. This difficulty often exacerbates mental distress, and contributes to inefficient use of limited resources.

Finding x

Fragmentation of mental health funding in NSW through short term grants and program funding is a factor in the overall fragmentation of mental health services'.

Ms Suvaal moved: That Recommendation 2 be amended by omitting 'Health' and inserting instead 'Government and Federal Government'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Noes: Dr Cohn, Ms Faehrmann, Mrs Carter, Mrs Taylor.

Question resolved in the negative.

Resolved, on the motion of Ms Suvaal: That Recommendation 2 be amended by omitting 'Health' and inserting instead 'Government'.

Mrs Carter moved: That Recommendation 3 be omitted: 'That NSW Health enhance service and referral pathways and information sharing between State and Commonwealth Government agencies, non-

government and community-managed organisations, and private health care services to facilitate better access, affordability, and navigation of services, and to look to expand the employment of peer navigators to strengthen service navigation' and the following new recommendation be inserted instead:

'That NSW Health directs the Mental Health Commission to design and scope an electronic Mental Health record system within 6 months. The eMH record would be accessible to Medibank, Commonwealth Human Services, public health system, private and community mental health care providers. The records would only be accessible and shared when authorised by the patient, guardian or in the case of incapacity, an approved mental health officer.

Question put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann, Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Question resolved in the negative.

Ms Suvaal moved: That Recommendation 3 be amended by omitting 'enhance' before 'service and referral pathways' and inserting instead 'explore the enhancement'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Noes: Dr Cohn, Ms Faehrmann, Mrs Carter, Mrs Taylor.

Question resolved in the negative.

Ms Suvaal moved: That Recommendation 4 be amended by omitting 'include' before 'funding for the integration of programs' and inserting instead 'explore the inclusion of'.

Question put.

The committee divided:

Ayes: Mr Buttigieg, Mrs Carter, Mr Donnelly, Ms Suvaal, Ms Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Mrs Carter moved: That the following new recommendation be inserted after Recommendation 2:

Recommendation X

That NSW Health immediately funds, designs, and makes available a web-site which:

- Gathers all mental health services together in one place;
- Provides contact details for all services;
- Is up-dated every 3 months, to check accuracy and reflect feedback about accessibility and usability;
- Maps services delivery pathways';
- Is advertised widely;
- Is SEO optimised to be easily discoverable by searchers.

Question put.

The committee divided.

Ayes: Mrs Carter, Ms Taylor.

Noes: Mr Buttigieg, Dr Cohn, Mr Donnelly, Ms Faehrmann Ms Suvaal.

Question resolved in the negative.

Resolved, on the motion of Mrs Carter: That the following new recommendation be inserted after Recommendation 2:

Recommendation X

That the NSW Government ensure that the existing mental health service directories are widely publicised, updated every three months, and search engine optimised, as appropriate for the type of directory.

Ms Suvaal moved: That Finding 5 be amended by omitting 'are necessary' before 'for recruitment and retention of staff' and inserting instead 'can assist in the'.

Question put.

The committee divided.

Ayes: Mr Buttigieg, Mrs Carter, Mr Donnelly, Ms Suvaal, Ms Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Mrs Carter moved: That the following new recommendation be inserted after Finding 5.

Recommendation X

That the NSW Government addresses as a mater of urgency the concerns of clinicians with respect to their physical safety, and ensures that these are not masked by an increasing reliance on Telehealth.

Question put.

The committee divided.

Ayes: Mrs Carter, Ms Taylor.

Noes: Mr Buttigieg, Dr Cohn, Mr Donnelly, Ms Faehrmann Ms Suvaal.

Question resolved in the negative.

Resolved on the motion of Mrs Carter: That Finding 6 be amended by inserting ' and exercise physiologists' after 'pharmacists and dieticians'.

Mrs Carter moved: That Recommendation 6 be amended by inserting 'immediately' after 'That the NSW Government.'

Question put.

The committee divided.

Ayes: Mrs Carter, Ms Taylor, Dr Cohn, Ms Faehrmann.

Noes: Mr Buttigieg, Mr Donnelly, Ms Suvaal.

Question resolved in the affirmative.

Ms Suvaal moved: That Recommendation 6 be amended by inserting 'where industrially feasible' before 'increase'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Noes: Dr Cohn, Ms Faehrmann, Mrs Carter, Mrs Taylor.

Question resolved in the negative.

Ms Suvaal moved: That Recommendation 7 be amended by omitting 'increase resourcing' before 'for formal clinical supervision' and inserting instead 'map the feasibility of increased resourcing'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Noes: Dr Cohn, Ms Faehrmann, Mrs Carter, Mrs Taylor.

Question resolved in the negative.

Ms Suvaal moved: That Recommendation 8 be amended by omitting 'establish a caseload management system for clinicians in community mental health services to be able to work' and inserting instead 'explore mechanisms to enable the greater application of therapeutic services and discipline specific expertise to ensure clinicians are working'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly, Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Resolved, on the motion of Mrs Carter: That the following new recommendation be inserted after paragraph 3.113:

'Recommendation X

That the NSW Government urgently request the Federal Government provide HELP fee relief for mental health priority courses.'

Resolved, on the motion of Mrs Carter: That the following new recommendation be inserted after paragraph 3.113:

'Recommendation X

That the NSW Government provide fee free TAFE courses and qualifications in mental health care. The NSW Government facilitate relocation and housing for mental health care workers in the public system and address social and cultural barriers to relocation.

Ms Suvaal moved: That Recommendation 10 be amended by omitting 'to coordinate with the Australian Institute of Health and Welfare to provide' and inserting instead 'explore, with the Australian Institute of Health and Welfare, the provision of'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly, Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Mrs Carter moved: That Recommendation 11 be omitted: 'That the NSW Government advocate for the collection of data on gender and sexuality by the Australian Bureau of Statistics to assist with service referral and planning' and the following new recommendation be inserted instead:

'That the NSW Government investigate and implement the best means for the collection of data on gender and sexuality to assist with service referral and planning'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly, Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Mrs Carter moved: That Recommendation 12 be amended by inserting the following paragraph at the end of the existing recommendation:

'The development of role definitions should include a consideration of whether all people experiencing mental illness have the same peer assistance needs, or whether because of different experiences and presentations, different peer support needs will be required.'

Question put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann, Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Question resolved in the negative.

Resolved, on the motion of Mrs Carter: That paragraph 3.118 be amended by inserting at the end:

'The development of role definitions should include a consideration of whether all people experiencing mental illness have the same peer assistance needs, or whether because of different experiences and presentations, different peer support needs will be required.'

Ms Suvaal moved: That Recommendation 13 be amended by omitting 'commit' and inserting instead 'looks' before 'increase and maintain funding'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Noes: Dr Cohn, Ms Faehrmann, Mrs Carter, Mrs Taylor.

Question resolved in the negative.

Mrs Carter moved: That Recommendation 13 be amended by inserting 'Immediately' after 'That the NSW Government'.

Question put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor, Dr Cohn, Ms Faehrmann.

Noes: Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Question resolved in the affirmative.

Ms Suvaal moved: That Recommendation 14 be amended by omitting 'increase' and inserting instead 'explores the increase of'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly, Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Resolved, on the motion of Mrs Carter: That Recommendation 14 be amended by inserting the following paragraph at the end:

> 'All government funding is to be contingent on programs and services demonstrating that they meet agreed KPIs relating to mental health outcome, that their program or service has met and engaged successfully with a consumer need, and that this need is ongoing.'

Mrs Carter moved: That Recommendation 15 be omitted.

Question put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann, Ms Suvaal, Mr Buttigieg, Mr Donnelly,

Question resolved in the negative.

Mrs Carter moved: That Recommendation 15 be amended by omitting 'including consideration of payroll tax surcharges implemented in other jurisdictions'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly, Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Ms Suvaal moved: That Recommendation 15 be amended by omitting 'pursue' before 'innovative revenue streams' and inserting instead 'explore'..

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly, Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Resolved, on the motion of Ms Suvaal: That Recommendation 16 be amended by inserting 'additional' before 'provision of lower-stimulus'.

Ms Suvaal moved: That Recommendation 16 be amended by inserting 'look to' before 'support the provision'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly, Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Ms Suvaal moved: That Recommendation 21 be amended by omitting ‘expands’ before 'the Safe Haven Program' and inserting instead ‘explores expanding’..

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Noes: Dr Cohn, Ms Faehrmann, Mrs Carter, Mrs Taylor.

Question resolved in the negative.

Resolved, on the motion of Mrs Taylor: That Recommendation 21 be amended by inserting 'where feasible' after 'Safe Haven program to be a 24/7 service'.

Resolved, on the motion of Ms Suvaal: That Recommendation 22 be amended by inserting 'supported living services such as' before 'the Housing and Accommodation Support Initiative' and inserting 'PCLI' before 'programs'.

Ms Suvaal moved: That Recommendation 22 be amended by omitting 'invest in the expansion of' and inserting instead 'explores continued investment in'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Noes: Dr Cohn, Ms Faehrmann, Mrs Carter, Mrs Taylor.

Question resolved in the negative.

Mrs Carter moved: That Recommendation 23 be amended by omitting ‘return’ and inserting instead ‘map the feasibility of returning’ before 'the mental health line' and inserting 'including consideration of how local interests are best served and resource constraints on Local Health Districts' after 'all Local Health Districts'.

Question put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann, Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Question resolved in the negative.

Resolved, on the motion of Ms Suvaal: That Recommendation 25 be amended by inserting 'in conjunction with NSW Health’ before ‘NSW Police’.

Ms Suvaal moved: That Recommendation 25 be amended by omitting ‘be’ before 'activated as a secondary response' and inserting instead ‘explore being’.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly. Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Mrs Carter moved: That the following new recommendation be inserted after Recommendation 26:

'Recommendation X

That the NSW Government release the review into the policy of the response protocol of the NSW Police Force to acute, high risk mental health episodes. The review should include the consultations and engagement that informed the report.'

Question put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann, Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Question resolved in the negative.

Mrs Carter moved: That paragraph 4.177 be amended by omitting 'while' before 'many stakeholders were supportive' and omitting 'the committee notes that PACER is not currently funded past 2025 and that this is an opportunity for the NSW government to transition to a health-led approach'.

Question put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor, Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Ms Suvaal moved: That Recommendation 27 be amended by omitting 'implement' and inserting instead 'continue to explore the implementation of' and inserting 'and PACER' after 'Western Sydney Mental Health Acute Assessment Team'

Mrs Carter moved: That the motion of Ms Suvaal be amended by omitting 'the implementation of'.

Amendment of Mrs Carter put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor,

Noes: Dr Cohn, Ms Faehrmann, Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Amendment of Mrs Carter resolved in the negative.

Original question of Ms Suvaal put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor, Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Noes: Dr Cohn, Ms Faehrmann.

Original question of Ms Suvaal resolved in the affirmative.

Mrs Carter moved: That Recommendation 27 be omitted 'That the Government implement a health-led response to mental health emergencies, informed by the experiences of the successful South Australian Mental Health Co-Responder program and the Western Sydney Mental Health Acute Assessment Team, including informed risk assessment through access to medical records, as well as support for carers of the person experiencing crisis' and the following new recommendation be inserted instead:

'That the NSW Government reviews its decision to cease funding the PACER program in the light of the review into the policy of the response protocol of the NSW Police Force to acute, high risk mental health episodes'.

Question put.

The committee divided.

Ayes: Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann, Ms Suvaal, Mr Buttigieg, Mr Donnelly

Question resolved in the negative.

Ms Suvaal moved: That Finding 16 be omitted 'Community treatment orders are being overused and misused in New South Wales to better ensure access to care in the context of an under-resourced community mental health system that is unable to support people voluntarily' and the following new finding be inserted instead:

> 'In the context of an under-resourced community mental health system, community treatment orders have the capacity to be overused or misused to involuntarily facilitate engagement in care'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly, Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Ms Suvaal moved: That Recommendation 29 be amended by inserting 'review capacity to' before 'increase support to patients'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly.

Noes: Dr Cohn, Ms Faehrmann, Mrs Carter, Mrs Taylor.

Question resolved in the negative.

Ms Suvaal moved: That Finding 18 be omitted 'The statutory presumption of duration of a community treatment order is in favour of the maximum period of time which undermines the principle of least restrictive care and treatment under the Mental Health Act 2007'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly, Mrs Carter, Mrs Taylor.

Noes: Dr Cohn, Ms Faehrmann.

Question resolved in the affirmative.

Resolved, on the motion of Ms Suvaal: That Recommendation 30 be omitted 'That the NSW Government amend the *Mental Health Act* 2007 to reduce the standard period of a community treatment order to six months if not specified, and consider additional amendment to ensure that community treatment orders are only used as the least restrictive means of providing care in the community, as intended' and the following new recommendation be inserted instead:

> **Recommendation x**
>
> That the NSW Government reviews the Mental Health Act 2007 with regard to community treatment orders and the overriding principal as least restrictive means of providing care.

Ms Suvaal moved: That Recommendation 31 be amended by inserting 'assess what is required to' before 'adequately fund the digitisation'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly,

Noes: Dr Cohn, Ms Faehrmann, Mrs Carter, Mrs Taylor.

Question resolved in the negative.

Ms Suvaal moved: That Recommendation 33 be amended by omitting 'adequately' and inserting instead 'assess what' before 'resource community mental health services' and inserting 'require' before 'to assertively follow up patients'.

Question put.

The committee divided.

Ayes: Ms Suvaal, Mr Buttigieg, Mr Donnelly,

Noes: Dr Cohn, Ms Faehrmann, Mrs Carter, Mrs Taylor.

Question resolved in the negative.

Resolved on the motion of Ms Suvaal: That the following new recommendation be inserted after paragraph 2.122:

'Recommendation X

'That the NSW Government consider establishing a centre of excellence for research, training, clinical supervision and support, in order to deliver specific evidence based therapies in trauma informed care.'

Resolved on the motion of Mr Donnelly: That:

The draft report as amended be the report of the committee and that the committee present the report to the House;
The transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry be tabled in the House with the report;
Upon tabling, all unpublished attachments to submissions be kept confidential by the committee;
Upon tabling, all unpublished transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry, be published by the committee, except for those documents kept confidential by resolution of the committee;
The committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;
The committee secretariat be authorised to update any committee comments where necessary to reflect changes to recommendations or new recommendations resolved by the committee;
Dissenting statements be provided to the secretariat within 24 hours after receipt of the draft minutes of the meeting;
The secretariat is tabling the report on Tuesday 4 June 2024;
The Chair to advise the secretariat and members if they intend to hold a press conference, and if so, the date and time.

6. Adjournment

The committee adjourned at 11.58 pm until Tuesday 11 June 2024 (Budget Estimates 2023 – 2024 Portfolio Committee 2 - Report Deliberative).

Holly Rivas
Committee Clerk

Appendix 4 Dissenting statements

Dr Amanda Cohn BA BMed MD MPH MIPH FRACGP MLC, The Greens

A number of key recommendations of this inquiry were supported unanimously. It's a testament to both the scale of the change that is needed in the mental health sector, as well as the quality of evidence heard by the committee, that so many recommendations have tripartisan support.

The Greens dissent from this report on a small number of important matters.

It is astonishing that the government and opposition were not able to agree that safe workloads for clinicians working in public mental health services, as well as remuneration that reflects their skills and the challenges of their roles, are necessary for recruitment and retention of staff. Similarly, they agreed to remove the recommendation to establish a caseload management system for clinicians in community mental health services. It is clear that unsafe caseloads are contributing to poor quality care and inability to provide assertive outreach as well as staff burnout.

Seven important recommendations were watered down by the Labor government, with the support of the Liberal/National opposition, so that instead of implementing these changes, the government is only recommended to "explore" them. It's gutless for the government to water down recommendations so that they are able to say they've been implemented when they consider or explore something (and potentially then recommit to the status quo!).

This committee has done the work of exploration and consideration during the inquiry process. The evidence is clear and unanimous that funding cycles shorter than 5 years leave community and not-for-profit organisations in a desperate cycle of constantly using their resources to apply for funding, and unable to give their staff job security or opportunities for growth. Increasing funding cycles to five years has already been implemented in some government departments and was consistently recommended throughout the inquiry.

Similarly, the evidence was both unanimous and compelling that police should not be primary responders to mental health emergencies - from consumers and carers, from service providers, mental health professionals and from the police themselves. People experiencing a mental health crisis need care, not law enforcement. The committee examined in detail successful health-led alternatives such as the South Australian Mental Health Co-Response program.

This is not the time for further investigation, exploration, or consideration. The time for this reform is now.

We owe it to the people who were retraumatised by telling us their stories to take the urgency of this reform seriously. 52 people experiencing mental health distress died in interactions with NSW Police during the past 5 years. How many more people will come to harm while the government "continues to explore" the implementation of a health-led response to mental health emergencies? The Greens will not stop advocating for this until it is implemented across NSW.