PORTFOLIO COMMITTEE NO. 2 - HEALTH

Tuesday 3 September 2019

Examination of proposed expenditure for the portfolio areas

MENTAL HEALTH, REGIONAL YOUTH AND WOMEN

UNCORRECTED

The Committee met at 9:30.

MEMBERS

The Hon. Greg Donnelly(Chair)

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Emma Hurst (Deputy Chair)
The Hon. Rose Jackson
The Hon. Trevor Khan
The Hon. Natasha Maclaren-Jones
The Hon. Tara Moriarty
The Hon. Walt Secord

PRESENT

The Hon. Bronnie Taylor, *Minister for Mental Health, Regional Youth and Women*

CORRECTIONS TO TRANSCRIPT OF COMMITTEE PROCEEDINGS

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

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

The CHAIR: Welcome to the public hearing for the inquiry into budget estimates 2019-2020. Before I commence I acknowledge the Gadigal people, who are the traditional custodians of this land. I also pay respect to the Elders past and present of the Eora nation and extend that respect to other Aboriginals who may be present now or later today. I welcome Minister Bronnie Taylor to her first budget estimates—I am sure it will be a successful one—and accompanying officials to this hearing. Today the Committee will examine the proposed expenditure for the portfolios of Mental Health, Regional Youth and Women. Today's hearing is open to the public and is being broadcast live via the Parliament's website.

In accordance with the broadcasting guidelines, while members of the media may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that you must take responsibility for what you publish about the Committee's proceedings. The guidelines for the broadcast of proceedings are available from the Committee secretariat. All witnesses in budget estimates have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In these circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days.

Any messages from advisers or members' staff seated in the public gallery should be delivered through the Committee secretariat. Minister, I remind you and the officers accompanying you that you are free to pass notes and refer directly to your advisers seated at the table behind you. Transcripts of his hearing will be available on the web from tomorrow morning. Finally, could everyone please turn their mobile phones to silent for the duration of the hearing. All witnesses from departments, statutory bodies or corporations will be sworn prior to giving evidence. Minister, I remind you that you do not need to be sworn as you have already sworn an oath to your office as a member of Parliament.

ANTHONY BODY, Acting Executive Director, Regional NSW, Department of Planning, Industry and Environment, affirmed and examined

STEVE ORR, Acting Deputy Secretary, Regional NSW, Department of Planning, Industry and Environment, affirmed and examined

PHIL MINNS, Deputy Secretary, People, Culture and Governance, NSW Health, sworn and examined

ELIZABETH KOFF, Secretary, NSW Health, sworn and examined

NIGEL LYONS, Deputy Secretary, Health System Strategy and Planning, NSW Health, sworn and examined

MURRAY WRIGHT, Chief Psychiatrist, NSW Health, sworn and examined

SIMONE WALKER, Deputy Secretary, Strategy Policy and Commissioning, Department of Communities and Justice, sworn and examined

MELINDA NORTON, Director, Women NSW, Department of Communities and Justice, affirmed and examined

The CHAIR: Thank you all for coming along. I declare the proposed expenditure for the portfolios of Mental Health, Regional Youth and Women open for examination. Questioning of this portfolio begins now. All witnesses including the Minister will be questioned in the morning session. After the lunch break we will continue questioning government witnesses. The Minister will not be questioned in the afternoon and evening sessions. Minister, there is no provision for any witnesses to make an opening statement before the Committee commences questioning so we will begin our questioning with the Opposition.

The Hon. TARA MORIARTY: Good morning, Minister. Of the current Mental Health budget can you tell us how much is allocated to acute services and how much is allocated to community-based services?

The Hon. BRONNIE TAYLOR: As I have said before, the entire Mental Health budget is $2.1 billion for current investment in the 2019-2020 budget for mental health services, which focuses on improving the lives of people living in New South Wales with mental illness by delivering better care in hospital, better care in community-based services for their families, for their carers and in the community. We have got multiple funding initiatives including $103 million in 2019-20 as part of the statewide 10-year mental health reform plan, including $7.7 million to expand specialist community-based older people's mental health services. This investment will help meet the needs of our ageing population and deliver improved mental health care and support.

We have also got over $5.2 million to expand mental health residential aged-care partnership services to assist long-stay mental health patients with aged-care needs to transition to the community under stage one of the Pathways to Community Living Initiative. It also includes approximately $2 million for non-government aged-care providers and approximately $3.2 million for specialist clinical mental health services provided by local health districts. We have a really exciting announcement as well in terms of community spend with over $5 million being invested in eating disorder services throughout New South Wales. I think this is a really good announcement and clearly demonstrates that the Government sees this as a priority area. We know that there is a rising incidence in that area, particularly in young women. That has been a really great investment as well.

The budget also incorporates $19.7 million for suicide prevention. Over $19 million of that money will be directed into this year's budget into phase one of the Suicide Prevention Plan—another really good initiative demonstrating that the Government sees this as an absolute priority; it is also one of the Premier's Priorities to reduce suicide. In addition to that, there has been $23.5 million over four years to expand the capacity of Lifeline and Kids Helpline. I am really excited about this initiative because I think one of the things that we know with young people is that they are really comfortable with text messaging and phones and screens, and one of the trial parts of this project, of this funding, will be looking at SMS messaging as a means of communicating. I will be really excited to see how that progresses and if that is, in fact, as successful as we are really hopeful that it will be. That is a really great initiative as well.

We are also looking at Project Air, which is funded $1.1 million per annum from 2017-18. This is a terrific project that is run currently within a lot of our schools and it looks at young people with multiple personality disorders. That is a really great initiative as well. We have support for peer workers. In the mental health sector it is really impressive, I have found, that they are very, very progressive in terms of using peer workers and in using people with lived experience in their facilities. I think this is a terrific initiative and it is something that we are hearing back from consumers that they are really positive about because they can relate to someone who has had a lived experience. We have provided $2.7 million per annum in the Peer Supported

Transfer of Care, which will be really good and will allow us to deliver a framework and support for peer support workers out there. Definitely, as I said, on the ground the results and the anecdotal evidence that I am hearing are extremely positive in that department. Also, as part of our expenditure, we are investing $700 million in the statewide mental health capital infrastructure program, with $20 million going towards that this year in planning phases. We have some very exciting initiatives coming out of that as well. This is a record spend in Mental Health. It is the most that has ever been spent in terms of capital infrastructure and in terms of ongoing costs. I think that is a really good thing. Those are some of the things we are doing with the Mental Health budget. There is so much more but, yes, I am happy to keep going.

The Hon. TARA MORIARTY: No, that is okay. I have plenty more questions about how the money is being spent. As a side question from that, you just mentioned some funding in the aged-care sector regarding mental health. Last night in a news story we were advised that certain members of the public were living in government-provided dementia facilities or aged-care facilities and sharing the facility with murderers who should otherwise be in jail. Are you responsible for that?

The Hon. BRONNIE TAYLOR: In 2007, when the Labor Government was in power, it established the Mental Health Review Tribunal to ensure that an independent assessment of mental health clients would be undertaken and ensure the safety of the community and the safety of the patients themselves. The Mental Health Review Tribunal is comprised of expert people who provide expert advice, according to the legislation. It deals with situations such as this. I have great confidence in the Mental Health Review Tribunal. I think it was a great initiative. Are you saying that perhaps it should not be an independent body, with the Mental Health Review Tribunal?

The CHAIR: I do not want to cut the Minister off but that response was reduced to a personal pronoun "you".

The Hon. BRONNIE TAYLOR: I beg your pardon, Chair.

The CHAIR: The honourable member was not in Parliament at the time. I think the Minister should configure the answer. Also it is not up to the Minister to be asking questions of a member around the table. This is budget estimates.

The Hon. BRONNIE TAYLOR: I understand, but if I may finish? I may ask the Chief Psychiatrist, Dr Wright, if he would like to comment further on the Mental Health Review Tribunal and the processes by which it undertakes these comprehensive assessments.

Dr WRIGHT: Thank you. Obviously I cannot speak about a specific case, but I think in terms of a process the tribunal has oversight of all people who are considered under the forensic provisions of the New South Wales Mental Health Act. When people are in custody and are determined to be forensic patients there are dual processes. One includes the importance of them receiving treatment for whatever their condition is. It is actually quite important that there be a very carefully scrutinised transition towards the end of a custodial sentence for someone to go back into the community. You can appreciate that someone who has a mental illness or cognitive impairment, if that transition is not carefully managed that could have catastrophic consequences.

The role of the tribunal in that is to bring an independent set of expertise to determining whether the person is fit to be transitioned from a fully custodial environment into a non-custodial environment and has a conditional release. It is important that the conditional release occurs because if, for some reason, the risks have not been fully appreciated, the tribunal has very significant powers to be able to re-detain someone or take them back into custody if there are any problems whatsoever. It is actually one of the safest ways to achieve that transition process from being in a custodial environment into a community environment.

The Hon. TARA MORIARTY: I do not want to interrupt you. I accept what you are saying in that regard and I know that you cannot talk about individual situations. But my understanding of this situation is that some of these prisoners—one of them has over a decade left on his sentence and yet he has been living in this facility alongside unknowing members of the public and their families were not aware of this. He is not transitioning back into the community. In fact, he has been let out of jail to live in the community next to very vulnerable people. Are you comfortable with that? Is that really something that the Government supports?

The Hon. BRONNIE TAYLOR: I might ask Dr Lyons to comment if that is alright.

Dr LYONS: I am happy to assist, Minister. I will make a couple of comments in addition to what the Minister and Dr Wright have indicated. The tribunal has quite rigorous statutory tests that decide whether or not conditional release is appropriate. That is under sections 43 and 74 of the Mental Health Act 1990. Basically, that requires the tribunal to be satisfied, on the evidence available to it; that the safety of the patient or any member of

the public will not be seriously endangered by the patient's release; that other care of a less restrictive kind that is consistent with safe and effective care is appropriate and reasonably available to the patient or that the patient does not require care; and (c) that the person has served sufficient time in custody already.

The tribunal must also have regard to a report from a psychiatrist or other appropriate expert who is not involved in treating the forensic patient. There is that independent assessment clinically. There has to be an assessment of the person or any member of the public that they are not a serious endangerment by the person's release. In that process there is a very rigorous assessment clinically including not just from the treating team but also independently of the treating team. Furthermore, the site where the person is going to be conditionally released to is involved in making the assessment to ensure that the care they can provide is appropriate and that it will be safely delivered and there is no compromise to any other person's safety in the process. In 2017 the Government commissioned an independent review of the Mental Health Review Tribunal and its role. The Hon. Anthony Whealy, QC, undertook that review. He actually made some comments in relation to this area and in regard to forensic patients. At page 33 of the report, he said:

> The review considers that the legislative test for leave and release is appropriate and that the tribunal applies a rigorous approach to assessing risk and safety making decisions on leave and release conservatively and responsibly.

The Hon. TARA MORIARTY: I direct this question to the Minister but I am happy for the other witnesses to answer. I have just asked about three convicted murderers who are living with vulnerable members of the community in government-run facilities. First of all, Minister, are you comfortable with that? Secondly, how many more people who have been convicted of serious crimes are living in these kinds of circumstances in the community?

The Hon. BRONNIE TAYLOR: As has been said by Dr Lyons and by Dr Wright, what happens is that there is a comprehensive assessment done by the Mental Health Review Tribunal, and the staff at the facility accepting these people are also spoken with. Based on this level of expertise, a decision is then in the best interests of everyone, to ensure the community is safe and to ensure the patient is safe.

The Hon. WALT SECORD: Minister, this was an explosive story on Channel 7 last night. Are patients in that nursing home safe or not—yes or no?

The Hon. BRONNIE TAYLOR: I thank the Hon. Walt Secord for his question. I will not be commenting on specific instances that are raised in a news report. I think that the answer—

The Hon. WALT SECORD: You were asked yesterday to comment—

The Hon. BRONNIE TAYLOR: I would like to finish.

The Hon. WALT SECORD: You were asked yesterday to comment and you refused.

The CHAIR: Order!

The Hon. WALT SECORD: You were asked to comment yesterday—

The Hon. BRONNIE TAYLOR: Please do not raise your voice and point your finger at me.

The Hon. WALT SECORD: You have a responsibility to protect elderly patients.

The CHAIR: Order!

The Hon. TREVOR KHAN: Point of order: The Minister was answering the question—

The Hon. WALT SECORD: No, she was not.

The CHAIR: Order!

The Hon. TREVOR KHAN: The Minister was answering the question and was interrupted by the Hon. Walt Secord. He should allow the Minister to answer her question uninterrupted and then ask his next question if he is dissatisfied with it.

The Hon. WALT SECORD: I am very dissatisfied. The Minister has not answered the question.

The CHAIR: Order!

The Hon. WALT SECORD: Are patients safe in that facility—yes or no?

The CHAIR: Order! It is not "she"; it is the Minister.

The Hon. WALT SECORD: I am sorry.

The CHAIR: The Minister.

The Hon. BRONNIE TAYLOR: Thank you, Chair. As I was saying, the Mental Health Review Tribunal makes a decision. I have all confidence in the Mental Health Review Tribunal and the decisions it is making. This was a story on the Channel 7 news report. I will take advice from the Mental Health Review Tribunal. If the Hon. Tara Moriarty would like anyone to comment further, I am very happy for them to do so.

The Hon. TARA MORIARTY: No. Just one more follow up question on that. So you mentioned that people were consulted following the decision of the tribunal. Were the people living in the facility consulted or were their families, if they were not able to make decisions, consulted on who these residents would be living with?

The Hon. BRONNIE TAYLOR: I might ask Dr Lyons to comment on that question. My understanding is that the Mental Health Review Tribunal and the facility are both consulted.

Dr LYONS: That is correct. And the facility would have been involved in making an assessment about whether it was an appropriate environment, based on the conditions of those prisoners as to whether or not they were able to be cared for safely and that the care of other residents would not be compromised in the process. The facility that they are living in is a specialist aged-care facility that actually provides care to some of the most vulnerable elderly people in our community, mostly those who have behavioural disturbances as a result of ageing processes and dementia, and that there are many of those patients who live in that facility. We provide a whole range of additional supports over and above what is usually provided into a residential aged-care facility to provide that care, including oversight of specialist geriatricians, specialist psychogeriatricians who have a responsibility to look not only at the aged-care side of things but also at the mental health side of things and the teams that actually support them.

There is actually a process under the tribunal for ongoing monitoring of the care that is provided. So, as Dr Wright indicated, if at any stage there is a concern or a change in the person's condition that means that the conditional release has to be altered. Then at that stage that care can be provided back in Long Bay in the aged-care services. So there is an ongoing process of assessment to ensure that that environment continues to be safe and that the care is appropriate and that the other residents are safe as well. Having said that, I indicated that this is a specialist facility. There are many similar types of patients with behavioural disturbances, and that whole unit is designed around ensuring that the needs of all of those residents are carefully managed to keep them all safe from each other and in an appropriate environment.

The Hon. WALT SECORD: Dr Lyons, how many more convicted murderers are in nursing homes in New South Wales? You said there are other situations like that? How many others are there?

Dr LYONS: As I talked about in relation to Garrawarra, which is the recognised mental aged-care facility, there are many other residents who are not under the circumstances that we are talking about here.

The Hon. WALT SECORD: But convicted criminals in nursing homes?

Dr LYONS: That is not what I was mentioning.

The Hon. WALT SECORD: What were you saying?

Dr LYONS: I am talking about people who live in the community, who get old and have behavioural disturbances which means that they are required to be in a specialist facility like Garrawarra.

The Hon. WALT SECORD: I think "murderer" is a behavioural disturbance. Is that right? You are using euphemisms here.

Dr LYONS: I was talking about residential aged care and the ageing process generally, and the fact that these facilities are provided to many other elderly people, including the two people who were mentioned in the news report.

The Hon. WALT SECORD: But you have not got to the core question: Are the residents into that nursing home safe?

Dr LYONS: So that would be an ongoing assessment by the clinical teams. If there was any concern about safety of any individual or other residents then appropriate action would be taken, including through the Mental Health Review Tribunal.

The Hon. WALT SECORD: I put it to you that we are only talking about this because Channel 7 ran an explosive report last night. You would have ignored it otherwise.

The Hon. BRONNIE TAYLOR: "Explosive report" is in your words, Mr Secord.

The Hon. WALT SECORD: I think everyone in the community would say this is explosive.

The Hon. BRONNIE TAYLOR: As we have said very clearly—

The Hon. TREVOR KHAN: Point of order: I understand that budget estimates are robust but, for a start, the rules with regard to the treatment of witnesses that were adopted in 2019 provide that witnesses are to be treated with courtesy. That is No. 19 of those rules.

The Hon. WALT SECORD: And I am doing that.

The CHAIR: Order!

The Hon. TREVOR KHAN: And the second point is, again, witnesses are entitled to answer without being interrupted by the Hon. Walt Secord.

The CHAIR: I think we know how this goes: question followed by answer followed by question.

The Hon. WALT SECORD: Yes. The question is simple: Are residents in the nursing home in Waterfall, with two convicted murderers in their midst, safe? Yes or no?

The Hon. BRONNIE TAYLOR: Those people have been assessed by the Mental Health Review Tribunal to be able to be where they are and we have faith in the system of the Mental Health Review Tribunal, which was established under your Government in 2007.

The Hon. TARA MORIARTY: Minister, just going back to my question, so obviously you support the fact that there are murderers living in the community with vulnerable dementia patients.

The Hon. BRONNIE TAYLOR: That is not what I said.

The Hon. TARA MORIARTY: How many more people are in this situation?

The Hon. BRONNIE TAYLOR: What I said is that there is a complex and comprehensive system by which people with mental health issues are evaluated and assessed by experts, as Dr Wright previously said. So these people have been assessed by the independent body of the Mental Health Review Tribunal that was established in 2007 to undertake this procedure. They have done that. They negotiate with the facility about the care and needs of these people. Dementia is a complex issue and it is one that we know can be completely and utterly devastating to families. We have assessed this through the independent process.

The Hon. TARA MORIARTY: Minister, how many more people are in this situation? How many more convicted murderers or violent criminals are living in community facilities with vulnerable people?

The Hon. BRONNIE TAYLOR: The people that are living in facilities have been assessed independently by the Mental Health Review Tribunal.

The Hon. TARA MORIARTY: How many? How many are there?

The Hon. BRONNIE TAYLOR: I would have to take that on notice.

The CHAIR: Let us take it on notice. There are still about 20 seconds left.

The Hon. WALT SECORD: She does not know. Minister, you do not know how many convicted murderers are in nursing homes in New South Wales—

The Hon. TREVOR KHAN: Point of order—

The Hon. WALT SECORD: —other than the two exposed by Channel 7 last night?

The Hon. TREVOR KHAN: Point of order: At the commencement, the Chair indicated that witnesses are entitled to take questions on notice and the witness has done precisely that. It is inappropriate for the Hon. Walt Secord to, in essence, flout what the Chair has already said the witness is entitled to do—that is, take the matter on notice.

The CHAIR: Time has run out. I am not quite sure whether, if the Hon. Walt Secord had completed his question, it would have been at variance to what in fact had been taken on notice. But be that as it may, the time has expired. So we will now move onto the crossbench and start with the Deputy Chair, the Hon. Emma Hurst.

The Hon. EMMA HURST: Good morning, Minister. Vets are four times more likely to commit suicide compared to the general population, with one vet taking their own life every 12 weeks according to the Australian

Veterinary Association. A lot of this has to do with working with unhealthy animals, having to euthanise healthy animals. What is the Government doing to address this mental health crisis within the vet profession in New South Wales, noting the unique stresses and demands of being a vet as distinct from other jobs?

The Hon. BRONNIE TAYLOR: I thank you very much for your question, Ms Hurst, and I congratulate you on being Deputy Chair of this Committee. I had the great privilege of sitting on the New South Wales veterinary board for a number of years before I entered Parliament. I actually spoke about vets in my maiden speech. I think they are an incredible bunch of individuals that are highly cerebral, highly scientifically based and do a tremendous job. They are particularly important and very valuable members in rural and regional communities because of the nature of the work that they do. My understanding of recently speaking on the ground is that many vets are under a lot of pressure in terms of the drought and the devastating impact that it is having across the regions and in terms of animal welfare, which can often be absolutely soul destroying as to what is happening out there because of our lack of rain at the moment.

We actually have looked at a demand-driven drought resilience support fund, which will be established within the Department of Primary Industries, and the Rural Assistance Authority and Local Land Services will distribute grants to drought-affected communities for any program that supports mental health—and that includes vets. I would like to assure the Hon. Emma Hurst that this is at the forefront of my mind. I will have regular contact with the New South Wales veterinary board to make sure that our vets are okay and that they are receiving the support that they need, and particularly in those areas. I think it is a very good question and it is something that really is—and I say this very genuinely—at the forefront of my mind, and we are looking through our mental health strategy in terms of drought support funding. We are looking at ways, at the moment, that we can look to support them better.

The Hon. EMMA HURST: I know that you are talking about the drought and vets working in rural areas, but this is actually something that affects vets—

The Hon. BRONNIE TAYLOR: All vets.

The Hon. EMMA HURST: Yes, all vets. So people even just working with small, domesticated, companion animals. Is anything being done in that area as well?

The Hon. BRONNIE TAYLOR: Sorry, I always get a bit diverted to rural and regional matters. Yes, there is. We know that suicide is a big issue in our community and so that is why we have implemented the suicide prevention plan, in which we are investing $87 million in total and over $19 million this year in phase one. It is also one of the Premier's Priorities to reduce suicide in New South Wales by 20 per cent. In this year's budget there will be $19.7 million, in exact terms, to support that. What we will be looking at generally in terms of suicide prevention is the elimination of suicide and suicide attempts by people already in care in the mental health system; also, expansion of after-care services. What we know with suicide attempts—I will ask Dr Wright to comment further—but one of the really important things that we do know that is demonstrated by clinical evidence that if people have intents of suicidal behaviour and they have intent to harm themselves, if we can stop that thought process, even just before they may look at attempting the act, we can have a lot of success.

The Hon. EMMA HURST: Sorry to stop you, Minister. In regard to the unique stresses and demands for vets—obviously there are some great programs being put forward in regard to suicide in general—I am wondering what is being done for those particular people? A lot of this is related specifically to the demands of their work.

The Hon. BRONNIE TAYLOR: Vets and all professions will be captured in the suicide prevention strategy. We have to look across the board at all issues. In terms of vets, as I said, I can assure you it is forefront in my mind. When we are looking at a whole of suicide prevention approach, we need to look at the whole picture. Yes, there are unique things to vets, there are unique things to doctors, there are unique things to horticulturists, but what we need to do is to look across broadly and we can learn from each of them. We will definitely be learning stressors that are faced by vets. I imagine they will have some similar stressors to doctors, nurses and human health professionals.

The Hon. EMMA HURST: But they do have a much higher suicide rate compared to those occupations.

The Hon. BRONNIE TAYLOR: They do. We will be looking at that through the suicide prevention strategy, absolutely. Dr Wright, do you want to comment any further on that?

Dr WRIGHT: Yes, I am happy to. You raise an important point. There are similarities amongst the professions and I think some of the issues are around that are vets are particularly empathic towards their patients and the families, and they are often working in relative isolation. There has been an increasing awareness over the

last decade or so that the professions that we do not usually see as being vulnerable to depression and anxiety are actually quite vulnerable. They are perfectionistic in terms of their approach to work and because of that plus their empathic approach means that when they have a bad outcome that can be enormously distressing. They are also running small businesses, and that is a challenge. They often have relative isolation from their peers. It is similar to other professional groups like dentists and medical practitioners and lawyers, as a matter of fact.

They are all people who are fairly demanding of themselves and do not necessarily take failure terribly well. When they have a bad outcome that vulnerability is there. I think the very fact that you are raising it reflects that there is an increasing community awareness, which is one of our biggest barriers. So people can be aware that, even though they are outwardly in a successful profession, they could have a particular vulnerability and they need to access those services or people close to them need to encourage them to access services. I think, as the Minister was saying, much of what is in the suicide prevention strategy tries to make those services more accessible and more available continuously for people, including our professions.

The Hon. EMMA HURST: Just switching to your capacity as Minister for Women but still talking about vets, you would be aware that the veterinary profession is dominated by women. The 2018 statistics show that the profession is 67 per cent female. These are very high-achieving women that have studied for over five years to get their degrees and do very stressful work saving the lives of beloved animals. Despite that, the average salary for vets is less than $80,000 per year and there remains a significant gender pay gap between male and female vets. What is the New South Wales Government doing to support female vets and to reduce that gender pay gap for vets?

The Hon. BRONNIE TAYLOR: It is really fascinating how the majority of vets coming through now are women and how disproportionate that is as opposed to how it was years ago. I know particularly at Charles Sturt University we have quite a lot to do with the student vets and it is an interesting phenomenon. I think it is great; I think it is fantastic that women are embracing the profession of veterinary science. In terms of the gender pay gap in terms of vets, a lot of vets work out of a private practice so it is not a fee regulated by the Government. I will ask Ms Walker to expand on that.

Ms WALKER: I think one of the best opportunities we have when we are thinking about the gender pay gap, whether it relates to vets or other professions where women are dominant, is the work that we are doing to track that.

The CHAIR: Could you move the microphone closer?

Ms WALKER: As I was saying, I think the opportunity we have, whether it relates to vets or other professions dominated by women, is to ensure that we are tracking the gender pay gap because part of it is there is an awareness raising that we need to do that this exists. While people look to women in those professions as being stand-outs, as having really solid educations and really great qualifications, there is not an awareness of the difference in pay levels. There is significant work being done inside the Government about acknowledging the pay gap and tracking it, especially for women in senior leadership roles. We see that inside the Government and outside the Government. It is fair to say that women in government senior leadership roles have less of a pay gap than they do in private business. Tracking and raising awareness is some of the work that the Minister certainly has taken on.

The Hon. EMMA HURST: Moving on from vets. Similarly, there is a lot of scientific evidence showing a higher incidence of mental health issues for slaughterhouse workers, particularly those that are working on the kill floors. They are prone to a particular type of post-traumatic stress disorder [PTSD] known as perpetrator induced traumatic stress. This is in relation to the people who are actually taking the lives of animals every single day. What, if anything, is the Government doing to address this particular mental health issue for slaughterhouse workers?

The Hon. BRONNIE TAYLOR: In general, the Government is investing record amounts of money in mental health space to deal with all of these things. As to that specific disorder, I might ask Dr Wright if he would mind commenting.

Dr WRIGHT: I cannot comment on the specifics of post-traumatic stress disorder as it relates to slaughterhouse workers, but I can say that the notion of vulnerability to PTSD in people through their everyday work is something that we have become much more aware of over the last 15 years or so. It started with people working as first responders and emergency personnel and armed services, but we are now much more aware that it is a wider range of individuals. Alongside of that is a better understanding of the evidence which supports how to effectively engage people in treatment at an early stage. We have in New South Wales an evidence-based set of guidelines for treatment of PTSD, which has been released in the last couple of years, which is extremely

useful. The other side of that is making sure that if there are particular professional groups who have an increased vulnerability that they have some training in that area so they can look out for early signs amongst themselves and amongst their colleagues. One of the most important things about any person suffering from PTSD is early intervention—the longer you wait, the harder it is to treat.

The Hon. BRONNIE TAYLOR: Can I just add that in 2018 the NSW Mentally Healthy Workplaces Strategy was launched as a $55 million package over four years to promote mental health in the workplace. I would also say to organisations that know that they have workers that are experiencing any type of PTSD or, for that matter, just to make your workplace a mentally healthy one is a huge positivity that they would look at that program. The strategy is led by SafeWork NSW and I think that it is a really great thing for anyone to encompass. I am certainly trying in my office workplace to have a mentally healthy workplace. It is really important and I encourage everyone to do so. If there are organisations out there that you know are doing that, I would suggest they go and look at this as well.

Ms CATE FAEHRMANN: When a patient attends an emergency department [ED] experiencing a mental health issue and undergoes a psychiatric assessment that shows they are required to be admitted to an mental health unit and that unit is at capacity, what happens to the patient?

The Hon. BRONNIE TAYLOR: Any patient who presents to an emergency department and is found to require care under the Act will be found a bed to stay. Are you asking me if they are actually scheduled—

Ms CATE FAEHRMANN: They can also wait for some time. Is that correct?

The Hon. BRONNIE TAYLOR: The waiting times for people in emergency departments, recently the data that has come out is very positive and shows that our patients are seen within a timely manner.

Ms CATE FAEHRMANN: The national Bureau of Health Information [BHI]—the report that came out several weeks ago—in fact said that between 2013 and 2014, and 2017 and 2018 the number of mental health related emergency department presentations in public hospitals grew by 18 per cent, a faster rate than the overall growth in emergency department [ED] presentations; that the median time patients spend in emergency departments was 40 minutes longer for mentally ill patients compared to patients with no mental health problems; and that in south-west Sydney hospitals one in 10 mentally ill patients was stuck there for over 24 hours. So there is a fair bit of data to say that there are not enough beds and that people who you would think would need a bed and treatment the most are waiting in excruciating conditions for too long.

The Hon. BRONNIE TAYLOR: I just refer you to—because you are referring to the BHI report—page 57, which clearly states that the time is measured from the time the patient presents to the time they depart. We all know that when we enter an emergency department—I was there a couple of weeks ago with my daughter—you are triaged for the particular situation you present with. In terms of people presenting with mental health issues, these are complex conditions that require complex, multidisciplinary assessments. It is not a case where you have a broken arm, you have an X-ray and you have a cast put on it. There are often comorbidities presenting that need a wide-ranging assessment.

People who are in emergency departments are still being treated for their illness—just because they are there does not mean that they are not being treated. We know that emergency departments are not the ideal situation for mental health patients. We would much prefer to treat them in the community as best we can, but there are times and situations where people need to present to emergency departments; that does not mean, by any standard, that they are not being treated for the conditions that they have at the time.

Ms CATE FAEHRMANN: Many are discharging voluntarily before they receive treatment because they do not want to wait around. How many leave the emergency department without being treated—without going into a unit, if they are assessed as needing to go into a unit?

The Hon. BRONNIE TAYLOR: Under the Mental Health Act 2007, of which we are all a part, we refer to "least restrictive care". We have provisions under the Act where we can involuntarily detain people if they are a risk to themselves or a risk to the community. Otherwise, we practise least restrictive care. It would be a travesty if we entered into a situation where anyone with a mental health illness needed a compulsory stay in a health facility. We know that we have really good community follow-up and we have really good investment in community mental health teams. If people choose to leave the service that they have presented to, that is their choice. However, if that person is a risk to themselves or to anyone, and deemed that way by the expert clinician, they will be assessed and they will be treated accordingly. I might ask Dr Wright to comment further on that—

Ms CATE FAEHRMANN: When there are not enough mental health beds in the units, what happens? Because we do not have enough mental health beds, do we?

The Hon. BRONNIE TAYLOR: Our mental health beds run at an 87 per cent occupancy rate, so I think that clearly demonstrates that we do.

Ms CATE FAEHRMANN: You are saying that there are enough mental health beds in New South Wales?

The Hon. BRONNIE TAYLOR: I am saying to you that the data clearly states—I am talking about that facts and the data—that we run at an 87 per cent occupancy rate for our mental health beds.

Ms CATE FAEHRMANN: In an article in *The Sydney Morning Herald* on 29 May 2018 University of New South Wales Professor Gordon Parker, veteran public hospital psychiatrist and founder of the Black Dog Institute, spoke out about Australia's public psychiatric system—"in slow and painful decline" were his words. He said that New South Wales had a record 60 vacant training positions for psychiatric trainers. He also described the stress of overstretched emergency departments, where 50 per cent of up to 30 patients waiting for a psychiatric assessment should be admitted to the psychiatric units that are full to capacity. He said psychiatrists were "under tremendous pressure" to discharge patients before they were fully well to make room for new patients. He also said:

> [They] end their day aware that they were unable to find a bed for someone at high risk of suicide, that the depressed patient who needed close observation as their treatment unfolded has been prematurely discharged.

Are you saying that Professor Parker is lying when he spoke publicly about that?

The Hon. BRONNIE TAYLOR: No, I am certainly not saying that Professor Parker is lying. What I say to you is that we have a mental health system where, if we talk about community mental health—which you mentioned in your question—we have three million client contacts by community mental health services to more than 130,000 community mental health patients. We have had 40,254 overnight mental health separations—that is 40,254 occasions of service within that for mental health patients. We have over 700 mental health facilities and services; we have 290 that are dedicated to mental health—

Ms CATE FAEHRMANN: Specifically in relation to emergency departments, psychiatrists at emergency departments and in those public hospitals are not under pressure to discharge patients prematurely to free up beds for people waiting in emergency departments to fill those beds?

The Hon. BRONNIE TAYLOR: When mental health patients—consumers—present to emergency departments they have undertaken a very comprehensive assessment. There would be no way that people are being coerced or asked to discharge people earlier. That just does not happen. When you work in the health system you understand that all of those really good people, doing a really terrific job, will make a clinical assessment at the time as to what is the best care for the patient. We have 2,785 average available mental health beds and that is an increase of 80 per cent since 2010.

Ms CATE FAEHRMANN: Thank you. Moving on to—

The Hon. BRONNIE TAYLOR: Seclusion and restraint.

Ms CATE FAEHRMANN: —the Government's plan to implement recommendations of the review of seclusion restraint and observation of consumers with mental illness in New South Wales health facilities, particularly in relation to the May 2019 implementation update. Under the recommendation, it says:

> There should be an immediate review of the design and use of safe assessment rooms using a co-design methodology.

Statewide safe assessment room guidelines are being finalised for publication. Where are those guidelines up to?

The Hon. BRONNIE TAYLOR: I am very well aware of the reports and I am also very well aware of your interest in seclusion and restraint because you have asked me many questions in the past in the Chamber about it. I am delighted that Dr Wright, who has championed this report—and it is often referred to as the "Dr Wright report"—is here today. I might ask him to comment on that for you, so you can hear that directly from him.

Dr WRIGHT: The particular issue you are raising about the safe assessment rooms—

Ms CATE FAEHRMANN: Particularly the guidelines.

Dr WRIGHT: Yes. I cannot tell you precisely when the guideline will be released but there is a process underway. Co-design is not a quick fix. What we found when we did the review was that with the best of intentions those facilities had been established without the appropriate input of the consumers and the carers. Fixing that

problem in retrofitting those services is actually quite complex. The guideline is certainly a very significant priority for the ministry and the mental health branch.

Ms CATE FAEHRMANN: In relation to the timeline I have in front of me, that milestone is to have this completed by February 2019. The latest plan implementation update of May 2019 states that as of 31 May 2019, which of course is three months ago now, State assessment guidelines are being finalised for publication. It talks about consultation that has already happened, which is good. I think that is what you are referring to. It states the draft guidelines in forming a partnership—it sounds like that has happened. It is three months now. Why are these guidelines not available now for hospitals to look at?

Dr LYONS: I might respond to that. It has a very important recommendation out of the review of seclusion and restraint. The use of safe assessment rooms in emergency departments is not just through what occurs from the clinical side in emergency medicine but involves having a co-design from consumers and people who have a lived experience and also involves the mental health services. What has been undertaken through the Agency for Clinical Innovation is they have an emergency care institute and a mental health network. They have been responsible for coming together and undertaking through a process of co-design with consumers a way that we can more appropriately use those safe assessment rooms, meeting the needs of the consumers and ensuring that the care that is provided is appropriate, based on the review's recommendations. That has taken a little bit longer but has been deliberately done to ensure there has been co-design in the process. The advice I have is that those guidelines are almost finalised now and ready for publication and they should be released prior to the end of this calendar year.

The Hon. TARA MORIARTY: I return to the aged care facility. Are the convicted murderers who are living in that facility free to come and go as they please? Can they roam around the facility as they please?

The Hon. BRONNIE TAYLOR: Can they run around the facility?

The CHAIR: No, that was not the word. I think the word was "roam", not "run".

The Hon. BRONNIE TAYLOR: That is an operational issue in terms of the facility and what they feel is appropriate. As I said, I do not know the individual cases. I am not sure what stage their mental condition is at. I will have to take that on notice.

The Hon. TARA MORIARTY: Minister, they are convicted murderers. I am not asking about their mental condition; I am asking if they are free to come and go from the facility as they please. I think that is an extraordinary answer. Are they free to come and go as they please?

The Hon. BRONNIE TAYLOR: My answer to you is that I will take that on notice.

The Hon. TARA MORIARTY: They are convicted murderers. Do you think that they should be able to come and go as they please?

The Hon. BRONNIE TAYLOR: These individuals to whom you refer have been assessed by the independent Mental Health Review Tribunal. They have been assessed to be able to be in a facility, in consultation with that facility, to be there in a safe and effective manner. It has been assessed that for these individuals that is the best place for them to be for their care.

The Hon. TARA MORIARTY: But courts have sentenced them to very long sentences in prison. They should be in prison. I understand your answer that the Mental Health Review Tribunal has found that they could be in this facility and that you support that, which is extraordinary in itself, but what is your opinion? Do you think that it is okay for convicted murderers who should otherwise be in prison still serving their sentences—and they have very long sentences to go—to be able to freely come and go from these facilities as they please?

The Hon. BRONNIE TAYLOR: As I have said before, I refer to my previous answer.

The Hon. WALT SECORD: Minister, have you launched an investigation after last night's explosive report on Channel 7? Did the Government launch an investigation or review the situation?

The Hon. BRONNIE TAYLOR: The review of these individuals to whom you refer have been comprehensively reviewed by the independent Mental Health Review Tribunal, which consists of experts in legislation, and they have had comprehensive assessments to assess their mental health. It has been decided that they are deemed fit to be residents in the facility. That was explained before in previous answers. If you keep asking me—

The Hon. WALT SECORD: Do you guarantee—

The Hon. TREVOR KHAN: Point of order—

The CHAIR: The way it goes is an answer is followed by a question.

The Hon. BRONNIE TAYLOR: I have answered the question. You may ask it in 15 different formats but the question has been answered.

The Hon. WALT SECORD: Can the Minister guarantee safety of the residents in the nursing home, knowing that there are convicted murderers in their midst? Can you guarantee their safety?

The Hon. BRONNIE TAYLOR: The individuals that you have mentioned have been assessed under the Mental Health Review Tribunal, which consists of experts that have assessed that is the best place for them to be for their care and that they are not at risk to themselves or to anyone else. Those facilities deal with these situations. They are aware of it. They were consulted fully.

The Hon. TARA MORIARTY: You were asked earlier about providing information about how many other people live in that situation. I acknowledge that you have taken it on notice but in relation to the other people who are living in the facility, are the people who are living with them in other facilities or other communities or their family aware of those circumstances?

The Hon. BRONNIE TAYLOR: My understanding, as I answered previously, is that the facility is fully aware of the situation. Whether or not facilities choose to declare that information to people is a matter for the facilities and that is very much an operational issue.

The Hon. TARA MORIARTY: Do you think it is a matter for the Government, not just the facilities, to have some responsibility for the safety and concerns of the families of the people who are living in these facilities and the people who are living in it themselves?

The Hon. BRONNIE TAYLOR: With absolute respect, I believe that we need to have an independent and robust system to assess people on their medical and their psychosocial needs. Those decisions should be made by experts and that is exactly why in 2007 the Labor Government instituted the independent Mental Health Review Tribunal so that decisions on people's care, their capacity and their safety are made by experts. That is why we have an independent tribunal.

The Hon. TARA MORIARTY: I note your answer is in relation to the interests of those prisoners who are living in these facilities. But my question was in relation to the interests of the community that needs to know who is living their midst and the other residents who are not convicted murderers who are living in these facilities. What do you say to their interests?

The Hon. BRONNIE TAYLOR: I refer to my previous answer.

The Hon. TARA MORIARTY: What was that previous answer? You have not actually answered that question, Minister. You have referred to the interests of the patients about whom we are talking and that they were assessed but I am asking about the interests of the people who live alongside them and their families and the community.

The Hon. BRONNIE TAYLOR: And, with respect, what I said to you was that is an operational issue for those facilities.

The Hon. TARA MORIARTY: Long Bay prison has a couple of aged care facilities. Why are these people not living in those facilities?

Mr MARK TAYLOR: Because the individuals in question have been assessed by the independent Mental Health Review Tribunal, which was established in 2007, which does an independent assessment—independent from government—to make the assessment that is the best for the consumer at the time, and that is what has happened.

The Hon. TARA MORIARTY: Earlier, Minister, you referred to the Mental Health budget for 2019-20. Will you confirm the figure for the Mental Health budget?

The Hon. BRONNIE TAYLOR: It is $2.1 billion.

The Hon. TARA MORIARTY: What was the Mental Health budget for the last financial year?

The Hon. BRONNIE TAYLOR: For the last financial year? I would have to ask one of my departmental officers, as it predates me.

Dr LYONS: We will get it for you. But it has increased by $100 million on the budget last year for the investments that are being made this year. I will get the exact figure for you.

The Hon. TARA MORIARTY: Can you clarify that because having looked through the budget papers it was $2.1 billion, just to assist.

Ms KOFF: The initial budget for 2019-20 was $2.1 billion and it represents 8.8 per cent of the Health budget. Last financial year it was $2.011 billion.

The Hon. TARA MORIARTY: The Mental Health Coordinating Council released the *Mental Health Matters* report stating that New South Wales has one of the lowest per capita spends in Australia on mental health. Do you think the budgeted amount is enough, given what I would call a crisis in the mental health system?

The Hon. BRONNIE TAYLOR: This is a record spend in mental health. It is a budget that is increasing every day. Money just does not appear out of bags or out of anywhere else; it needs to be very consistently and responsibly looked at. I am really proud to be part of a government that is increasing the mental health budget for record spending. I think that is something to be really proud of. We have demonstrated that this is a priority for the Government. It is also a priority for the Federal Government. We have recently seen the Federal Minister Greg Hunt come out and speak very passionately about the need for enhanced services and better coordination of services. It is actually a good thing that the budget is increasing. It is a record spend that has ever been done in mental health.

The Hon. TARA MORIARTY: What is the current State target for seven-day post-discharge community care?

The Hon. BRONNIE TAYLOR: Are you referring to the fact that we have a policy that says that we need to follow up in the community at least seven days post an acute admission?

The Hon. TARA MORIARTY: Yes.

The Hon. BRONNIE TAYLOR: Sorry, can you repeat?

The Hon. TARA MORIARTY: What is the Government's target for that care?

The Hon. BRONNIE TAYLOR: Seventy per cent.

The Hon. TARA MORIARTY: Why is it 70 per cent? That seems low.

The Hon. BRONNIE TAYLOR: The Bureau of Health Information [BHI] report recently came out and it was talking about, I think, 75 per cent follow-up in terms of people who had presented to or had an admission in an acute facility. What we have to realise as well is that people choose whether they are going to be followed up. Some people may choose they do not want to be followed up. That is my first point. My second point—and this is particularly prevalent in rural and regional communities where people have really effective and very sincere relationships with their GPs—is that they may choose to be followed up by their GP and not a community mental health team. They also may choose to be followed up by a private psychologist or a private psychiatrist. When BHI captured that data it said that there is also that ability to demonstrate and articulate that people may choose to be followed up by practitioners of their choice and not necessarily community mental health teams.

The Hon. TARA MORIARTY: I accept that there are some people who might want to make their own arrangements or not use the community mental health facilities but 70 per cent for seven-day post-care is the Government's target. Why 70 per cent? Why not 95 per cent or 80 per cent? Why is it so low?

The Hon. BRONNIE TAYLOR: It is because I think we acknowledge that people will choose. People have the right to choose the health care that they want, especially when it is voluntary health care. If they choose to be followed up by a private psychologist that they may be seeing themselves or a private psychiatrist that they may be seeing or their GP, then that is really a matter for them.

The Hon. TARA MORIARTY: It is not to allow for the fact that there should be care but when people seek care it is not always available?

The Hon. BRONNIE TAYLOR: No, I do not think that is what the policy is saying at all. I think we know that we have had over three million community client contact occasions of service. We have 130,000 community mental health clients that we are servicing. I think what that demonstrates is that they are actually doing a pretty good job with a very high volume of people.

The Hon. TARA MORIARTY: As a local example, can we look at the Hunter New England Local Health District. In five of the seven hospitals offering acute mental health care, the seven-day post-discharge rate

decreased between 2016-17 and 2017-18. Have there been any investigations as to why this was the case in that local area?

The Hon. BRONNIE TAYLOR: As that is a specific question on an operational issue, I might go to Dr Wright or Dr Lyons.

Dr WRIGHT: The seven-day follow-up target is a national target as well. It is quite a useful benchmarking target for us to make comparisons between the different States. Having run those sorts of services, it is quite a challenging target because you are juggling multiple responsibilities within those community clinical services. In addition to the Minister's comments, I think I should say that we monitor those at a local level, district level and State level quite carefully. We see more in it than simply "Did seven out 10 people get seen within seven days after they were discharged?" It tells us something about how effectively that community-based service is managing its multiple responsibilities. It is a clinical indicator, which I think is quite useful. It is very challenging and that is good in a target like that because if a service is struggling for whatever reason—it might be unexpected leave, it might be excess demand, it might be any number of things—then that will come up as a deterioration in performance, as you identified, in a particular service.

We have a clinical governance system and performance monitoring system across NSW Health where that is picked up at multiple levels. Then it raises questions, What is happening at that particular service?—which means that its previously good performance seems to have dropped off. Sometimes it is an obvious explanation such as unexpected leave and then the service can take action to respond to that. Sometimes it takes a little bit more effort to try to find out why that deterioration has happened. But I think they are being monitored on a monthly basis at the very least at every level in the system. It is a very helpful way for us to know overall what the health of our community-based systems is.

The Hon. TARA MORIARTY: After a patient is discharged, is there a particular standard level of care that is required afterwards or is it a matter for each patient and their medical practitioner? Is there any kind of standard that is required?

The Hon. BRONNIE TAYLOR: Do you mean in terms of set clinical pathways?

The Hon. TARA MORIARTY: Yes.

The Hon. BRONNIE TAYLOR: Mental health is very complex and everybody is different. Often what you find is that people who are experiencing a mental illness often have other comorbidities—they often have other health issues that are affecting them in terms of their physical health as well. In terms of clinical pathways—and that is really an operational issue; I cannot help myself as a nurse sometimes and I will let Dr Wright answer that in terms of clinical pathways—every person would be assessed on their need and their unique circumstances. These really are individuals with very unique circumstances that change at different times, and sometimes quite rapidly. Sometimes they are stable for years and not having to re-enter systems. Dr Wright, in terms of clinical pathways, did you want to elaborate? Ms Moriarty, is that what you wanted?

Dr WRIGHT: Building on what the Minister has said, I think it is a matter of an individual assessment and treatment planning. When someone is being transitioned from, say, an inpatient service into an ambulatory service—that could be a community mental health service; it might be a community mental health service in combination with the general practitioner or a private psychologist or a psychiatrist or an NGO for follow-up—all of those things are unique to that particular individual. What we have in our policy and guidelines is the importance of making sure that at that transitional point there is an effort put in collaboratively between the treating team so that those services or individuals who are going to follow them up and the consumer and the family reach an agreement about precisely what the ongoing plan should be, including the frequency and the nature of the follow-up. Your question is a good one because it is really very important that it is not a "one size fits all" in any situation. Sometimes that follow-up might be a follow-up later that day face to face; sometimes it could be a phone call in a few days. It really depends on the circumstances of the individual and their level of comfort and the level of comfort of the other treatment providers and their families and carers.

The Hon. TARA MORIARTY: I accept that there needs to be individual management of individual people's personal situation, particularly when it comes to something like mental health, but what kind of processes or practices does the Government have in place to stop people from falling through the cracks? There have been a number of very serious incidents involving people suffering from mental health who have sought treatment but have not been able to get it in whatever circumstances and who have then in recent months gone on to—in fact, three people have been killed over the past couple of months.

I want to be really careful; I am trying to be sensitive, but this is the forum to have a discussion about the gaps in the system. Can you give us some information about what kind of systems you have in place to stop people from falling through the cracks, particularly those people who have come to the attention of the system by presenting at an emergency department or through their own mental health program or through the justice system or through the housing system or other areas of government? What processes have you got in place or are you looking at to stop people from falling through the cracks and then causing harm in the community?

The Hon. BRONNIE TAYLOR: I thank you for the really sensitive way in which you phrased your question; I really appreciate it. The latest data in 2016-2017 shows that New South Wales had the highest number of treatment days per person seen by community mental health services, which is higher than any other State or Territory. But there is no doubt that we need to ensure that we have really good service coordination between services and that services are talking to each other. I know when I was a registered nurse it was one of my greatest frustrations. I think it is really important that information is shared when it is shared in the appropriate way, understanding all of the limitations with confidentiality.

I think one thing that we have to remember that is very paramount here is that we operate under the Mental Health Act, which we all agreed to at various times—I was not here when we voted for that but we did in 2007. I think that it stresses least restrictive care. So I think that what we have to realise is that clinicians are doing assessments on individuals at the time that they present—they are comprehensive assessments, they are thorough assessments and they are done by the professionals that they need to be done by. If someone presents and they demonstrate that they are at risk to themselves or to others, then there is capacity in the Act for them to be scheduled. If they present and they are deemed to be not at risk to themselves or to other people at the time of presentation, then they will be admitted and they will be there under voluntary care.

In terms of follow-up in the community, I think we are seeing increased investment in that. It is certainly something, as Minister, that I would like to see us focus on; I think it is important. I think the primary aspect of mental health care is paramount. I think what we have to realise as well is that in things like mental health we have to be able to provide systems where people can enter and exit that system. I liken it sometimes to what I have seen over the last 30 years in cancer care. I think that you can have a really acute phase of your illness that you need really acute intervention; then I think you can move into a situation for years where your disease or your mental illness—and I mean disease when I talk about cancer—is quite stable. So I think that you need to be able to transition easily through the system, and that means through the acute and the non-acute system. I think that is something that we are all constantly working towards and constantly want to make better and better. Every day in the mental health system these clinicians and these experts are working towards making this a better system and the best system that it can be for the people that it represents; that is all of our obligation.

Ms CATE FAEHRMANN: I just want to go back to the discussion we were having before in relation to the safe assessment rooms and the review. The recommendation was that there should be an immediate review of the design and use of safe assessment rooms using a co-design methodology. It says in the "What we are doing" part that the department has filled in that the review commenced with an audit to identify the number and location of safe assessment rooms in New South Wales. Did the review or the audit also look at the safety aspect of those rooms or was it just the number and location of the safe assessment rooms? Did it look at the design and safety aspects of them?

Dr WRIGHT: I do not think you could do one without the other, and I think this point has been well understood in the conversations that I have had since the review was released, which is that obviously it is not just about the number; it is also about the appropriateness of the design and also, might I add, about the decision to use the safe assessment room. I am sure you have read this report in great detail. I think the larger concern that we had was that sometimes that was a default option and that everyone with a potential mental health issue was being directed towards that part of the emergency department.

So I think a good outcome would be much less use of that room, full stop. So the alternative pathways for people with a mental health problem in the emergency department was actually a very significant recommendation of that review. But, in looking at the actual design of the facilities, when we look at the number, is the identified part of the emergency department which is called the safe assessment room actually appropriate for that purpose?

The Hon. BRONNIE TAYLOR: May I just add very quickly to that? I think that we should be very proud and commend the clinicians for the fact that since 2010-11 the rate of seclusion in New South Wales public hospitals has almost halved. I think that is a huge feat and I think what it demonstrates is that the culture is changing. I think that this has been a very long-term initiative from specialist clinicians and everyone that works within mental health—well before my time as Minister. There has been a concerted effort to look at that culture

change. I think that is a really tremendous statistic because I think that it demonstrates that we are working towards a much more progressive mental health system.

I was just going to add that $20 million was allocated in the 2018-19 budget to improve the therapeutic environment. I know I have spoken about this before, but I have seen those rooms that they have transformed at sites. I particularly remember the one at Hornsby. You walk into these rooms now and they are not as I remembered them 30 years ago when I did my nursing, when you would walk into these bleak rooms—

The Hon. TREVOR KHAN: Surely not.

The Hon. BRONNIE TAYLOR: I know, surely not 30.

Ms CATE FAEHRMANN: I have still had people tell me their experiences though over the last couple of years to say that they have been pretty appalling and just added to their mental stresses at the time.

The Hon. BRONNIE TAYLOR: I absolutely acknowledge that 100 per cent, and we need to get to that point. But I am saying we are not there on all sites yet; I am not going to be not transparent about that. But I do think in the ones that we are in we are working towards that, and it really demonstrates that when you see those rooms that have been done recently you feel a lot calmer as soon as you walk in, and that is what we want.

Ms CATE FAEHRMANN: In terms of the audit, you said that we have some safe assessment rooms in emergency departments which have undergone whatever transformation is needed to be more appealing—that is probably not the right word to use.

The Hon. BRONNIE TAYLOR: More appropriate.

Ms CATE FAEHRMANN: Did the audit uncover emergency departments that had safe assessment rooms which were deemed unsafe by the auditors?

Dr LYONS: I would have to take that on notice. I think the assessment was done not around just the assessment rooms but also around the policies and procedures, and the approaches the clinical staff took to use them. The rooms themselves were one issue but, as Dr Wright has indicated, it was about the clinical care and the practices of when were patients actually in those rooms, what level of interaction with staff occurred and those aspects, which have been probably the focus rather than the physical environment itself.

Ms CATE FAEHRMANN: I assume that some individual emergency department safe assessment rooms were less ideal than others. There are obviously going to be safe assessment room guidelines that are being finalised for publication and, fingers crossed, released in the next few months. What else is being done with those individual hospitals that have been identified as needing to up their standards and improve their standards over and above the guidelines that will be released? Are they being held to account or given instructions to improve their rooms and policies and procedures?

Dr LYONS: There are multiple factors that are actually being taken into account in responding to the review. As Dr Wright will fully know, there are a suite of recommendations that came out of that review. They included not just things around the assessment rooms but also around policies and procedures and the investment in clinical leadership to support and oversight the care that is being provided right through the mental health teams. They also included things like establishing a safety program for mental health which is well advanced now across the State under the auspice of the CEC.

There are many things that we are doing to support the improvements in patient care, not just around the physical environment but also, very importantly, around staff, around culture, around leadership, around practices that are occurring not just in our emergency departments but across our acute mental health units. The focus is on de-escalating and ensuring that we minimise incidents where people need to be—for their own protection and the protection of other patients—secluded for a period of time.

The CHAIR: Dr Lyons, just for Hansard, what is the acronym CEC?

Dr LYONS: Sorry, it is the Clinical Excellence Commission. It is the body established around safety and quality in New South Wales.

Ms CATE FAEHRMANN: Minister, one of the recommendations was that there should be an immediate review of the design and use of safe assessment rooms and the guidelines are already six months late. We have just heard that they will be released by the end of this calendar year, hopefully, even though this implementation plan says they are being finalised for publication. It sounds as though the guidelines are delayed. Will you commit to ensuring that they are released as soon as possible?

The Hon. BRONNIE TAYLOR: I absolutely commit to them being released as soon as possible. We have been looking at this in detail. We need to get it right and I can assure you it will be my expectation that the guidelines will be released as soon as possible.

Ms CATE FAEHRMANN: On 26 July 2019 the *Border Mail* reported that CCTV at Nolan House, Albury, is no longer in use. According to the NSW Nurses and Midwives' Association patient and staff safety will be put at risk as a result of this. The cameras were originally installed within Nolan House as a result of two separate Coroner's recommendations but were removed on recommendation of the Victorian Chief Psychiatrist. Can you confirm if you are aware of this?

The Hon. BRONNIE TAYLOR: I am aware of that, yes.

Ms CATE FAEHRMANN: Have you ordered that the CCTV cameras be reinstalled?

The Hon. BRONNIE TAYLOR: What I have done is I have met with the local member who drew this to my attention. We had a meeting about it at which Dr Wright was present to address the issues that arose. As you know it is also a facility that is on the border with Victoria. There were cross-border issues that came up. Dr Wright was with me in that meeting. As it was an operational issue I might ask Dr Wright to comment further on that.

Dr WRIGHT: The issue of CCTV in inpatient facilities is actually quite a tricky one because there are obviously privacy and confidentiality issues which we need to be careful of. But there is also the issue of maintaining a safe environment. It is not a blanket yes or no about CCTV. It is about where it is and how it is used. Sometimes there is a concern that CCTV is used as an alternative to direct patient engagement and observation. That was a concern that I understand was one of the factors in that particular facility. I do not condone—and nor do any of my colleagues—the substitution of CCTV for person-to-person interaction. After the meeting with the Minister and the local member I had a conversation with my colleague from Victoria, the Victoria Chief Psychiatrist, to talk through that particular issue.

There had been a long conversation between the Victoria Chief Psychiatrist and the Victorian Chief Nurse and the executive management, directors and staff at that particular facility about the utilisation of CCTV and the need to develop other processes as well. It did not happen overnight and was done through a fairly prolonged process of consultation. As a result of that conversation with the Victorian Chief Psychiatrist I formed the view that it was actually done in a consultative fashion with the concerns for both patient and staff safety in the forefront of their minds.

There is an ongoing process of consultation with the local service management and the Victorian health service that is responsible for the day-to-day management of that facility. It is complex when there is a facility that sits within New South Wales, on the border, and is being run on behalf of New South Wales by Victoria. I think we have a memorandum of understanding between the Ministry of Health and the Department of Health and Human Services in Victoria which outlines what the expectations and responsibilities are, particularly in relation to the mental health service. These are things that are tricky because there are always slightly different cultures between the different States. It is more about having a robust and reliable process of communication, consultation and problem-solving between our services. I think this particular incident has probably helped us to freshen up that process and make sure we keep those lines of communication open.

The Hon. EMMA HURST: As the Minister for Mental Health, Regional Youth and Women, you would be aware of the link between domestic violence to women and animal abuse. An Australian study showed that at least 50 per cent of women who were in domestic violence situations reported that their violent partner hurt or killed a companion animal. The study also showed that 33 per cent of women in domestic violence situations remain in a domestic violence situation and remain in danger in order to protect a companion animal. There have also been studies that showed that children who witnessed animal abuse are likely to go on to commit violence and be violent offenders themselves. What work has the Government been doing to recognise the link between domestic violence to women and animal abuse and to address the mental health issues associated with committing animal abuse in the first instance?

The Hon. BRONNIE TAYLOR: I thank you for your question. When I first entered Parliament I was Chair of the Responsible Pet Ownership Committee, which is a committee of the Parliament. This was an issue that came up within the confines of the committee. To be honest, I found it really distressing that women were not leaving relationships because they did not want to leave their pets, but even more so how the pets were being used by the perpetrator to get at the women. I still find it absolutely reprehensible and quite alarming. I might ask Ms Walker to elaborate on this issue because we have joint programs with the RSPCA, which is a terrific

organisation. It is looking at these issues so we can help people and make sure that their pets are safe, enabling them to leave the situation they are in. Ms Walker will elaborate on the program.

Ms WALKER: The NSW Domestic and Family Violence Innovation Fund funded in its first round the Safe Families Project, which was a project that was done with the RSPCA. They worked with two refuges to ensure that those refuges were able to take pets when they had situations of women and children fleeing domestic violence, knowing that we have good evidence that some women delay leaving or feel unable to leave because of their pets. The project itself has not been evaluated yet but the early signs are very positive. We already have two more refuges in Port Macquarie and Maitland that will take on the project. The project is in its early stages but I think it shows that what we are doing is taking a good evidence base and working with that to make a difference, particularly for women and children in their experience post leaving.

The Hon. EMMA HURST: How much funding was given to the RSPCA for this program specifically?

Ms WALKER: The early stage of the pilot received $61,600 from the innovation fund.

The Hon. EMMA HURST: And do you know how much it cost the RSPCA all up for the project?

Ms WALKER: We could approach the RSPCA and ask for that information.

The Hon. EMMA HURST: If you could take that on notice to get that information that would be great. Just going back to the second half of my question—sorry, I did give you a double-barrelled one there—what is the Government doing to address the mental health issues that are associated with animal abuse and with the actual committing of animal abuse acts in the first place, particularly around children witnessing animal abuse and going on to be offenders themselves?

The Hon. BRONNIE TAYLOR: I do not want to go into everything that I have repeated in terms of the budget and what we are doing. In terms of specific programs for mental health I would have to take that on notice. This is probably a matter for the police Minister, but we do know and evidence demonstrates that when people perpetrate violent crimes against animals they can go on to then perpetrate violent crimes on humans. So we definitely need to look at those programs in terms of how we address that and how we work at that. But that really probably would be more of a question for the police Minister.

The Hon. EMMA HURST: Yesterday the Minister for the Prevention of Domestic Violence said that he was quite interested in the idea of having a register for animal abuse to be able to sort of ascertain some of these links. Is that something that your Ministry would be interested in as well?

The Hon. BRONNIE TAYLOR: If that is what the Attorney General said—and he is the cluster lead in my cluster for the Ministry of Women—I am sure that I would agree.

The Hon. EMMA HURST: Great. Thank you.

The Hon. BRONNIE TAYLOR: I'm a good girl.

The CHAIR: Safe answer.

The Hon. EMMA HURST: In the *NSW Women's Strategy 2018-2022 Year Two Action Plan* you note that women are more likely to volunteer than men and that a significant number of volunteer organisation managers, coordinators and leaders are women. Given that women are already performing a significant amount of unpaid work in the volunteer sector, why is one of the targets of the year two action plan to increase female volunteer activity rather than decreasing the gender pay gap and ensuring that women are properly paid for the work that they are doing?

The Hon. BRONNIE TAYLOR: Decreasing the gender pay gap is something that we are looking at every day and it has been mentioned in the plan as well. Women do a great bulk of volunteering. I actually think that is a really fantastic thing and I think that everybody should do some volunteering, regardless of their gender. But we are looking at the gender pay gap as well. It is a myriad of issues, and I think, too, that the best way to address these issues is to look right across all of the portfolios. That is what the NSW Women's Strategy and the action plan do. That is what is really important to reiterate here—when we are looking at these things, there is not going to be one thing in isolation that is going to address the gender pay gap. It is going to be a myriad of issues across a myriad of departments.

It is my job and the job of the Office for Women to make sure through the strategy that those key performance indicators that are met, that we are talking to other departments and that we meet regularly, which I know that the Office for Women does, to make sure that we are looking at those things. In terms of volunteering and women doing a higher proportion of that—and you mentioned that that is because of the gender pay gap—I

think that women do tend to volunteer because I think that we tend to do a lot of those things whether they are at schools or whether they are at things in our communities. But I think we are seeing that, as I said, all people really should look into volunteering because it is a great thing, and we are constantly addressing the gender pay gap. Was there anything that you wanted to add to that, Ms Walker?

Ms WALKER: Just to emphasise that three of the outcomes that we really want to see as part of women's strategy are economic opportunity and advancement, health and wellbeing, and participation and empowerment. And I guess I want to say that volunteering is really a good opportunity for people to get broader experience that will help them access the workplace and increase their economic participation as well as their participation. And that is what we really want to promote through that. So that is the opportunity of having the volunteering effort in the actual plan.

The Hon. EMMA HURST: Minister, you mentioned that everybody should be volunteering. So wouldn't we then want to increase male volunteering rather than increasing female volunteering more, considering most volunteering is being done by women?

The Hon. BRONNIE TAYLOR: Absolutely. I cannot agree more. I recently had this experience with a really good friend of mine so it is a bit of a personal story but it relates directly to your question. She had actually been out of the workforce for quite some time. She was a really qualified woman and an amazing person and was really keen to get back in but just was not really sure how to do that and did not sort of feel that she had the confidence. The reason I say this story is because I think this relates to many, many women across New South Wales. But what she ended up doing was going to volunteer in a place in her community which led her to part-time employment, which then led her to consulting, which has recently in the last month led her to full-time employment. I think that volunteering actually plays a really good role in that and particularly for women that have chosen to be out of the workforce for a period of time, because I think it absolutely can lead to that. Do I want to see more men volunteering? Would I like to see better gender balance in terms of volunteering? One hundred per cent. I do not disagree with you. Let us get them all out volunteering.

The Hon. EMMA HURST: The animal rights movement is a prime example of a sector that is primarily both volunteer- and female-led as well. Has the Government provided any particular support to women in this advocacy movement who are rescuing, rehabilitating and helping native animals, companion animals or animals that have been in battery cages and giving them a chance at life in the hen industry? Is the Government doing anything in that particular sector to help women?

The Hon. BRONNIE TAYLOR: In terms of specific programs, I know that in animal shelters and things that are run by councils that we are constantly supporting—I know in Cooma that the RSPCA helps with the running of the Cooma shelter or pound. Sometimes we call it a pound or shelter. They are getting support from people in their communities. I am certainly a very big supporter of my local RSPCA and the incredible work that it does. I know very well what great work the Cat Protection Society does with Kristina out at Newtown. I have come across her through Responsible Pet Ownership [RPO] and I am really happy to support that in any way that we can.

The Hon. TARA MORIARTY: I just want to wrap up where we were before, Minister, in relation to the serious issues as a result of the three deaths that have occurred over the last couple of months. Again, I want to be really sensitive and careful about how I deal with this, but we were talking earlier about some of the gaps and the individual failings in the system over recent months. I just think that there is an expectation in the community that there be some response from the Government. I am sure you are aware of the first thing I want to ask about, the incident involving a father who killed his five-year-old son while having a psychotic episode. This was in June this year. News reports stated that the man's partner and mother sought his voluntary admission to a mental health facility in Hornsby. Are you aware of that incident and if that is correct?

The Hon. BRONNIE TAYLOR: I am aware of the incident. The death of that little boy was a tragedy and I extend my deepest sympathies to his family and to those that loved him. It is our job to continually review and improve the care that is provided to those who need it. To that end, root cause analysis has been conducted by Northern Sydney Local Health District and Western Sydney Local Health District with assistance from the NSW Health Chief Psychiatrist, who is here today, and the Clinical Excellence Commission. I can advise the committee that review processes are being followed and recommendations from these reviews will be implemented. However, I respectfully say that I cannot discuss the specifics of this incident. Again, my heartfelt condolences go out to the family.

The Hon. TARA MORIARTY: Thank you. I accept your answer in terms of not being able to discuss the specifics of this incident. I am very sensitive about that as well and about the family. But you have just talked

to us about a review. Will the results of that review be made public, those that relate to the system failings? Not just the specifics of this family, but what happened at the hospital?

The Hon. BRONNIE TAYLOR: Would you like to comment, Dr Wright?

Dr WRIGHT: Yes, I would. I can comment that my understanding is that matter is the subject of a coronial inquiry and that is the purpose of the coronial inquiry precisely: to address the issue you raise. There was a root cause analysis performed and that would almost certainly also be considered by the coronial inquiry.

The Hon. TARA MORIARTY: I want to be careful and sensitive to this, but I want to get a response from the Government and an update on some information because I do think there is a lot of public interest in the circumstances surrounding the incident involving a person by the name of Jessica Camilleri in relation to the killing of her mother. Has there been any review by the Government of the circumstances in that case? She is obviously well known to the system and I think there should be some comment from the Government about where that matter is.

The Hon. BRONNIE TAYLOR: Again, I cannot make comments on individual cases.

The Hon. TARA MORIARTY: A review of any system failings rather than that particular incident?

The Hon. BRONNIE TAYLOR: After any incident of this nature there is a review. We will look at the recommendations of that review.

The Hon. TARA MORIARTY: Will any information resulting from that review be made public?

The Hon. BRONNIE TAYLOR: In terms of the review of the recommendation, Dr Lyons?

Dr LYONS: The reviews that are undertaken in our system as a result of critical incidents are the root cause analyses looking for system issues. If there are any concerns around not just the system issues, but the care that has been provided or the responsibilities of clinicians not being undertaken appropriately, of course there is the avenue of reporting through to the Health Care Complaints Commission for further investigation. But as has been indicated by Dr Wright, these incidents almost always become the subject of a inquest and a coroner's case, which is absolutely the public airing of what the system issues were and what the circumstances that led to her death were. We contribute to those processes quite actively.

The Hon. ROSE JACKSON: Minister, what representations did you make to the Premier or the Minister for the Prevention of Domestic Violence with the abandonment of the 25 per cent reduction in reoffending rates in the Premier's priorities?

The Hon. BRONNIE TAYLOR: I made no formal representations.

The Hon. ROSE JACKSON: Even though close to 80 per cent of domestic violence victims are women and women are considerably more likely to be victims of domestic violence, you did not think it was appropriate for you to comment at all when that target was abandoned?

The Hon. BRONNIE TAYLOR: No, I did not say that I did not think it was appropriate.

The Hon. ROSE JACKSON: But you did not comment?

The Hon. BRONNIE TAYLOR: The question that you asked me was did I make formal representations to the Premier. I am well aware that you asked the question of the Attorney General yesterday, who is the Minister for the Prevention of Domestic Violence, and you received an answer from him, and I ask that you refer to that.

The Hon. ROSE JACKSON: I am asking you in relation to your capacity as Minister for Women whether you thought that it was appropriate for you to contribute to that conversation about whether that target was going to be abandoned from 2021-2023 and your answer is, no, you did not think it was an issue that would affect women in this State?

The Hon. BRONNIE TAYLOR: No. Again, I would say to the Hon. Rose Jackson that you asked me if I made a representation to the Premier about a target that is the Premier's target. This Government takes the issue of domestic violence very seriously. Yes, I am the Minister for Women and I have a real concern about the issue of domestic violence. My job as the Minister for Women is to make sure that across all departments that exist within the Government that we are looking to promote the issues that affect women. You asked this question of the Attorney General and he gave you the answer yesterday. He is the Minister responsible for domestic violence; he holds the budget. He is the cluster lead in this Government and he holds the portfolio of reducing domestic violence for women. I think that is demonstrating how highly this Government puts this issue and how

much we are working towards resolving it. As I say to you and I have said to you in the Chamber numerous times; I do not hold the budget for domestic violence; it does not sit in my portfolio.

The Hon. ROSE JACKSON: Why did the Government not take on board then head of BOCSAR's recommendations, Don Weatherburn, from a year ago that these targets were not going to be met and consider revision of some of its programs in order to ensure that we were closer to meeting the 25 per cent reduction by 2021 instead of changing the goal posts and kicking the goal out to 2023?

The Hon. BRONNIE TAYLOR: Again I say to the member that she asked these questions yesterday of the Attorney General and I ask that she refers to those answers. He is the Minister responsible for the questions that you ask. I do not hold the budget and this is budget estimates.

The Hon. ROSE JACKSON: You are the Minister responsible for women in New South Wales so I am asking you about this issue. You answered questions from my colleagues about domestic violence. It is referred to on page 23 of the women's strategy. Domestic violence is a core issue for women in New South Wales. I am asking you as the Minister representing women in New South Wales: Why didn't the Government take on advice from the head of BOCSAR from a year ago that those targets were not going to be met and revise some of the screening programs you were using to actually try to meet it as opposed to kicking out the guideline?

The Hon. BRONNIE TAYLOR: As I have said to you numerous times, this Government takes domestic violence very seriously. The Attorney General recently signed up to Our Watch, which was something that was absolutely commended and has been really well received by everyone. The Hon. Rose Jackson, you asked these questions of the Attorney General yesterday. I state again, the Attorney General in his portfolio is the Minister for the Prevention of Domestic Violence. This is budget estimates; he holds the budget for domestic violence. He is the cluster lead in the Government of numerous Ministers and he is the one who is responsible for that. When we look at domestic violence we look at it across all sectors. As Minister for Women it is of great concern to me and it is something that we are constantly working towards reducing.

The Hon. ROSE JACKSON: You mentioned Our Watch. How much of the Change the Story framework that is central to Our Watch has been included in the NSW Women's Strategy?

The Hon. BRONNIE TAYLOR: We recently joined Our Watch, as you are well aware. In terms of the women's strategy with domestic violence we are looking at things like empowerment and we are looking at financial literacy. I have asked the Council for Women's Economic Opportunity [CWEO] to specifically look at financial literacy. We know that one of the reasons that women feel they cannot leave a domestic violence situation is that they do not feel that they are financially secure enough to do so. This is a real issue and a real life practical problem. What I am doing as the Minister for Women is I have asked CWEO to look specifically at this issue in terms of women's financial literacy so that we can look at combating these things so women feel they have the confidence and the financial literacy and the ability to, if they find themselves, god forbid, in a situation of domestic violence, leave that more easily than they are.

The Hon. ROSE JACKSON: The answer is none. Yet you made the point that you only recently joined Our Watch. But at present none of the Change the Story framework that is central to that has been included in the women's strategy. Is that something that you will look to include in future updates of the women's strategy? It runs until 2022, so there is still a while to go on it. Is that something you would include in future reference points on that strategy?

The Hon. BRONNIE TAYLOR: I would say to you very respectfully that in the women's strategy, through things like economic empowerment and women's health and wellbeing, it very much already sits within that.

The Hon. ROSE JACKSON: Your position is that the Change the Story framework that is essential to Our Watch is already very much included through the women's strategy?

The Hon. BRONNIE TAYLOR: I am not the Minister that signed up to Our Watch. I am not the Minister for the Prevention of Domestic Violence.

The Hon. ROSE JACKSON: Were you consulted on that?

The Hon. BRONNIE TAYLOR: I am the Minister for Women and we had the women's strategy that works across all levels of government to assess things at different stages and different levels. Everything I do as Minister for Women, every decision that the Government makes I want to look at that through the lens of what is best for women. I am not responsible for the budget for domestic violence.

The Hon. ROSE JACKSON: On regional youth, when is the Government going to release its regional youth policy?

The Hon. BRONNIE TAYLOR: Thank you very much for the question on regional youth. I am very, very excited about that.

The Hon. ROSE JACKSON: So, when? I do not have a lot of time.

The Hon. BRONNIE TAYLOR: That is okay, it is all right.

The Hon. ROSE JACKSON: It was announced in May last year.

The Hon. TREVOR KHAN: Point of order—

The Hon. ROSE JACKSON: Apologies, Minister.

The CHAIR: I think the Minister is going straight to the date, I can feel it.

The Hon. BRONNIE TAYLOR: We are in the process of choosing our regional youth task force at the moment. We had over 300 applications for that, which is actually very exciting.

The Hon. ROSE JACKSON: According to the website 231, but maybe that needs updating.

The Hon. BRONNIE TAYLOR: Okay, well, what a great result and what a great initiative that for the first time ever there is a Minister for Regional Youth.

The Hon. ROSE JACKSON: Applications closed in August, when are we going to get the regional task force?

The Hon. TREVOR KHAN: Point of order—

The CHAIR: The Minister is entitled to answer the question.

The Hon. ROSE JACKSON: Apologies, Chair.

The CHAIR: She is getting towards that.

The Hon. WALT SECORD: Minister, you can still answer it.

The Hon. BRONNIE TAYLOR: I do not need direction, thank you the Hon. Walt Secord. We are in the final stages of announcing the regional youth task force.

The CHAIR: We have the final 12 minutes, which will be divided between the two crossbench members.

The Hon. EMMA HURST: Gender pay gap statistics released by the Workplace Gender Equality Agency on 15 August 2019 revealed that the national gender pay gap has gone marginally down—by 0.6 per cent—but the pay gap in New South Wales went up 0.8 per cent. As the Minister for Women, are you concerned by that increase?

The Hon. BRONNIE TAYLOR: Differences in pay between men and women during their working life can exacerbate the gender pay gap, and retirement savings and the impact on women's financial security later in life. We are looking at our public service and ensuring that we are an attractive, progressive employer for women. As one of the largest employers in New South Wales, the New South Wales Government wants to lead by example in bringing down the gender pay gap. The Premier's Priority for a world-class public service, which includes a goal to increase the proportion of women in senior leadership roles to 50 per cent, is another example of the Government working to close the gender pay gap. We are also committed to making all government sector roles flexible, on an "if not, why not" basis. Work in this space is being undertaken. I think we all have a responsibility to make sure that we can provide flexible work practices for women. I have three young mothers in my office at the moment and I ensure that they have the flexibility they require to do their jobs and balance all of the things in their lives.

A number of indicators measure and track aspects of women's pay and these include measures of average hourly, weekly and annual earnings for full-time employees. In 2018, 38.7 per cent of senior leadership roles in the New South Wales public sector workforce were held by women. This was up from 37.4 per cent in 2017. Although that is not a huge jump, I think it is heading in the right direction and that makes me happy. It also makes the New South Wales public sector more progressive than the private sector, where women hold just over one-quarter of board directorships on ASX 200 companies. As the New South Wales Government we need to set the example for the private sector to follow and I think we are doing that. The gender pay gap is a complex issue

and that is why we have committed to ensuring that 100 per cent of roles across the government sector can be made flexible. I think this is really important.

For myself, when I went back to work after my maternity leave with both my girls, the most important thing to me was to be able to have that flexibility and to be able to negotiate with my boss—that I would be happy to work in the evenings or different times from home, but I really wanted to get to that school assembly where Hannah or Holly might be getting something. It is important and now we live in a world where we can have a lot more flexible work practices. We have incredible information technology [IT]—not so incredible in some parts, but getting more incredible by the day—and I think flexible work takes up many different forms.

The Hon. EMMA HURST: Do you have any thoughts around why our progress on pay equality, particularly in New South Wales, has gone backwards?

The Hon. BRONNIE TAYLOR: Recently I met with the Commissioner for Gender Equality, Rose Lyons, who is based in Canberra. We had quite an avid discussion on this. She has a lot of things that she is working on and she feels very confident that a lot of those will progress.

The Hon. EMMA HURST: Can you detail some of those?

The Hon. BRONNIE TAYLOR: At the moment I can't off the top of my head. She feels very confident that we are now in a space where we can continue to reduce this. I understand it has gone backwards but I think we have gone forward on other issues. We have to keep forging. Was there anything you would like to add to that, Ms Walker?

Ms WALKER: I would just reiterate the demonstration that the New South Wales public service can show for the rest of the New South Wales economy about the benefit of having women in senior roles—the diversity of thought that that brings, is a great example. We will push this issue forward.

The Hon. EMMA HURST: Minister, are you willing to take on notice what the commissioner is doing?

The Hon. BRONNIE TAYLOR: Yes, there is a report and I will take that on notice and get it to you as soon as possible. I can also arrange a meeting with her, for you, if you would like? She is quite a sensational individual.

The Hon. EMMA HURST: Okay. That is great. The Bureau of Health Information released a report in August 2019 titled *Healthcare in Focus: People's Use and Experiences of Mental Health Care in NSW*. The report found that mental health related presentations had grown at a faster rate than overall emergency department presentations, particularly amongst young adults. It also found that patients under 24 presenting with mental health related issues were twice as likely to spend longer than four hours in an emergency department. What changes are going to be made so that these young people can get the help that they need in a timely manner?

The Hon. BRONNIE TAYLOR: I am aware of that report. I will ask Dr Lyons to comment further, but can I just start by saying you are absolutely right and it is factually correct that there has been an increase. One thing I want to point out, which I think is really important, is that we are halfway through the process of our Living Well strategy—our mental health reform, which was a 10-year reform done in New South Wales—which the Mental Health Commissioner is in the process of reviewing at the moment. I look forward to getting that report. One thing that we have clearly demonstrated—I talked before in a previous answer about culture change and I think there has been a significant shift in culture in New South Wales mental health services. This is a really good thing.

As we destigmatise the issues surrounding mental health, we encourage people to put their hand up and to say, "I am not feeling so well. I am not feeling great about this, but I feel okay about seeking some help." This is a huge advancement. We are seeing those rising rates, which I know none of us want to see because it is concerning to us that more people are presenting with mental health issues, but I make the point that it means that more people are seeking help because of the great work done not by me but done by the people at this table and all of the clinicians about destigmatising mental health. I think that is tremendous. I ask Dr Lyons to quickly comment further on that.

Dr LYONS: The first thing to say is that the Bureau of Health Information report looked at the total of the healthcare system, so it was not just the care provided through NSW Health services. A lot of that is provided by primary care, general practitioners, specialists in private practice, non-government organisations and the like. The big issue there for us is that it shows that in comparison with other countries around the world our healthcare system is standing up pretty well and certainly was not considered to be in crisis, as many would paint it to be. That is a positive thing. What it highlighted is that many people in the community know who their primary care

provider for their mental health condition is and they are able to access that care in hours. The difficulty is what happens after hours. We believe this is a big issue, not just for us—because we often receive those patients through emergency departments—but about what we can collectively do to enhance other methods for accessing mental health care, particularly in after-hours situations.

In addition to the things that the Minister outlined, things that may be leading to the increase is the intersection between drug and alcohol issues and mental health conditions. Unfortunately, we are seeing an increase in those occurring and that care is primarily provided through our emergency departments. The challenge for us is that it is not just the physical care and the mental health care; it is the intersection of those. When someone presents with self-harm or an indication of where they have been involved in ingesting other drugs, the medical teams need to be involved in providing an assessment about what those consequences are before an accurate mental health assessment can be made. That often leads to a significant amount of time and it can contribute to the length of time those people spend in the emergency departments—it is because comprehensive care is being delivered.

All of those things were acknowledged through that report and it highlights the significant investments that we are making in the access lines—how do we improve access for young people through Lifeline, particularly some of the novel ways for people to access their care when they need it through text services. We are also investing in particular areas that affect young people, such as eating disorders, where there has been a further investment made to try to support people and ensure they are getting the care they need.

Ms CATE FAEHRMANN: What is the status of the Government's implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to New South Wales mental health units?

The Hon. BRONNIE TAYLOR: I might defer that to Dr Wright.

Ms CATE FAEHRMANN: Particularly in relation to the Official Visitor Program. I think the NSW Mental Health Commission made a submission to this optional protocol 10 or 12 years ago.

Dr WRIGHT: I think the most appropriate thing would be for me to take that on notice. I am aware of the convention and also the role of the Official Visitors and the importance of that in relation to our mental health services.

The Hon. BRONNIE TAYLOR: I am very happy to elaborate on the Official Visitors if you want me to, if that was part of your question.

Ms CATE FAEHRMANN: Yes, because that is where I was getting to.

The Hon. BRONNIE TAYLOR: I meet with the Official Visitors regularly in my role as mental health Minister. Can I just say I think it is a really fabulous initiative in terms of health care. I think that having worked in health most of my life to actually see the way that they operate is something I think that we should all be really proud of within our system. It allows for people who are Official Visitors to enter into our acute units and actually see the care that is being done but do it sort of anonymously and to observe. That allows me as Minister as they report to me to hear what they are finding out on the ground and if that collaborates with things that I am hearing as well.

I actually recently spoke at their conference. They are an incredible bunch of people and include people that have been mental health nurses. I recently worked with a person who was a general practitioner in another country who does not operate here but is part of the Official Visitors Program. One of the things that they are telling me as well that I was really pleased to hear—I met with them a fortnight ago—is that they are really seeing now the progressive culture change that is starting to exist within the mental health service. They do not need to tell me good things; they tell me what is happening on the ground. I think as Minister to hear that was really fantastic—again, not the work that I have done but a lot of the work that the people sitting here have done. They have seen that. They have seen what is happening in all aspects of mental health care. There is a lot of change to still keep going but they were very pleased with where we are at the moment. But I do meet with them regularly.

Ms CATE FAEHRMANN: What happens to the reports that they give you?

The Hon. BRONNIE TAYLOR: I read those reports, and I presume everyone has oversight over those as well, that inform us for the decisions that we make in terms of progressing mental health forward in the State.

Ms CATE FAEHRMANN: Do they make any recommendations for changes or do they just tell you the problems?

The Hon. BRONNIE TAYLOR: Certainly when I meet with them—and I hope I am not talking out of school—I am very up-front and transparent about everything I do. I seek their advice. I listen to it and, yes, they provide me with regular reports as to what they have been doing and the issues that they find.

Ms CATE FAEHRMANN: The Mental Health Commission of NSW in July 2017 made a submission in relation to the optional protocol I referred to before specifically in relation to the Official Visitors Program and called for Official Visitors' reporting to be made public rather than reporting just simply to the mental health Minister, in the spirit of transparency. Rather than reporting to just one person about all the problems they find in the system, the Mental Health Commission is recommending that those reports should be made public. What is your view on that?

The Hon. BRONNIE TAYLOR: If the Mental Health Commission of NSW is recommending that those reports are made public that is something that has not been done previously. I am happy to look at anything as the mental health Minister but at the moment those reports are not made public.

Ms CATE FAEHRMANN: Do you have any thoughts as to why the Mental Health Commission of NSW would suggest that reports from the Official Visitors Program should be more transparent?

The Hon. BRONNIE TAYLOR: I am happy to take that on notice and speak to the Mental Health Commission about that comment.

Ms CATE FAEHRMANN: But, Minister, with respect, you taking that on notice to speak to the Mental Health Commission about that comment probably is a bit of a cop-out because—

The Hon. TREVOR KHAN: Point of order: My point of order is twofold. The first is the witness is entitled to take the matter on notice. The second is the member is inviting the Minister to speculate upon what another party might or might not be thinking about in terms of making a recommendation.

The CHAIR: The member will rephrase the question slightly.

Ms CATE FAEHRMANN: Thank you for agreeing to take the question on notice. I certainly hope that a comprehensive report back will be provided after you speak with the Mental Health Commission.

The Hon. BRONNIE TAYLOR: Dr Lyons has said he is happy to comment if that is to your agreement.

Dr LYONS: If I could add a couple of things about my experience with the Official Visitors Program which is primarily around coming into the mental health services and providing an independent objective assessment from a patient and carer and customer and client point of view around the care that is provided. The feedback is usually provided at the local level for service improvement purposes. The feedback that occurs through that program is primarily to the clinical director, the nurse unit manager and the manager responsible for the mental health services at the local level. It is all designed around creating a feedback loop that allows the assessment to be received and then responded to at the local level more so than at the system level.

The CHAIR: Thank you, Minister, and I thank the representatives from departments and agencies. It has been a very productive morning. That concludes this morning's session.

(The Minister for Mental Health, Regional Youth and Women withdrew.)

(Luncheon adjournment)

The CHAIR: Welcome back. There is no need to go through the formalities as we did this morning; the witnesses have been sworn in or affirmed this morning. We will go to questions. We have allocated a period of three hours—from 2.00 p.m. to 5.00 p.m.—and we will proceed in 20-minute blocks between the Opposition and the crossbench. Three hours seem tight. People can get up and have a bit of a stretch of the legs. Afternoon tea will arrive at some point. You are welcome to get up and perhaps get the staff members behind you to get you a cup of coffee—it is entirely up to you. Please appreciate this is a three-hour block so we will try to make it as comfortable and reasonable as possible. Are you okay if we begin the questioning?

Ms KOFF: Yes, thank you.

The CHAIR: The members will direct their questions to the relevant person. Ms Koff, with your role, perhaps you might end up getting more questions directed to you—I cannot predict that. The members will identify who they wish to ask the question of. Is that okay?

Ms KOFF: Understood.

The Hon. TARA MORIARTY: It is a general question but it is a follow-up from some of the things that we talked about this morning. In relation to the number of questions that were asked this morning about the prisoners living in aged-care facilities, has there been any action taken since this morning in relation to this? Are there any investigations lodged or any movement on that topic?

Ms KOFF: No, we reiterate what Minister Taylor said this morning: It was a decision on the Mental Health Review Tribunal and it was on the basis of their legal and psychiatric expertise that the patients or the individuals were moved there. Privacy laws prevent any disclosure in relation to the nursing home they are in, and that is consistent with both aged-care legislation and State legislation. The disclosure cannot occur. The only other comment that I would add to that is that the Garrawarra facility is a secure dementia-specific facility and, as such, the security levels are quite high for all individuals who are residents at Garrawarra.

The Hon. TARA MORIARTY: The Minister this morning also took on notice a couple of questions in relation to providing information about other instances, this particular facility and the arrangements in place for that. I expect that we will still be receiving those answers despite that privacy announcement?

Ms KOFF: Yes.

The Hon. TARA MORIARTY: Moving on, you would be aware of the Bureau of Health Information report entitled *People's use and experiences of mental health care in NSW*.

Ms KOFF: Yes.

The Hon. TARA MORIARTY: Were you concerned about some of the statistics that came out of the report?

Ms KOFF: I will hand that to Dr Lyons.

Dr LYONS: What we were pleased about is the international comparison with other mental health services in other countries around the world. As I indicated in my response in the morning session, this was a review not just of the health care that is provided by the New South Wales health system but also within New South Wales by health systems generally. That includes all the services that we are responsible for and also all of the other services that are provided. The vast majority of mental health care is probably provided outside of the services that we are directly responsible for, with people who seek care from their general practitioner and from psychologists and psychiatrists who are working outside of the New South Wales health system. It was a general review that showed that we performed quite well and that the system is not in crisis as often people would make out, which was, I think, encouraging.

There were things in there that highlighted where we need to further work, and we are committed to learning from these exercises and building in improvements to what services we provide and how they intersect with other services. There is a need for better connection between the services that we are responsible for and the other services. There were clearly issues around accessing care after hours for people. For people who know their primary carer and have a relationship with the primary carer—and that is quite solid—the issue is that when they have an issue that they need care for out of hours, how do they access appropriate care? Often what it leads to is attending to an emergency department for that care. What we would like to do is to ensure that there are other mechanisms for people who access care and that they know about those and that they can access them more easily.

There is a need for us to think about what we do in that space and what investments we make there. There is no doubt that there are issues around what happens in emergency departments and whether emergency departments are the right place for people to attend with every condition that they have. What we need to do to provide further supports and to provide appropriate care potentially in different settings. That is an area that we will continue to focus on our attention on: How can we appropriately support models of care outside of emergency departments that allow access to appropriate supports without needing to be going through a busy emergency department every time? There are also issues around waiting times for care in emergency departments. We talked about some of that this morning and what some of the constraints are around why people might wait longer for access to the care that they are seeking and what we can do. A part of that solution would be also those models that will divert care appropriately away from emergency departments into different settings, and we will continue to focus our attention on those areas as well.

The Hon. TARA MORIARTY: To expand on that, do you have any information as to why people who sometimes present with mental health issues do have to wait so long in emergency departments?

Dr LYONS: We do. Often there may be other factors involved in their attendance; it is not just with a mental health condition. It might be that there are other factors at play as well—in particular, issues around

self-harm, where there may be either attempts that they have made on themselves that have caused them injury that need to be addressed and assessed. That could be the injection of drugs, whether they are prescribed drugs are other drugs, which again need to be assessed by the medical teams in addition to the psychiatric care or the mental health care to be provided. Those are factors that buy in as well and are factors that account for why sometimes these assessments can take longer than in other patients. They are often presenting with quite complex conditions.

The Hon. TARA MORIARTY: Obviously, I acknowledge that there are some positive parts to the report and you have referred to some of the negative parts. Can you give us some information about what work you guys are doing, or Health generally, to improve some of these statistics and findings?

Dr LYONS: We recognise that it is in everyone's interest for us to provide more care in settings that are not requiring hospital admission. There is a focus and it came out of the Living Well reform, which is a 10-year strategy, as you know; we are about halfway through that. There has been investment in a range of services with a focus around the particular needs of specialist client groups and also with a focus on moving the care from inpatient care to outpatient, community-based care. If you look at the investments we have been making over the past few years—and we talked a lot about inpatient care today and about access to inpatient care—we have been making specific and targeted investments in community-based services and specialist services that people can access without requiring admission to hospital, and that will continue to be a focus.

In fact, as we are moving into the services that we purchase in NSW Health—the arrangement we have in place is that we purchase activity through a local health district [LHD]—we have targeted the purchasing of more community-based activity quite deliberately. In looking at how the resources we have available are distributed, we are focusing on accessing or purchasing more activity in the community settings so that the shift is that, while additional investments are going into admitted care, we are also targeting and incrementally increasing the community-based care. We are trying to shift the focus, with more resources going into the community than into the acute setting because we want to see more care being provided in the community. In fact, that is consistent with what a lot of experts in this area are saying about the need for investment in that space and the need for more supports and the community settings that allow people to stay well and not have to be admitted to hospital with a deterioration in their condition.

The Hon. TARA MORIARTY: I want to ask on a couple of specifics on that, in terms of figures that are out of whack in particular areas. Across the Sydney Children's Hospitals Network, 45 per cent of mental health presentations and 37 per cent of non-mental health presentations did not meet the clinically recommended treatment times. Why are the figures so high in that network, for example?

Dr LYONS: Sorry, could you repeat those figures?

The Hon. TARA MORIARTY: Across the Sydney Children's Hospitals Network, 45 per cent of mental health presentations and 37 per cent of non-mental health presentations did not meet the clinically recommended treatment times. The figures are pretty high for that network. Why are they high in that network?

Dr LYONS: That will be a reflection on the level of activity coming through the emergency departments. What you have there, it sounds to me, are figures of those who have attended with mental health conditions and those who have attended the emergency department for other conditions, and the proportion of not meeting the clinically recommended time frames is slightly higher for the mental health conditions. That was a pattern that was seen right throughout the services and it reflects the fact, as I said, that people who are presenting to our emergency departments with mental health conditions are often quite complex and have other factors at play, which can sometimes lead to a slower assessment and definitive treatment period in the emergency department because there are more people who need to be involved in providing that care.

The Hon. TARA MORIARTY: One of the findings that was in that report was that 65 per cent of inpatients in the Sydney children's hospitals network did not believe that the care they received made a difference to their social and emotional wellbeing. So it sort of goes to the stuff we were talking about this morning about follow-up, how people feel about the treatment. I know you guys are doing a lot of work on awareness of mental health and certainly in high-population areas people would be presenting, but when they do present they are not feeling as though the experience is what they should be getting when they seek urgent help. Can you talk to that?

Dr WRIGHT: I think the area of consumer satisfaction is one which is really quite important in terms of continually improving the quality of our service. The way that we would use that information is starting at a team or a facility level and then going all the way up through the different parts of the organisation to essentially pose the question to the service that there seems to be, if you like, a lower level of satisfaction at this service than there is in a peer-related service. I cannot comment on what that peer kind of relationship is between that particular

children's hospital and others, as to whether that is a figure which might be similar or different in other facilities, but as part of our performance review process we would pose that question to that service and internally they would be asking that themselves: Is that something which is an expected result if you are dealing largely with children and adolescents or is that out of kilter compared to other services?

So it is not so much does that single point of time tell us anything important about the service but it is more about the changes for that service. I am afraid I do not know what the previous satisfaction surveys were for that particular service. If it is going down that would be a concern; if it is going up that would give me some kind of reassurance. If it is similar to other services or different to other similar services, again that would lead to more robust conclusions. It is something which has changed quite a lot over the last few years in that we previously had largely pencil and paper tests for consumer satisfaction and we have moved to an online and electronic version of consumer satisfaction both in New South Wales and across the country and it does allow us to make those kinds of comparisons. It is useful for the individual services, it is useful for the consumer because they can give some pretty direct feedback about their own experience, but I find it is an important thing in terms of improving your services. That does not tell you why you got the result for that particular service but I think it puts it into context.

Dr LYONS: If I could add to that? The BHI report also revealed that people with longstanding mental health conditions did report more negative experience than other patients and that may be due in part to how we provide that care in the emergency department setting and whether or not we have got enough focus around mental health care needs in particular. What we are doing there is establishing more mental health consultation liaison nurse roles in emergency departments and there are some examples of where nurse practitioners have also been introduced into the emergency departments to support the particular needs of people who are presenting with mental health conditions.

Examples of that are at Prince Alfred Hospital where they have got a nurse practitioner-led service model operating as a pilot, testing and evaluating the impact that has, and that is also underway at Dubbo and Maitland hospitals' emergency departments. It is about that better assessment of the mental health needs and seeing whether we can change that sense of how people feel about their satisfaction with the service that is provided compared with others who are attending. So it is highlighting the areas that we can do better and giving us an opportunity to introduce and test and try new approaches.

The Hon. TARA MORIARTY: That particular example of those nurses, is that a new program? How many of them are there? Is that something that you are looking to roll out? What is the timetable for that? Can you give us some more information?

Dr LYONS: It is a relatively new model that is being introduced and is being evaluated at the moment. Depending on the evaluation, it then can be extended to other emergency departments if it is shown to be successful.

The Hon. TARA MORIARTY: Just to clarify, are you trialling it in one place?

Dr LYONS: No, as I indicated it is at Royal Prince Alfred Hospital at the moment and also underway at Dubbo and Maitland hospitals' emergency departments, so in three different emergency departments.

The Hon. TARA MORIARTY: Presumably you would all be aware of the New South Wales Audit Office report which was tabled last week entitled *Mental health service planning for Aboriginal people in New South Wales*. Who can I direct questions to about that report?

Ms KOFF: Yes.

The Hon. TARA MORIARTY: It was a pretty damning report. Do you acknowledge the report's findings?

Ms KOFF: We are accepting of the recommendations of the report, yes.

The Hon. TARA MORIARTY: All of the recommendations?

Ms KOFF: There were two recommendations that arose from the report and we have accepted those recommendations.

The Hon. TARA MORIARTY: What kind of conversations have you had with the Minister for Mental Health about the report?

Ms KOFF: The Minister was fully briefed, as is traditional Audit Office process. They discussed with us their approach to undertaking the audit: They engage with relevant people across the health system and other stakeholders to assess and accumulate the information that is necessary to form the recommendations of their

report. We then have some conversations with them about their findings and provide feedback in a covering letter as to our perspective on their recommendations. And of course we had that discussion with the Minister concurrently with those to flag what the findings of the report will be.

The Hon. TARA MORIARTY: As I have said and as you have acknowledged, the report was pretty damning and it found that the Government has no specific plans for addressing mental health in Aboriginal communities or, more specifically, with Aboriginal communities and that is despite the fact that mental health and related issues are actually the biggest killer of Indigenous people in New South Wales and the highest reason for low life expectancy. I acknowledge that you will accept the recommendations but this is not new information. What work has been done on this issue prior to this report?

Dr LYONS: Could I just add to your comments about the findings of the review? One of the issues that we highlighted with the Audit Office in the process of conducting the review—and their findings were around the lack of connection between services and the need for case management or coordination—was an issue around the data in connection with information to get a clear picture of the care that is provided in the different settings. We acknowledge that those are very much issues that we grapple with as well because much of the care that is provided to Aboriginal people for mental health care is in services that we are not responsible for and we would like to have much more information about that care being connected up. That is an issue that we have raised with the Commonwealth and will continue to raise with the Commonwealth as a really important enabler of us being able to assess the patterns of care, whether we are meeting the needs of individual communities, whether we are focusing enough on the specific needs of a particular client or patient groups.

There is no doubt there is a need for getting better joined-up data. We are very strong advocates of the need for that, not just in the mental health care space but across the services that we are responsible for and where they intersect with services that are provided outside of our system. So it is a big issue for us. We are continuing to focus care on what we need to do to support working with Aboriginal people and the people who provide care to ensure that we are meeting their needs specifically, and we will take on board the recommendations that came out of that Audit Office report. As you say, it was tabled only about last week or the week before, so it is relatively recent. We will be working on a response to ensure that we can address those recommendations in due course.

The Hon. TARA MORIARTY: You're right. It was a very recently tabled report. Again, I appreciate that you accept the recommendations and I acknowledge the answer you just gave. But this is a really significant issue in these communities. As I said, mental health related issues are the biggest killer of Indigenous people in New South Wales. Surely there has been some more work or more thought put into this as an issue prior to this report by—

Ms KOFF: There are a couple of comments that I would make, as we tag team on this issue. We had discussions with the Audit Office before it embarked on this audit because we do not plan for Aboriginal mental health services in a dedicated and specific way. The way we plan for health services for the Aboriginal community in New South Wales is to ensure we provide culturally safe and appropriate services across all clinical areas. We do not have dedicated Aboriginal emergency departments, nor do we have dedicated Aboriginal exclusive mental health services, nor do we have dedicated exclusive services for every clinical specialty for the Aboriginal population.

Our challenge is a health system, which is what we have been doing work on and which is referenced in the Audit Office document about the Aboriginal framework for health services that we are progressing across New South Wales. We have done a mid-term evaluation on the Aboriginal health framework. As I said, specifically part of what we are attempting and working with the Aboriginal community is to develop the services that are culturally appropriate and safe for it to access more readily. But you are right in saying that the incidence of mental health issues, especially suicide rates in the Aboriginal community, are higher than in the non-Aboriginal community.

Ms CATE FAEHRMANN: I want to talk about the mental health workforce. The 2019-20 budget provides for 1,060 additional medical staff and 880 allied health staff. How many of these additional staff will be psychiatrists? Do you have that information?

Mr MINNS: It is not possible to answer that specifically at this point. The workforce allocations that are in the budget and over the next four years will be the subject of operational decisions about demand in the system and where they allocate their workforce. Having said that, there are a few things I can say about the psychiatry workforce. The first point would be that psychiatrists are in a shortage across Australia. We have significant geographical variations in New South Wales. Even the psychiatrists we have are not necessarily where we would like them to be. There is also an issue of a shortage of services for children and adolescents and older

people. If you look at New South Wales, we have the most psychiatrists when compared to other States. But we would still say that psychiatry is under-subscribed in New South Wales in terms of the number of trainees we have compared to the trainee positions we could make available.

New South Wales Health does—almost consistently—continuing evaluation of future workforce requirements and when we look at our website that deals with specialties and subspecialties, we have more than about 75 specific career specialties that we highlight. We categorise them for the new medical workforce to encourage them to think about where they might choose to progress their career. What we say about psychiatry is that they represent substantial career opportunities. We are telling our current junior medical officers and interns that this is a career where there are substantial future career opportunities over the next 15 years. It is not alone in that category. Dermatology sits in that category. General practitioners sit in that category. In the system we could have more trainees this year than we currently have, if we could attract young doctors into it.

Ms CATE FAEHRMANN: Does the Government have a target for the ratio of psychiatrists to patients or people in New South Wales, for example, in the city and the regions?

Mr MINNS: Not specifically in that regard. If I talk about trainees, looking at the past five years, we have grown the number of available trainee positions for psychiatry from about 420 to more than 500.

Ms CATE FAEHRMANN: But is it correct that there is a fairly big number of those that are vacant?

Mr MINNS: That is correct.

Ms CATE FAEHRMANN: And you said you are having trouble filling them?

Mr MINNS: Yes. We are not unique in that across Australia. There is a question here about the options that young doctors have in training and where do they want to pursue a specialty or subspecialty. At the moment we are not attracting enough of them into psychiatry. Our view, together with the Health Education and Training Institute and the relevant college of psychiatrists for Australia and New Zealand, is that we would all say that based on projections we need to have more trainees coming into the system. Part of the reason we are working with the Ministry, the health system and mental health branch within the Ministry to produce a psychiatry workforce plan or revised strategy by the end of the year is because of this context.

Ms CATE FAEHRMANN: What incentives does the department provide for trainee psychiatrists or psychiatrists to move to regional New South Wales? For example, I have a ratio here of major cities having about 22 psychiatrists and trainee psychiatrists for every 100,000 residents while inner regional areas have six and outer regional areas have three. That is according to the College of Psychiatrists. You are probably aware of that ratio.

Mr MINNS: We have a variety of workplace strategies designed to promote rural and regional medical placements. If you like it might be an area where I provide the committee with a written brief.

Ms CATE FAEHRMANN: Are there incentives as opposed to just promoting a place?

Mr MINNS: There are scholarships. There are medical training positions in the regions where people are able to study there rather than come to the city. It is quite a detailed area. The arrangements apply to all or very many of the specialties because this issue of attracting people to rural and regional placements is relatively consistent across the workforce profile.

Ms CATE FAEHRMANN: The budget has provided for these additional medical staff and allied health staff but is it proving difficult for the Government to fill the positions it has provided for because they are unattractive?

Mr MINNS: I think it is just a constant challenge to recruit people to certain roles in our health system. There is a rural and regional dynamic around workforce attraction. That is why we have both the measures in place but currently we also have a project running that is designed to look at the specific issue of rural and regional attraction and retention. In that context we are looking at the prospect of how we might provide incentives to attract the workforce to those sorts of placements.

Ms CATE FAEHRMANN: I referenced him earlier this morning but Professor Gordon Parker, the veteran public hospital psychiatrist, has suggested that the stress of over-stretched emergency departments is ensuring that trainees and young psychiatrists are becoming profoundly disillusioned. I am using his words. Psychiatrists were also under enormous pressure in the public system. He says it is a slow death in quality in public psychiatric care. Do you agree with that?

Dr LYONS: Could I just make some comments and I might also get Dr Wright to make some comments about what we are doing to respond. This is an environment which is, I think, challenging for us. There is no doubt that public sector psychiatry is very different from private sector psychiatry.

Ms CATE FAEHRMANN: It is probably under-resourced, is it, Dr Lyons?

Dr LYONS: No, it is a very different type of care that is provided. In fact what the public system does is actually provide care for some of the more complex and vulnerable patients.

Ms CATE FAEHRMANN: Of course, acute.

Dr LYONS: As a result we are also providing 24/7 care, whereas a lot of services that operate in the private sector in rooms do not operate after hours.

Ms CATE FAEHRMANN: Exactly and that is why the incentives need to be there, you would think, to ensure that these positions are filled.

Dr LYONS: The things that we could offer that are different are that we are in an environment where—when people are training as students and when they are then training as junior doctors in our system and then we make decisions about what career they might follow and they go into registrar training posts—at each and every stage we offer an environment that supports that psychiatry is a good option to go into and that there are good career paths available for people who might go into those areas, that multidisciplinary teamwork is supported, that people can work in environments that are stimulating and rewarding and that the culture is supportive of good clinical care. Now, that is a challenge because we do operate in environments that are, as you have highlighted, busy. They are under pressure. The patients that need the care are often complex and vulnerable. But they are also some of the things that can be very rewarding for clinicians if they are working in that space. If people feel they are valued and are contributing as part of a team to good patient care, that can be a very attractive element of what we provide.

Ms CATE FAEHRMANN: Is there a target?

Dr LYONS: Could I ask Dr Wright?

Ms CATE FAEHRMANN: Sure. I just have one minute left.

Dr LYONS: Yes. Dr Wright might also respond to some of the things we are doing around how we provide that supportive culture and leadership.

Ms CATE FAEHRMANN: What you have said just sounds wonderful, but there are these vacancies that indicate that people are not—my question is: Does the Government or the department have a target to fill those positions? If there are vacancies there, what do you do?

Mr MINNS: Let me just talk a bit about the positions. Yes. So we have got a total number of qualified psychiatrists, by head count, of 480 people in the system at May or June this year. That works out to 332 full-time equivalents [FTEs]. They are supported by 464 visiting medical officers [VMOs], and it is hard to convert them to FTE. If we talk about that population of full-time psychiatrists—

Ms CATE FAEHRMANN: What was that? You had the full-time equivalents and the locums, do you mean, essentially? No?

Mr MINNS: No, visiting medical officers.

Ms CATE FAEHRMANN: What was the number of full-time equivalents, did you say? Sorry, I missed it.

Mr MINNS: It was 332. Out of that 332, in May of this year—and this moves around across the year—we had 80 vacancies. Sixty of those are actually being filled as at that pay point in June by locums and contractors. So the unfilled positions in the system that we would like to have are about 20 off that base of 332, supported by VMOs. Then our training workforce in 2018 was 456. So 456 additional people to those numbers are in trainee roles. Now, to your point about targets, we have been increasing the number of training positions available each year for the last five years. But you are correct. We are not at the moment managing to fill all of those. But that is not unique to this specialty. That is a question about the demands for medical workforce growth and some of the choices that junior doctors are making.

The Hon. EMMA HURST: The NSW Health website lists a number of health impacts of climate change, and one of these is mental illness. Can you talk about what you consider to be the most pressing mental health impact of climate change both now and in the future and what the Government is doing to address this?

Dr WRIGHT: I think the most pressing one right at this moment is drought. I think that the impact of climate change in an Australian context, we understand, is likely to be more extreme weather events and more and prolonged drought. Those things have an impact on everyone's wellbeing. Obviously, for the people who are most vulnerable it can have an impact on people who have either pre-existing mental health issues or have a vulnerability to mental health concerns. It is the impact of a stressor, and so that is very significant. I think that there are so many ways in which the impact of climate change can have either a direct or an indirect impact on mental health. We are quite conscious of the fact that when you have an extreme weather event like a prolonged heatwave, some of the people who are most vulnerable in a heatwave are the people who are socially isolated, living on their own without carer support. They are often people who have a mental illness.

In New South Wales we have procedures to respond in the event of prolonged heatwaves to ensure that those people with mental illness who are living in isolation are actually checked upon because sometimes the sorts of things that others might do naturally in the course of an extreme weather event are difficult for people with enduring and complex mental health problems. I could go on. We have got a track record in responding to disasters, whether it be bushfires or floods or droughts. If you want to generalise, the impact of climate change is that it is going to affect the community and the vulnerable members of the community in a more slow-moving way, as would an event like a flood or a bushfire. So it is that the same principles apply: There is an immediate response which is quite practical, but there is actually also quite a long-term impact on vulnerable people. It is a significant and ongoing issue for those people.

The Hon. EMMA HURST: Is there any push from the Government or any plans within the Government to help combat some of these issues in advance? A lot of it is about procedures on the ground, as you mentioned. Do you know of anything to help mitigate some of these mental health issues?

Dr WRIGHT: I think that, again, if we use the drought as an example, there is actually quite a body of knowledge and evidence within New South Wales as to how to try to anticipate some of the impacts of the drought on vulnerable individuals. For instance, there is the Rural Adversity Mental Health Program based at the Centre for Rural and Remote Mental Health out at Orange. They have a very successful drought response program which, when it was first introduced, was introduced for the duration of a drought event. Given the success of the program and the relationship between, I guess, the issues that they were finding and some of the other challenges that rural and remote communities experience such as the loss of population, the loss of some essential services, et cetera, et cetera, one of the learnings was that these support services should stay permanent. In answer to your question, it is during the particular event you learn certain things and then you realise the generalisability of those things for the benefit of the population all the time.

Dr LYONS: If I could just add on that, those sorts of examples are about where we are looking at preventive measures, building in community connections and building resilience for communities—not targeting individuals who have actually got mental health conditions, but finding how to make the community more supportive and able to withstand these sorts of events. That is the focus of some of that investment and where that model has been so important.

The Hon. EMMA HURST: Orygen, the National Centre for Excellence in Youth Mental Health, released a report called *Food for thought, the relationship between diet and outcomes for depression and anxiety*. It found that in children, adolescents and adults there is evidence to suggest that unhealthy dietary patterns, particularly the consumption of processed meats and products high in sugar and fat, are a risk factor for both depression and anxiety. Orygen reviewed eight studies that showed a significant improvement in depression symptoms with dietary intervention. Do you agree that diet is important for mental health? If so, how is this information being made known to the public?

Dr WRIGHT: I am not aware of that report and so we would have to take that on notice.

Dr LYONS: Could we just add about how the importance of nutrition in care of people with mental health conditions is known to us, and we do have a number of activities underway. One of those included some work that was done down at the Agency for Clinical Innovation. It has a nutrition network. One of the things that was highlighted in that nutrition network was that in caring for people who have lifelong mental health conditions there are often issues around weight gain and poor diet which contribute not only to their mental health condition but also to other physical condition. There has been a whole piece of work done with guidelines to support the sorts of nutrition we should be providing while people are in our care and with a focus on how we can keep them healthy and ensure that the diets that they are eating are keeping them as healthy as they possibly can be, both physically and mentally.

The Hon. EMMA HURST: Will that include the supply of processed meats, which are a class one carcinogen along with cigarettes?

Dr LYONS: I do not have that level of detail in relation to the guidelines.

The Hon. EMMA HURST: What programs does the Government have in place to promote and support the well-established mental health benefits of living with a companion animal, if any?

Dr WRIGHT: I am not sure whether there is a health-wide policy, but I know a number of individual services are examining this quite closely. I think it is probably still at the level of individual service. In my experience this is how enduring change happens in our services: A particular unit or a particular service recognises the potential value, explores it, pilots it and shares the learnings with others. I am aware of some individual services, but I do not think there is a service-wide thing at this stage.

The Hon. EMMA HURST: Is the Government providing or planning to provide any financial or other support to people with mental illness who adopt companion animals?

Dr LYONS: Not to our knowledge, no.

The Hon. EMMA HURST: This morning I asked the Minister questions about mental health issues that are more prominent in certain professions such as the veterinary profession and slaughterhouse workers. It seemed from the response that I received that most of the Government's programs are more broadly targeted at mental health workplaces generally or in the general population. Does the Government have any formal systems in place whereby it tracks mental health issues in particular professions or industries so it can identify those sectors most in need and take action?

Ms KOFF: No, as the Minister mentioned this morning, as part of the work, health and healthy mental health workplaces is a whole-of-Government initiative that does also extend to the private sector to ensure that people understand and can identify mental health issues and the environment is supportive of people in those situations where they are working. In terms of targeting specific professional groups, we ourselves had some issues with junior medical officers. We had a number of adverse events with junior medical officers [JMOs] and developed a JMO wellbeing program in response to some of those issues that we experienced. Whilst collectively we do not target all professions and track them, that information is well documented in national reports as to the various professions. From our perspective it is important for the professional associations to work in partnership with us to address some of those issues.

The Hon. WALT SECORD: I just have to follow up a question from the Hon. Emma Hurst. Ms Koff, you used a phrase "adverse situations". What were the adverse situations? I am not sure what you mean by that phrase.

Ms KOFF: Could you expand?

The Hon. WALT SECORD: You said junior doctors and you said there were "adverse situations".

Ms KOFF: Yes, there were a number of JMO suicides.

The Hon. WALT SECORD: I did not understand, because you used the word "adverse". Dr Lyons, in another committee there was some evidence that revealed that 17 patients at the Northern Beaches Hospital waited longer than 24 hours in the emergency department. How many of those patients were actually mental health patients that waited longer than 24 hours?

Dr LYONS: I do not have specific numbers about numbers of patients who waited at Northern Beaches Hospital available to me at the moment.

The Hon. WALT SECORD: Could you take that on notice?

Dr LYONS: I am happy to take that on notice.

The Hon. WALT SECORD: I am not sure who to direct this to, the Involuntary Drug And Alcohol Treatment [IDAT] Program, particularly in rural and regional areas, and how it would impact on people fighting the scourge of ice. Is there anyone who would have information on the Involuntary Drug and Alcohol Treatment Program?

Dr LYONS: I defer to Dr Wright, if known. But it is in the broader Health portfolio.

The Hon. WALT SECORD: Chief Psychiatrist, could you help me with that?

Dr WRIGHT: It depends on the detail of the question, but I am happy for you to ask the question.

The Hon. WALT SECORD: I am trying to find out does it exist. I understand there are between eight and 12 beds for the entire State. I am trying to get a gauge on what services are available for people who need major treatment for ice addiction in regional and rural areas.

Dr WRIGHT: The involuntary part of the program, if you like, is the last cab off the rank. I think it needs to be seen in the context of a much larger set of services. Thankfully a significant majority of people with substance abuse problems actually present for voluntary treatment and there are services addressing that, including people who are addicted to methamphetamine around the State. I cannot tell you the precise number of beds, but there are beds in Orange and northern Sydney. These are the two services. The model is quite different from the model for mental health services in that the involuntary treatment of people with substance use problems really is a last desperate attempt for someone who is likely to die if they do not receive treatment. It is a scarce resource and it is one that is very reluctantly used because of the fact that you are depriving someone of their liberty for that process.

The Hon. WALT SECORD: I understand this is a situation where they are either a danger to themselves or a danger to the community.

Dr WRIGHT: In most cases the people who are put through involuntary drug and alcohol treatment, the major risk is that they are going to die as a result of their addiction.

The Hon. WALT SECORD: If you live outside of Sydney, Wollongong or Newcastle in regional New South Wales, how many beds would be available for treatment for ice? For example, if I had a child who I needed to get into an ice treatment program how many beds would there be outside of Sydney, Wollongong and Newcastle?

Dr WRIGHT: I am afraid I cannot answer that question.

Ms KOFF: No, and our preference would be to have those questions in the Health portfolio, Mr Secord.

The Hon. WALT SECORD: You are director-general, can you assist me?

Ms KOFF: When we go to Health on Thursday the Chief Health Officer, Dr Kerry Chant, is responsible for the drug and alcohol portfolio and will be able to describe it in detail.

The Hon. WALT SECORD: The reason I am asking questions about ice is that this Government was elected on a clear platform where it said it was going to create a regional youth strategy tackling mental health, alcohol, drug rehabilitation and unemployment. That is why I asked you about ice. The Deputy Premier and the Minister repeatedly said that they were going to tackle ice. That is why I am asking you. I thought you would come to this committee and you would be able to tell me the number of treatment beds in New South Wales for young people grappling with the scourge of ice. Is there anything you can tell me about what the Government is doing to tackle the scourge of ice in rural and regional areas?

Dr LYONS: Mr Secord, my understanding is that there is a special commission underway at the moment looking at this very issue. I think in part that we have not come expecting detailed questioning on that. That inquiry is due to deliver its finding early next calendar year. We have been actively playing a part in providing advice and input to that inquiry.

The Hon. WALT SECORD: Next calendar year? It was going to be October.

Dr LYONS: The special commission is due to report on 28 January 2020.

The Hon. TREVOR KHAN: Point of order—

The CHAIR: A point of order has been taken.

The Hon. WALT SECORD: They pushed it back.

The Hon. TREVOR KHAN: The point of order goes to the previous issue, that is, the witness is answering and the Hon. Walt Secord comes in over the top.

The Hon. WALT SECORD: I apologise for that. I am a bit excited because I was originally told it was going to be September-October and now it has been delayed to the new year.

Dr LYONS: It is due 28 January 2020 is the advice I have.

The Hon. WALT SECORD: I was unaware that the deadline for the inquiry into ice was pushed back to next year. I direct my questions to a person who can answer about youth unemployment.

Mr ORR: We will attempt to answer your question.

The Hon. WALT SECORD: What is the current rate of youth unemployment in New South Wales outside of Sydney, Wollongong and Newcastle?

Mr ORR: It varies on the region you are in. Generally youth unemployment is higher in regional New South Wales compared to Sydney metro, Wollongong and Newcastle. It is around the 13 per cent to 14 per cent mark.

The Hon. WALT SECORD: Is it correct that Coffs Harbour and Grafton have the highest recorded youth unemployment rate in New South Wales?

Mr ORR: I believe that is correct.

The Hon. WALT SECORD: What measures is the Government taking to tackle youth unemployment, which is the highest in the Coffs Harbour and Grafton areas?

Mr ORR: I guess there are a couple of things. Just to cover your original comment, which was about the Regional Youth strategy, the Government has committed to: firstly, the creation of a ministerial portfolio for Regional Youth and the Minister was here earlier covering that; and, secondly, the creation of a Regional Youth Taskforce, which nominations were called for earlier this year. The Minister is getting close to finalising the membership for that task force. Two of those members will come from the North Coast. The role of the task force is to provide the Minister with advice and information about strategies to deal with youth-related issues within New South Wales. As well as that, the Minister and the Government broadly have the Stronger Country Communities Fund, of which $50 million will go towards Regional Youth. That is administered on a local government area [LGA] basis. Most local governments start with $750,000, which is notionally split 50-50 between youth activities and other infrastructure for community-related activities.

That is the broad framework. In terms of the approach and the building of the framework, there are four key pillars that the Government is going to be working on and working with the task force on. Notionally, they are about work—so finding youth a job within regional New South Wales, of which there are a number of thoughts that have been put forward. There are a number of existing programs that the Government runs, such as apprenticeships and the like, which you are probably aware of, but the intention is to flesh those out and build up towards the release of an action plan in February next year. Unemployment—jobs—is one of those; wellbeing is another; moving around and things to do—both the connectivity issue, transport and digital connectivity is another part; and then things to do with the communities is the forth pillar.

The Hon. WALT SECORD: Are there any programs to help students in rural and regional areas who want to access university programs?

Mr ORR: Access university programs?

The Hon. WALT SECORD: Or do university studies in regional centres?

Mr ORR: Yes. Broadly, the challenges that youth face in regional New South Wales are pathways to work—be that a pathway to university and some of the challenges that young people face in accessing university studies within regional New South Wales. We are mindful of those challenges, but I think the other challenge that has become more prominent is pathways for those who do not want go to university and the challenges around that. We are doing some specific work within certain communities. In Cobar, for instance, there are a number of mines and we are working with the mines and the high school to provide pathways for those young people to move from high school into the mining sector. In Tamworth we are doing something similar with the meat processing sector. Yes, I think the broader challenge is not only university, but also to create pathways between school and work.

The Hon. WALT SECORD: My original question was about country kids getting access to university programs. Are you aware of a program called the Country Universities Centre [CUC]?

Mr ORR: Yes.

The Hon. WALT SECORD: Have you done any evaluations on the effectiveness of the CUCs?

Mr ORR: The CUC has been in place now for a relatively short period of time, so in terms of whether any evaluation has been done on the program, I am not aware of any. Perhaps I could take that on notice.

The Hon. WALT SECORD: Are you familiar with the efforts to establish a CUC program in Griffith?

Mr ORR: I am aware. In terms of where CUCs are being rolled out, I am aware of the model.

The Hon. WALT SECORD: Are you aware of the Griffith one?

Mr ORR: Where specifically it is being rolled out at the moment. I understand where it is in some places, but I am not completely familiar with where it is going to be.

The Hon. WALT SECORD: You mentioned the mining sector in Cobar. What is happening there? Is that to encourage young people to work in new and emerging mines or what is that?

Mr ORR: One of the challenges that young people face is, if they do not want to go to university. which is a pretty well-trodden path, I think people are pretty familiar with what they need to do to go to university. If they want to get a job and, in this instance, in the mine, what is the pathway that enables that to happen? We provided a training course and notionally set up a mining skills academy in Cobar, in which there are a number of mines participating. The intention is to provide an easy pathway for those kids who want to go and work in a mine in Cobar. They do not have to leave the town, they do not have to travel long distances for training. I think you are familiar with where Cobar is.

The Hon. WALT SECORD: Yes.

Mr ORR: The intention is to enable them to transition from high school to work in a seamless way and to do that in partnership with the mines.

The Hon. ROSE JACKSON: I think my questions are to Mr Orr as well. Are you and your department, or your section of your department, responsible for Regional Youth strategy within the New South Wales Government?

Mr ORR: Yes. Last year we established the Office of Regional Youth, as part of the Deputy Premier's desire to bring Regional Youth more to the fore—

The Hon. ROSE JACKSON: That sits within Planning, Industry and Environment, does it?

Mr ORR: Yes. At the time it sat within the Department of Premier and Cabinet, and then with the machinery of government changes, which happened following the election, we moved from that department into the Department of Planning, Industry and Environment and the function of Regional Youth followed us.

The Hon. ROSE JACKSON: What is the budget for the Office of Regional Youth?

Mr ORR: There was no specific allocation. Can you find a budget allocation within the budget papers? No, you cannot.

The Hon. ROSE JACKSON: I did try to look. I am glad that you have confirmed that I did not miss it. It is just not there.

Mr ORR: I thought this question might arise. Currently we are allocating a number of staff—

The Hon. ROSE JACKSON: How many FTEs?

Mr ORR: I would say about 11 people who are working on the initiative both in Sydney and across regional New South Wales. Those teams are working on a number of things. One is the broader strategy and rolling that out, and they are also involved in the task force and the Stronger Country Communities Fund that I mentioned before.

The Hon. ROSE JACKSON: At present the Office for Regional Youth has no specific funding allocation. It has 11 staff pulled from other parts of the Department of Planning, Industry and Environment.

Mr ORR: Yes. If you look at some the functions we perform, the teams in the regions do whole-of-Government work, so notionally they have been involved in youth issues in the past. We are focusing their efforts more on youth matters. That has been going on but broadly and—if the Minister were here I am sure she would speak to this—the intention is to build up a strategy at the back end of this year and into the new year.

The Hon. ROSE JACKSON: The one announced in February next year?

Mr ORR: Yes. And then to seek further funding through the budget process next year to fund the strategy and, perhaps, bolster some of the resources that go towards it.

The Hon. ROSE JACKSON: Why was the deadline for the Regional Youth Taskforce applications extended? Was it because there were not many applications?

Mr ORR: No. We extended it fairly early on in the piece; it was not as though we waited. We clashed with school holidays, so I think we realised that it would be better to extend the period beyond the school holiday time frame. That is the main reason it was extended.

The Hon. ROSE JACKSON: I think you have alluded to this before, but are you able to give us any more detail about when we might expect the announcement of who is on the task force?

Mr ORR: Ultimately the Minister determines who is on the task force; it is the Minister's task force. I would imagine that will occur shortly. It is not far away from being considered, but the timing and the membership is a matter for the Minister.

The Hon. ROSE JACKSON: Understood. What relationship does the Office for Regional Youth and those 11 people have with FACS in relation to youth issues generally across government? Do you regularly meet with them? What is that dialogue like?

Mr ORR: Yes. In developing some of the strategy and some of the framework—the four pillars—so we have got a cross-agency committee which involves all the respective government agencies be they FACS, be they Transport, be they people from the arts and so the list goes on. We have been working right across government in terms of the work which we have done to date. I think that committee has met on five or six occasions so far.

The Hon. ROSE JACKSON: In relation to the four pillars—I think that was the phrase you used—one of those I think you mentioned to my colleague Mr Secord was about employment. Is another specific one of those around drug use and ice specifically?

Mr ORR: I think wellbeing covers off on a range of issues. Certainly in some of the consultations which we had in the middle of last year, one of our recurrent themes was about wellbeing. We spoke with a lot of school kids. We went into schools and talked to them in conjunction with the youth advocate. There was a number of themes which emerged through those consultations, and certainly one of the messages was about broader wellbeing.

The Hon. ROSE JACKSON: You ran those consultations last year. How many of them?

Mr ORR: There were 26.

The Hon. ROSE JACKSON: These are the youth forums?

Mr ORR: Yes.

The Hon. ROSE JACKSON: I think the Deputy Premier suggested that there would be 40. What happened to the other 14?

Mr ORR: In addition to those 26, there was some Ipsos work. So we engaged Ipsos to run a number of groups of people who have either left school or who are potentially harder to get to in terms of perhaps Indigenous people, groups of Indigenous people. Those are the groups which were additional to those 26.

The Hon. ROSE JACKSON: How much did you contract to Ipsos to do that work?

Mr ORR: I would have to take that on notice. I cannot remember the exact details.

The Hon. ROSE JACKSON: I have a couple of questions about youth mental health. What percentage of the mental health expenditure—I think it was $2.1 billion, as discussed by my colleague the Hon. Tara Moriarty earlier—was directed at child and adolescent mental health programs?

Ms KOFF: According to our budgetary figures, $27 million in infant child and adolescent services as part of the mental health reform—this is across a diversity of programs—$3.6 million to what we call Whole Family Teams, because I think the critical nature of child and youth mental health requires a family-based approach; just under $2.2 million for youth community living support services; $2.3 million for child and adolescent mental health services, which includes consultation, liaison, psychiatry, which is an important component; $1 million in the School-Link program; $11 million on Getting On Track In Time – Got It!, which is a dedicated program; and $680,000 for Aboriginal Got It!, which is a dedicated program for Aboriginal children in terms of the approach, once again reiterating a culturally safe and appropriate program designed for that population group.

I think it is important also to understand there are a range of other initiatives that we have in the youth program area. Obviously our Lifeline services and the call centres that we have to support those are critical in supporting the diverse range of programs. When we look at our eating disorders program too, that has a high registered population of youth.

The Hon. EMMA HURST: This morning the Minister advised that the Government had invested $61,000 in a partnership with the RSPCA to develop the capabilities of shelters to house the animals from domestic violence situations. This is a pretty insignificant amount of money given the scope of the problem, particularly in light of the statistics—nearly 33 per cent of women are remaining in domestic violence situations due to concerns about their companion animals, not to mention obviously the trauma that is involved in separating women and children from their companion animals at what is already a stressful time. Does the department have any plans to make further investments in housing for domestic violence victims together with their animals or for further programs with the RSPCA?

Ms WALKER: As I mentioned this morning, that pilot program is going to be extended to two other refuges. The nature of the funding that was received for the RSPCA Safe Families program was from the Domestic and Family Violence Innovation Fund. The way that fund works is really to take good opportunities and to test them out to see if they work, really with the idea that the uptake then of the project is often taken on by the agencies themselves who put that forward. What we want to keep doing is looking at how we make sure that we keep especially our women's refuges and our services as client focused and as client centred as possible. So we absolutely take on board the research that says some women do not leave because of their companion animals, and making sure that we keep working with our agencies about how to accommodate that.

The Hon. EMMA HURST: Does the future program that you were talking about receive extra funding from the department?

Ms WALKER: I will have to take that on notice.

The Hon. EMMA HURST: Could you also take on notice the amount of funding—if there is any— for the future programs? With the project with the RSPCA, are you working with them to monitor the success of the work and how it can be replicated if it is successful?

Ms NORTON: As part of the contracting arrangements for any of those programs under the innovation fund, they are required to do an evaluation. Also, as part of that contracting arrangement we talk to them regularly about progress. So we would be looking to continue those discussions. I am aware that the RSPCA has rolled out, following that pilot program, a more extensive program. It is called the Community Domestic Violence Program, which it runs more broadly across New South Wales, based on some of the findings of that initial pilot.

The Hon. EMMA HURST: Will the evaluation progress reports be made public?

Ms NORTON: I will probably take that on notice. I think where we can we obviously try to use information that is useful to others to produce that publicly. We certainly have information on our website about all the projects funded under the innovation fund.

The Hon. EMMA HURST: I want to talk a little about animal hoarding. It is considered a neuropsychiatric condition associated with the accumulation of a large number of animals and failure to provide minimal standards of nutrition, sanitation and vet care. It often comes about because the hoarders, who are overwhelmingly women, have psychiatric or psychological issues. However, when animals are removed by the authorities mental health assessment of hoarders is rarely arranged. As a result, recidivism after removal of animals is nearly 100 per cent. Is the department doing anything to address the mental health conditions of hoarding, given the serious impacts it can have on both humans and animals in New South Wales?

Dr WRIGHT: Not specifically animal hoarding but hoarding per se, I think that is certainly known to particularly our community-based services. It is not a clinical diagnosis in itself. There are a number of potential conditions that can contribute to someone who ends up hoarding, including hoarding pets. I think that it is an enormously challenging situation to manage both for the individual, for their family, often for their neighbours and the local community. And also it is not just mental health services; it often affects local government because there are often issues around hygiene which are raised.

You are quite correct: Recidivism is a significant problem. I think it is not through lack of interest or will; I think it is because it is actually a very challenging situation to manage. But it is one of those things where, at a local level, the sort of connection up of the various services—including the mental health and local government services—is actually an important part of trying to, I think in most cases, mitigate what is often a chronic and relapsing problem.

The Hon. EMMA HURST: You talk about hoarding more generally. Are there any support services within that mental health space that are specific for hoarding and that companion animal hoarding would fall under?

Dr WRIGHT: Not specifically. Fortunately, it is not a common problem but it is a difficult problem so it is more a case of the individual services being aware that the problem is there and then working collaboratively across often whole of government to try to manage the situation.

The Hon. EMMA HURST: More generally, I have a few questions regarding the acute health care. Would you be able to give me a general overview of where acute health care is up to and what is happening at the moment in that space?

Dr LYONS: Do mean acute mental health care?

The Hon. EMMA HURST: Yes, sorry.

Dr LYONS: Acute mental health care is one of the cornerstones of care that we provide in our system. It revolves around services that exist in every local health district [LHD] and they have a range of different levels of service available for people who need acute mental health care—ranging from general hospital beds that might have consultation liaison psychiatry services where people are admitted where they need mental health care as well as other conditions that they might need hospital care for, right through to our specialist mental health units and our mental health intensive care units. We operate six mental health intensive care units across the State. They are networked to ensure that the people who have the complex and highest care needs have services available to them, and where they are not available on every site and if people need access to those beds, then we can network our service to enable their referral to those beds to make sure that they are able to receive the care they need.

These are many of the services that we operate and then connect up with what goes on in the community: There are community health services and mental health services that link with those acute services. As well we have sub-acute mental health beds that create a step-up/step-down arrangement so that if someone is not needing the whole suite of acute care they can get some admitted care through sub-acute. They go up and down into the acute if required and out into the community in a supported way where there is appropriate level of clinical support provided to enable them to get the best care that they need.

The Hon. EMMA HURST: Do you have any statistics on how often these acute care teams are able to treat people with mental illness in the community as opposed to being admitted to a hospital or other facility, which obviously can be traumatic and a strain on public resources?

Dr LYONS: The vast bulk of the care we provide is actually in the community. I will try to bring the numbers up—I have not got them—but there are around five million occasions of service, I think, across our community mental health services each year, yet the admissions to hospital are around 100,000. The vast bulk of the work we do is to provide care in settings that are outside of hospitals. We try to titrate the care to ensure that people can receive care in a setting that is close as possible to where they live—that is, around family and other carer supports. We admit people into care and move them away from where they live only when that is absolutely necessary for their healthcare needs.

The Hon. EMMA HURST: Is a lot of that treatment and a lot of the intent of these acute healthcare teams focused on working with people after discharge from a hospital or facility or are there some other avenues to access, when you say that the majority are in the community.

Dr LYONS: Dr Wright will know this in more detail but both before and after. We have services that are provided to support. As I said earlier in response to other questions, most of the mental health care is actually provided by primary care general practitioners. We have many programs that are set up to provide support to GPs so they can deliver that care. Then we have a whole range of access points for community-based specialist teams for a whole range of different conditions and ultimately, if required, admission to an acute facility if the person's condition is such that it warrants it. The whole system is geared up around how we can provide support to people to keep them well and out of hospital. As we have indicated, there is a need to further that investment and the focus of what we are doing, particularly with the Living Well reform, is to shift that focus and make sure that investment occurs in places that enable people to stay well and to be well and within the community as much as possible. That is going to continue to be the focus of investment. I have a quick response to your question about the pets for therapy.

The Hon. EMMA HURST: Great, please.

Dr LYONS: I had some information coming in from around the State in response. Although we do not have a statewide program, many of our services have animal therapy as a part of what they do. Some examples are a visiting dog program that is part of the Wagga Wagga Mental Health Recovery Unit. In Tumut, the community mental health youth service uses horses for trust and behaviour treatment. Justice and Forensic Mental Health partner with Delta dogs to provide therapy for people in the Justice and Forensic Mental Health system.

While we do not have statewide programs, many of our services are seeing the benefit of providing that therapy and that care as part of a whole range of programs. They have, it is said, quite positive impacts.

Ms CATE FAEHRMANN: Dr Wright, I go back to the questions I have been asking about the *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*. I understand you led the team to undertake that review. The report says:

> After visiting 20 emergency departments, the review team had significant concerns about the design and use of safe assessment rooms. Typically the review team were confronted by small, noisy, cold rooms, often with no natural light, no activities to distract, no chair to sit on, no one to talk to, and only a foam mattress and blanket on the floor. Most commonly, the rooms were located in the middle of the emergency department or in a thoroughfare which is not a low-stimulus environment.

How many of those 20 emergency departments still have that environment for their safe assessment rooms?

Dr WRIGHT: I would have to take that question on notice. I guess the important point that you raised is that we did not visit every single facility in the State but it was a very strong impression of the facilities that we did visit. That is why several of the recommendations were built around trying to rectify that, both in terms of the design of the individual rooms—where they were sighted—but also, as I mentioned this morning, how they were actually used and ensuring that it was not a default option for anyone presenting with a mental health complaint. I cannot tell you what state those units are in today.

Ms CATE FAEHRMANN: When did the review team begin the review?

Dr WRIGHT: That was in the second half of 2017.

Ms CATE FAEHRMANN: Yes, and it was reported in December 2017. How much investment has gone in from the New South Wales Government into the implementation of the recommendations of this review, in terms of money?

Dr WRIGHT: I think there was a $20 million investment specifically in terms of improving the emergency department environment. That was very much, I think, an important and rapid response to the paragraph that you just quoted, which was a concern that those facilities were not appropriate to someone who is in a state of mental distress. There was a process of bidding by all of the local health districts to put up projects to improve the environment of their mental health emergency facilities. It was very much specific to each individual site. They were able to consult locally and determine what they could do—within a limited, minor capital works budget—to address the sorts of things that were identified in the review. My experience of visiting some services since that time is, firstly, the opportunity for the services to try to address concerns that they also had but were unable to address previously. They really embrace that opportunity and were really very pleased with what they had been able to achieve with a fairly limited investment in some cases.

Ms CATE FAEHRMANN: Which financial year was that $20 million capital works? Was that 2018-19?

Dr LYONS: The 2018-19 year.

Ms CATE FAEHRMANN: So that was expended. Every LHD who requested access to that $20 million. Were their requests met or was there unmet demand for that money?

Dr LYONS: I think the initial allocation was $20 million for 2018-19, as we have indicated, and my understanding is there is a further allocation being made in 2019-20 to continue the program because it has been so successful.

Ms CATE FAEHRMANN: And the same amount?

Dr LYONS: My understanding is it is. I am just trying to find the note that confirms the exact amount. When I have retrieved it I will confirm for you. But that has been a program that has been enormously successful, as Dr Wright said, and there has been a whole range of investment involving consumers, carers, families and clinicians across a number of the acute units in the State where there has been purchase of sensory modulation equipment and the creation of sensory rooms, new exercise equipment, designated exercise areas or gym spaces for people who are inpatients in care and treatment, and improving spaces where family can more comfortably visit their loved ones and have private conversations. They are just examples of the changes that have occurred and they have been very well received by patients, carers, family and clinicians providing the services, and they have made a huge impact.

Ms CATE FAEHRMANN: With the minor capital works program, if that was to specifically address the recommendations of the review of seclusion, restraint and observation—and this is in emergency departments, I am assuming—and this was undertaken, what is the exercise component?

Dr LYONS: The first phase is in acute mental health units; these are for people in inpatient areas.

Ms CATE FAEHRMANN: In the units as well as the emergency departments?

Dr LYONS: Yes.

Ms CATE FAEHRMANN: Have you set targets for reducing seclusion and restraint?

Dr LYONS: We have.

Ms CATE FAEHRMANN: Where are they found, those targets?

Dr WRIGHT: I think they are in the RoGS, the *Report on Government Services*. It is a national target and it has been in place for close to 15 years. The Australian Institute of Health and Welfare reports on the seclusion figures and they report them both from a jurisdictional and a national level. In recent times the reporting of those figures is down a facility level.

Ms CATE FAEHRMANN: In the last financial year have we been reducing the use of seclusion and restraint and New South Wales?

Dr WRIGHT: Yes.

Ms CATE FAEHRMANN: Have you got those numbers?

Dr WRIGHT: Yes. Between 2011 and 2018 I think the seclusion in New South Wales has halved; it has gone from about 11 cases per 100,000 beds down to five. So there has been a significant improvement. The point that we made in the seclusion review is that what we would like to see is a journey towards zero because I think that for most people who experience it it is not a therapeutic experience, it is traumatic. The fact that we have improved or halved the rate in the last seven years is reassuring but it is not sufficient going forward. It does make us feel that the strategies and the recommendations contained in the seclusion review, we believe, would help to continue that improvement.

Dr LYONS: Could I just come back to your question about whether it was allocated for this financial year as well? I can confirm $22 million has been allocated for 2019-20 for the continuation of that therapeutic environments program.

Ms CATE FAEHRMANN: What was the level of unmet demand of the original $20 million with local health districts in the 2018-19 year?

Dr LYONS: There is still a program to continue that work through not just the acute units and the rooms that would benefit from improvement there, but we will move into the safe assessment rooms in emergency departments more holistically as well. Once that guideline comes out that you talked about earlier today around how we appropriately provide care in a safe assessment room environment—the guideline that is coming out by the end of this year—the next step will be to go and then audit those environments and look at what other things we need to do to improve the physical environment as well as the guidelines for care that will change. It is going to be about how we support that change in clinical practice.

Ms CATE FAEHRMANN: The total funding so far to underpin the recommendations from this review has been $20 million last financial year and $22 million this financial year, and you are suggesting that there will be more. I am assuming that audit will reveal more capital works expenditure would be required, surely.

Dr LYONS: That is just a touch of the capital works program for Mental Health. That is specifically targeted to those particular recommendations that came out of the seclusion and restraint review. We have also got a $700 million statewide capital mental health program, which is in the forwards. We also have the investment that is being made across all of our acute hospitals as they get upgrades, and acute mental health units and psychiatric emergency care centres and emergency departments where they are a component of those upgrades. It is only a small component of the massive capital investment that is occurring across the State.

The Hon. TARA MORIARTY: I want to start by following up on some of the questions that were asked by my colleague the Hon. Rose Jackson, because I think the topic of youth mental care is particularly important for a range of reasons. Can I just clarify: The portion of the budget in Mental Health that is allocated to youth services, did you say that was $27 million? Can you just remind me of what that figure was?

Dr LYONS: I think it was $27 million.

The Hon. TARA MORIARTY: I think that is what it was.

Ms KOFF: Sometimes paper is a preference to going electronically, let me tell you.

Dr LYONS: While the secretary is looking for that exact number—that is for specific and targeted child and adolescent mental health programs—I think we also need to indicate that across our general services youth will be accessing a range of those general services that are included in the $2.1 billion recurrent spend. There are particular, specialised, targeted services and then youth would be accessing a whole range of other services as well.

The Hon. TARA MORIARTY: I can understand that. Just while you are looking for that, you also previously listed off some of the programs that fit within that amount of money. Can you give us some information about some of those programs? I understand that young people suffering from mental illness will use services across the board but within those programs that target youth what is being done to target youth? What is being done in terms of preventative care? Maybe start with the programs that you listed and give us some information about those.

Ms KOFF: Yes, certainly. I will go through some of the ones listed. The $3.6 million to expand the Whole Family Teams, increasing the number of teams across the State from four to seven. Those Whole Family Teams provide intensive, specialist mental health and drug and alcohol services to vulnerable families, because the security and welfare of the children in those settings with mental health and drug and alcohol issues is absolutely critical. The $2.17 million to deliver community-based psychosocial services to support young people recovering from severe mental illness. I think, as described earlier, mental illness can be a fluid state with an acute exacerbation and then a recovery phase. The Youth Community Living Support Services are managed by other community-managed organisations in Newcastle, Blacktown, Penrith, Lismore and Campbelltown.

The $2.2 million to expand the capacity of specialist mental health services to provide what we call assertive community in-reach and outreach and consultation liaison to services to the health, welfare and education sectors across nine LHDs. That is all about the coordinating interagency for young people and children experiencing mental health issues and covers emergency department, paediatric settings and community health centres. I think our recognition of the importance of early intervention is reflected in some of the initiatives around the School-Link. School-Link is an important program that strengthens mental health support services in schools, and the additional $1 million this year is part of the $3.37 million annually that we have across the State with 21 School-Link coordinators.

I mentioned the Getting on Track In Time - Got It! program. That is a school-based early intervention program that supports teachers to provide social and emotional learning from children from five to eight. So you can see we segment the population groups because their needs are really quite different. The Aboriginal group is located in south-western Sydney. That is a pilot program that really is looking to tailor specifically to the wellbeing of Aboriginal children and engage Aboriginal families in south-western Sydney.

The Hon. TARA MORIARTY: A number of those programs had specific references to areas around Sydney. Have you got any particular regional focus? I acknowledge that people access the system across the board but there would be less ability to access a range of health care or parts of the healthcare system in regional and remote New South Wales.

Ms KOFF: One that I will mention is one of Minister Taylor's champion projects which is the Wellbeing and Health In-reach Nurse Coordinator model. That supports children and young people to access health and social services in rural and regional areas. There was an election commitment of $3.4 million over four years for the coordinator positions. They are at the pilot sites of Young, Cooma and Tumut and we are looking at three new coordinators at Deniliquin, Murwillumbah and Lithgow. They are well distributed across the rural and regional areas. I think one of the other most important things that we do also is telehealth and telemedicine especially to support rural services with connectivity to mental health services. As was touched on earlier with the mental health workforce, we can supplement that workforce with telehealth coordination and communication. There are a number of programs where we can provide that support over the telehealth modality.

Dr LYONS: The only other additional thing I would add to what the secretary has already talked about is the headspace model which is actually a Federal Government funded program but has been recently announced to be expanded quite significantly. Of course we would want to leverage the investment that the Commonwealth is making into those headspace models as well, which have a specific target around youth and supporting youth.

The Hon. TARA MORIARTY: Is there any specific or targeted work being done in relation to youth suicide? Correct me if I am wrong, but I understand that the figures for youth suicide are higher than young people dying in car accidents. I know there is a lot of attention paid to that. Is there anything specific being directed toward people who are very vulnerable in that space?

Dr LYONS: We will be doing a lot more work as part of the suicide prevention framework and the $87 million that was announced in this year's budget over the next three years. We are just starting the implementation planning and a lot of the focus will be around what we can do for you. But in that space already we were one of the early signatories to the heads of agreement for the new National Health Agreement. As a result of that we were able to access some additional funds from the Commonwealth Innovation Fund.

One of the areas that we targeted was a youth architect pilot program to actually test and try some new models of what we can do to support young people who may have had self-harm attempts. We have invested across two New South Wales locations $4.2 million over the next four years. That will provide an intensive community-based assertive outreach service for young people following a presentation where they have undertaken an intentional self-harm episode.

The CHAIR: Where are those two locations?

Dr LYONS: I haven't got the allocations for those yet. That is being worked through as we make the investment. It will be a very important program that we will trial as a result of being able to access that benefit from the Commonwealth.

The Hon. TARA MORIARTY: In February this year the Government announced $88 million to provide every public school with two dedicated mental health experts to ensure that students have access to mental health support. Has the rollout of that program begun?

Dr LYONS: I think that was actually in Education and not in Health. We will need to get advice from our colleagues in Education about where that is up to.

The Hon. TARA MORIARTY: That's fine. Is the proposal that these mental health experts in schools will play more of an educational role or healthcare role?

Dr LYONS: I think they were funded through the Education budget is the point I am making.

The Hon. TARA MORIARTY: Will you have any input into that, or will these people be required to have some sort of expertise in mental health?

Dr WRIGHT: The School-Link is the health contribution to mental health in the education department. That is a program that has been around, again, for a number of years. There are ongoing developments of the School-Link service. Their role is, as the name suggests, to provide a linkage between the education-based resources which include school counsellors. I think that is what the announcement you are referring to is talking about. Connecting those in-school services to the mental health services so that the school-based counsellors will be providing services to individual students and the role of the School-Link is to both improve the capacity of those services and to connect the students to ongoing services out in the community as well. It is really about ensuring the pathways between the services within the school and the community-based services.

The Hon. WALT SECORD: Dr Wright, it is such an important program and the Government badged it as having a mental health component. What has been the involvement in the consultations involving you and your associates?

Dr WRIGHT: I don't have information about what the consultation was with the Child & Adolescent Mental Health Service but I think the school-based counselling services which are generally psychologists is a very substantial commitment through Education. I think there is quite a mature and good relationship between the school-based services and the mental health services. And it has been around for quite some time. I think it functions very well.

The Hon. WALT SECORD: What is your response to the pharmacological society's proposal to encourage community pharmacists in rural and regional areas where there are no mental health workers—because we know there are parts of the State where there are no mental health workers—to triage, assist or provide people with information or direct them? I know this occurs in the United States. What is your response to pharmacists planning to triage or encourage people?

Dr WRIGHT: I haven't seen the proposal. I would segue back to the comment before that we try to make use of distance communication and information technology to help to close the gap. Quite truly if someone is looking for advice about medication, the fact that they can't necessarily consult face to face with someone in their local community—which would be preferable—they can actually communicate using distance communication. I don't think it's necessarily that they don't have access to advice from mental health clinicians or doctors.

The Hon. WALT SECORD: I have had discussions with the Black Dog Institute and in certain parts of New South Wales, particularly I think Wentworth shire in the south-west corner of the State, there are no mental health workers whatsoever in the local government area. But I have been in the Northern Territory where they have had telelinks. Are you or the New South Wales Government working on areas to provide psychiatrists or mental health workers to people who are isolated in areas such as Wentworth shire where there are no mental health workers? Can you elaborate?

Dr WRIGHT: Yes and have done for a number of years. In fact, for a number of years I provided a service from Wagga into places such as Deniliquin and west. I think Dareton does actually have mental health clinicians and it also has visits from a psychiatrist who is based in Broken Hill. It has access to the services in Mildura as well. But to your larger point which is the use of telemedicine and video conferencing, that is something that has been used in New South Wales for the past 20 years, to my knowledge. With the improvements in the technology I think we are getting better and better at both public and private sector.

The Hon. WALT SECORD: Can I revisit a question I asked earlier about the Involuntary Drug and Alcohol Treatment Program? From your answer it seems that Orange and Royal North Shore are the two areas that offer this. You seemed to have had some concerns or reservations about this?

Dr WRIGHT: No, not at all. I think it is a really important—my comment is that it needs to be seen as a very small part of a much larger substance use service and that's all.

The Hon. WALT SECORD: I am sorry if I misunderstood.

Dr WRIGHT: I am strongly positive about it.

The Hon. WALT SECORD: Mr Orr, earlier you talked about not steering but encouraging young people in rural and regional areas that they may not want to go to university but they may in fact want to pursue TAFE or other training. With the looming sort of storm clouds with the economy, has there been a rebadging or reorienting of youth training programs in rural and regional areas—with the downturn and the drought?

Mr ORR: Certainly I think you would be aware of the Government's commitment in terms of apprenticeships and the money that has been put on the table to encourage young people into apprenticeships, as well as the skills portfolio. There are a number of initiatives in terms of linking industry with schools more broadly. To again come back to that issue that I mentioned before about pathways between school and work, there are a number of regional industry employment people who now work throughout regional New South Wales to bring greater linkages between industry and schools. Then there are a number of major infrastructure projects, which have a skills legacy element to them, whereby there are obligations on those lead contractors to employ young people within the workforce, to provide them with pathways and opportunities.

Those are a number of existing things at the moment, as well places within which we work. I mentioned Cobar and Tamworth. We are certainly doing work in the Snowy region to provide opportunities associated with the Snowy Hydro build—Inland Rail provides opportunities for young people to work on that particular project. So there are opportunities around that we are currently looking at. As well as that, through the development of a strategy, we will be talking to young people about what their views are in terms of what additional things could be done.

The Hon. WALT SECORD: What are the training programs in Tamworth? I had a briefing a couple of weeks ago about the extent of the drought and I learned that Australia at the moment has fewer animals on the land than it had at Federation.

Mr ORR: Yes.

The Hon. WALT SECORD: What are you training young people in Tamworth to do?

Mr ORR: In Tamworth there is relatively high youth unemployment—I think it is around 15 per cent or 16 per cent in Tamworth. There are three large meat processing companies—Baiada, Teys and Thomas Foods— all of which have issues with maintaining a stable workforce. There are no strong pathways between the school system and those meat processors. So the work that we are doing—similar to the work we did in Cobar–is to open up those pathways so for those people who want to work in that industry there is a clearer and cleaner way to work in that particular industry.

The Hon. WALT SECORD: You are familiar with the NSW Business Chamber. It has expressed its concern that it thinks apprenticeships start too late; it would like apprenticeships to start one to two years earlier. What is your response to that? The NSW Business Chamber believes that young men and women in that age group

are actually easier to get into apprenticeships because it says that they are still malleable. What is your response to that? Stephen Cartwright of the NSW Business Chamber has spoken about this.

Mr ORR: Yes. There is certainly debate about what is the right age. The school leaving age is at year 12, which you would be familiar with. I would imagine that some of these issues will be unpicked during the process. It will require us to talk to young people about their views and perspectives on what the right age is in terms of getting into the workforce. Anecdotally, employers do talk to us about whether the age is right and is it too late in terms of getting an apprentice who is 18 as opposed to the—

The Hon. TREVOR KHAN: You can do school-based traineeships.

Mr ORR: Yes.

The Hon. WALT SECORD: Yes. The business chamber made representations about that, too. It wanted to tweak it a bit. So that is where—

Mr ORR: I think those sorts of issues will certainly come out in the work that we are doing and the discussions we will have with the taskforce.

The Hon. WALT SECORD: You mentioned the work that you are doing. Are you talking about a review that is underway?

Mr ORR: No, the taskforce that will be established.

The Hon. WALT SECORD: The taskforce? Okay.

Mr ORR: The pillars that I talked about before. That all sets the frame for some of the focus that we will be bringing to youth and regional New South Wales.

The Hon. ROSE JACKSON: I have just a couple of follow-up questions from my colleague, Ms Moriarty. Of the $27 million that is specifically allocated for child and adolescent mental health programs, what percentage of that is allocated for rural and regional New South Wales—that is, outside Sydney, Newcastle and Wollongong?

Ms KOFF: I would have to take that on notice.

The Hon. ROSE JACKSON: I ask that because obviously there is some concern about specific difficulties in accessing mental health facilities for young people, particularly in rural and regional New South Wales. Would you agree that young people in rural and regional New South Wales do experience particular distinctive and acute mental health issues compared to city-based counterparts?

Dr WRIGHT: My view would be that they are not particularly distinct. I think that the challenge for anybody living in a rural or regional area is the access issue. There are child and adolescent mental health services in a number of our larger regional areas such as Orange and also in the Illawarra and in the Hunter New England area. I think the conditions that they experience are not necessarily different from the—

The Hon. ROSE JACKSON: You do not think that the specific, for example, youth unemployment issues in rural and regional New South Wales that have been discussed with Mr Orr might have a particular impact on regional youth? It is that much more difficult for them to find a job.

Dr WRIGHT: No, I think that if you have got increased stressors anywhere, whatever they might be, on an individual or even on a community basis, if there are higher levels of unemployment—we had a question earlier about the impact of climate change and the drought or other kinds of stressors—yes, that stress and all sorts of different kinds of stress can lead to higher rates of mental health problems amongst those communities. So if there are higher rates of unemployment, for instance, it does not just affect the youth; it affects everybody.

Ms CATE FAEHRMANN: I am not too sure to whom to direct my question. Has the Government ever funded community-led integrated suicide prevention programs that you know of?

Ms KOFF: I know some of the work that the Paul Ramsay Foundation is supporting in conjunction with the Black Dog Institute. That was rolled out in a number of districts that had a whole-of-community based response to suicide prevention. So if Murray or Nigel have any more details on those—

Dr WRIGHT: I think the short answer is yes. A very good example was in northern New South Wales in the Grafton area. It is called Our Healthy Clarence. That came off the back of some really serious community- based concerns about mental ill-health and, indeed, suicides among young people. I think the really important thing about that—and it is a model that has been of use in other parts of regional New South Wales—

is it really was a whole-of-community effort and it was not actually Health-led. Health was a very activity participant but it was local government and all agencies in those local communities. So they were the experts in terms of what were the contributors to the problem and they also put together a solution. My opinion, speaking as a psychiatrist, is that sometimes if something is seen as Health-led, or indeed mental health-led, that can actually make it difficult to get buy-in from the whole of the community. The fact that it was coming from the grassroots of the community I think made it quite a successful program.

Ms CATE FAEHRMANN: That was called Our Healthy Clarence, did you say?

Dr WRIGHT: Yes.

Ms CATE FAEHRMANN: What year was that?

Dr WRIGHT: My best recollection is I think it was 2016.

Ms CATE FAEHRMANN: So it sounds like it was something that was delivered, implemented and possibly evaluated—or possibly not, given half of these programs often do not have enough money for evaluation. Speaking from my experience working in the community sector before this job, why is it not still going?

Dr WRIGHT: I think it is still going. I think northern New South Wales was one of the Commonwealth's sites for the National Suicide Prevention Strategy. So I think success breeds success. I am not cynical about that; it created a momentum for change. I think that often one of the key challenges is: When you have got what looks like a community-based crisis and there is a response, sometimes that response peters out over time. I think the important thing is that that is being maintained in that area.

Ms CATE FAEHRMANN: Has the Government received approaches from organisations for more projects like that across New South Wales?

Dr WRIGHT: It is not so much about government receiving requests, it is about local communities learning from that experience and trying to adapt it to their own specific needs. I am aware that there was some interest from the Lithgow area on the same issue and more recently there has been some interest from the Kempsey area. It is not so much about getting funding to do things, it is about local will and collaboration.

Ms CATE FAEHRMANN: There are organisations I think that would like to do community-led integrated suicide prevention programs—Black Dog being one of them which you mentioned. I just wanted to check, within the Mental Health budget is there an allocation towards community-led suicide prevention programs specifically?

Dr WRIGHT: There was an allocation of funds, I think it was in 2017-18, for suicide prevention projects and that was in order basically to provide support for projects which had already been developed. There were eight projects across the State and they were all sorts of different projects from various different organisations. These are still underway. If I can take a step back. It is important and we have not mentioned it at all today. It is important to give mention to the Fifth National Mental Health and Suicide Prevention Plan, which is a national initiative. It has a very, very important focus on some fundamental changes to the way in which services connect up locally.

One of the key factors in that is about connecting primary health and the State-funded services at a local level and specifically around service delivery, including for suicide prevention. That feeds in perfectly with the initiatives which the Black Dog has been piloting across New South Wales and also with the Commonwealth suicide prevention strategies. There is an architecture around, I guess, the attempt to better connect up the different kinds of services that get funded both from the Commonwealth and the State level at a local level. When it comes to suicide prevention, and particularly community responses to suicide and to suicide prevention, that kind of fundamental change is really important to making an impact.

Dr LYONS: I have a little bit more detail on some of the examples. There have been eight mental health community-managed organisations that have been commissioned to develop and deliver community-based suicide prevention activities. They include activities that align with LifeSpan, which is a systems-based suicide prevention framework. The Black Dog Institute has been active in that space with not just the funding we provide but also with private funding piloting LifeSpan at four pilot sites: Newcastle, Illawarra Shoalhaven, Central Coast and Murrumbidgee. NSW Health is also supporting LifeSpan through local health district provided services in addition to what is being provided through Black Dog. There are some examples of where that has been supported and investment has been made at the local level.

Ms CATE FAEHRMANN: With that funding you just referred to, has that come through the Medical Research Support Program specifically? Is that what you are referring to? This is part of the medical research support that gives financial support to independent medical research institutes or is that specifically for a program?

Dr LYONS: I would have to take on notice about where the specific sources are coming from. What it says here is that it is through NSW Health funding. I would need to understand specifically what source that is. We might take that on notice.

Ms CATE FAEHRMANN: I am aware for the 2019-2020 budget the Black Dog Institute did a submission which called for support from the New South Wales Government. They said that they had received funding from the Commonwealth Government in relation to the 12 national suicide prevention trials, two of which are in New South Wales. That is the LifeSpan research trial I think you were referring to. They were seeking a funding commitment of $18½ million over four years to continue this work. According to Black Dog, they do say that the New South Wales Government does not fund community-led integrated suicide prevention programs and that, in fact—I will ask some questions in the Medical Research session on Thursday regarding it—we drastically underfund mental health research in New South Wales compared to other States. Are you aware of that funding submission? Has that come before any of the witnesses to assess whether that was worthwhile?

Dr LYONS: Certainly we have been involved in conversations with Black Dog about the LifeSpan model and about where there might be opportunities for further investment. It is about where we set, within the resources we have available, the boundaries around what we will commit to do. My understanding from the discussion was that we agreed we would look at supporting some additional sites but that we would not be able to do a statewide rollout. That was the conversation I recall having, but that was sometime back.

Ms CATE FAEHRMANN: I visited Black Dog a couple of weeks ago now and had a briefing on this program, the LifeSpan program. It is basically a data-driven suicide prevention intelligence system that allows sophisticated analysis of suicide clusters. I saw the various clusters. I think it is an incredible program and for $18½ million it does sound like the Government surely could do with supporting a few community-led suicide prevention programs, particularly ones that are bound to be successful.

Dr LYONS: I have clarification: There is $8 million over four years for the eight suicide prevention projects that I talked about, which is mental health branch funding not research programs.

Ms CATE FAEHRMANN: Can you repeat that?

Dr LYONS: I just had clarification on the issue around whether it was mental health research funding.

Ms CATE FAEHRMANN: Yes.

Dr LYONS: There is $8 million that is allocated over four years of the pilot program for the eight sites for the LifeSpan work and I am advised that has come from mental health branch funds not from the research program.

Ms CATE FAEHRMANN: That is good to know. On a different issue—homelessness—according to the NSW Homelessness Strategy, one-third of people seeking assistance from specialist homelessness services report having a current mental health condition. What is the usual mental health referral process for someone seeking assistance from a specialist homelessness service?

Dr WRIGHT: Can I clarify?

Ms CATE FAEHRMANN: If they go to a specialist homelessness service with a mental health condition, what is the usual referral process? Is there a mental health referral process within those services?

Dr WRIGHT: I think the referral process would be—I know there are some specific initiatives not far from this building run through St Vincent's Hospital network where they have got quite close connections between the homelessness services and the mental health services. But speaking more broadly, I think we have a statewide, if you like, intake process using the 1800 number which is available to everyone and all agencies regardless. That is the backup for all services, including homelessness services. I do not have the detail of the initiatives that operate in places like the inner-city homelessness programs, which I think have a much closer relationship with their mental health services.

Ms CATE FAEHRMANN: Is there a strategy within the department? Given that one-third of people seeking assistance from homelessness services do have some kind of mental health condition, are there particular mental health staff working particularly on homelessness? Is there a strategy? It does not sound like there is.

Dr WRIGHT: I do not have the detail around that.

Dr LYONS: I would say that the way those services operate—so there is nothing specifically being let out of the ministry as a statewide program or initiative in this space—each of the local health districts and their community teams will look at particular aspects around the communities that they are responsible for serving and they tailor their services to the particular needs of those communities. If you are in a city area and there are high degrees of homelessness then there will be community mental health teams that will have that as a key part of what they do. Recognising, of course, that it is a very challenging group to reach and to maintain service delivery to, but I am sure that they will be undertaking those models and testing what will work and how they can meet those needs in the most appropriate way. We are not driving something from the centre, as far as I am aware, particularly targeted around homelessness.

Ms CATE FAEHRMANN: Is there anything in terms of the workforce—psychologists or other mental health workers—being employed by specialist homelessness services? Is there any relationship there between the department and the specialist homelessness services, to ensure that there are mental health workers?

Dr LYONS: Not directly. Not from the ministry. As I said, the local health districts have a relationship at the local level, so there may well be examples through the local health districts community services where they have those relationships in place.

Ms WALKER: If I could just make a comment. Homelessness Strategy and the specialist homelessness services fit under the portfolio of Minister Ward and those questions are occurring tomorrow. One of the things we could talk about then is the assertive outreach program, which is to address homelessness and the Premier's priority to halve rough sleeping. Some of those assertive outreach programs, even though they do not specifically target people with a mental illness, we find that those programs end up working directly with people with mental illnesses. In those programs there is a coordinated staffing related to that. That may be an opportunity to talk about that further.

Ms CATE FAEHRMANN: It certainly sounds like a gap, given that this morning we spoke about, for example, the Aboriginal mental health report that came out two weeks ago and various groups within the community that are more vulnerable. The department has done strategies and has targets in relation to that but it sounds like there is not much within the department in relation to homelessness and that is all with the homelessness Minister and not much has been done within mental health. Would that be fair?

Ms WALKER: There is certainly some work being done through the Homelessness Strategy about people leaving hospital and not becoming homeless. Again, that is something that sits particularly with those outreach programs, which we can talk about more in that estimates.

Ms CATE FAEHRMANN: Alright, I will leave that. How many full-time employees are in the mental health branch of NSW Health?

Dr LYONS: I will have to take that on notice but I think it is around 50.

Ms CATE FAEHRMANN: Can you take that on notice in terms of the structure as well—the breakdown of employees? Are there employee surveys undertaken within the mental health branch of the Department of Health in terms of general health and wellbeing?

Dr LYONS: There is a People Matter Employee Survey that is undertaken as part of the whole Government. The public service undertakes those on an annual basis. We survey our employees across the whole of the ministry and the mental health branches are one of the groups that gets assessed as part of that, yes.

Ms CATE FAEHRMANN: How does the mental health branch rank for employee satisfaction against other branches of the Ministry of Health?

Dr LYONS: Comparative to the whole of the public service and the whole of Health, it compares well. But it does not compare well within the ministry. Comparative reference points are always important, I think. It is on the lower side of the whole-of-ministry response but it is higher than many of our other services.

Ms CATE FAEHRMANN: When you say many of your other services, could you clarify what you mean?

Dr LYONS: When I say across the whole of Health, the ministry is on the higher end as a group but the mental health branch is within the ministry results on the lower side, comparatively.

Ms KOFF: The engagement index for the whole of Health was 65 per cent and the culture index was 60 per cent in the most recent People Matter Employee Survey. Within the Ministry of Health itself, the engagement was at 70 per cent and the culture was at 70 per cent. That is Dr Lyons' reference point as to what

you are comparing with. This year within the ministry we broke it up according to divisions to give us greater granularity across the divisions within the ministry and, obviously, mental health sits within Dr Lyons' portfolio as deputy secretary of strategy and performance.

Mr MINNS: If I may, the last point I would make is that it is only in the last week—the last five working days—that we have given each executive director a briefing about their branch results. This year's survey results are only just coming in in the last two or three weeks and we go through a structured process to make sure people get the results, understand them and then start to work with their branch and their teams.

The Hon. ROSE JACKSON: I will direct some questions to Ms Norton and Ms Walker. In relation to the women's health strategy—and it might be preferable for you to take these questions on notice but nonetheless—I want some additional information about the Investing in Women Funding Program for 2018-19. I understand that there are seven program goals that it seeks to meet. I want some information about the breakdown of funding under each of those goals—women's economic opportunity, equitable workplaces, women in small business, women in science, technology, engineering and mathematics [STEM], women in male-dominated trades, and women in leadership roles and leadership pathways. If you have that information available now that would be great, but otherwise you can take it on notice.

Ms NORTON: We do not have it broken down in that way.

Ms WALKER: I think we could take it on notice.

The Hon. ROSE JACKSON: That would be great. The other element I would like broken down—this you may have—is holistically for the entire Investing in Women Funding Program how much of that funding was directed towards women in rural and regional New South Wales?

Ms WALKER: We certainly have information about that more broadly. In the Investing in Women program—the $400,000 Investing in Women Funding Program—there were a range of programs that were accessible for women in rural and regional areas in 2019. Those included the Northern Rivers Women and Children's Services Inc and the Women in Social Enterprise [WISE] project, operating on the mid North Coast and northern New South Wales. WISE is a social enterprise for women in Lismore and Northern Rivers to support disadvantaged and marginalised women to overcome barriers to economic participation, employment, entrepreneurial opportunities and to achieve financial independence—so that goes across a number of the areas you spoke about. Another is the Barnardos Australia Three Wise Women coffee cart project, operating in Murrumbidgee, Far West and western New South Wales. Again, it is a social enterprise providing training and employment opportunities for vulnerable Aboriginal mothers and young women with children recently released from prison.

The Hon. ROSE JACKSON: Of the $400,000, how much was allocated to those particular programs accessible for women in rural and regional New South Wales?

Ms WALKER: We will get that number for you. I have about seven listed here. Would you like me to go through them or we could put them together for you with the funding amounts?

The Hon. ROSE JACKSON: You can go through them if you have the figures available.

Ms WALKER: I think Ms Norton will have the figures.

The Hon. ROSE JACKSON: That is what I am particularly interested in—if you have the programs and how much was allocated?

Ms WALKER: Ms Norton, do you have the Northern Rivers Women and Children's Services?

Ms NORTON: I do: $25,000.

Ms WALKER: And the Barnardos Australia Three Wise Women coffee cart?

Ms NORTON: It is $45,800.

Ms WALKER: The next one is the University of Newcastle's women's financial literacy project, targeted to a number of priority groups. The dollar figure for that is—

Ms NORTON: Twenty-five thousand dollars.

Ms WALKER: It is tailored financial literacy workshops in the Newcastle and Lower Hunter region. The next one is The Femeconomy Connection Program, targeted to a number of priority groups for women working in regional New South Wales.

Ms NORTON: It is $49,100.

Ms WALKER: That is a 10-month remotely delivered and individually tailored accelerator program for female business leaders. The Exchange's Dubbo The Change program.

Ms NORTON: Fifty thousand dollars.

Ms WALKER: The Change is a program designed for regional women starting and scaling businesses east and west of the Newell Highway and operating in Murrumbidgee, Far West and western New South Wales. Mental Health First Aid in rural and remote New South Wales.

Ms NORTON: Is $25,000.

Ms WALKER: The project will equip women with the skills and strategies to assist people in their community who are experiencing a mental health problem. It is operating in the Illawarra, Shoalhaven and southern New South Wales. Finally, the Singleton Family Support scheme's Reclaiming My Place project.

Ms NORTON: It is $50,000.

Ms WALKER: So this is a free eight-week arts program facilitated by the University of Newcastle's Centre for Excellence for Equity and Higher Education, and operating in the Hunter and Upper Hunter region.

The Hon. ROSE JACKSON: Were there any specific programs funded for Indigenous women?

Ms WALKER: Certainly the project that I mentioned, the Three Wise Women coffee cart, which is for training and employment opportunities for vulnerable Aboriginal mothers and women recently released from prison. But we do have other Aboriginal projects that we can speak to.

The Hon. ROSE JACKSON: Under the Investing in Women Funding Program?

Ms NORTON: Yes. The Newcastle women's financial literacy project, which has already been mentioned, also incorporates Aboriginal and Torres Strait Islander women. There is the Sisters and Aunties delivered by the National Centre of Indigenous Excellence, which is specifically targeting Aboriginal and Torres Strait Islander women. The comedy program, which we have already discussed, includes Aboriginal and Torres Strait Islander women. Game Changer, which is accelerate your career in the arts, creative and cultural sectors and delivered by Accessible Arts, also is targeted at Aboriginal and Torres Strait Islander women and lastly the Drive Program, which is delivered by Thrive Services, which assists women who have experienced domestic violence, or who are financially or socially disadvantage to obtain a driver's licence.

The Hon. ROSE JACKSON: I want to ask a little bit about some of the New South Wales targeted priorities for women under the Women's Health Strategy, in particular priority 2, Health and Wellbeing. How much money in the 2018-2019 financial year resources went to women's health centres in New South Wales?

Ms WALKER: Women's health centres are funded by NSW Health, so that would need to be answered by the health Minister. That is my understanding.

Ms NORTON: Yes.

The Hon. ROSE JACKSON: You are not able to answer any questions about funding for women's health centres at all?

Ms WALKER: No, we do not have that information.

The Hon. ROSE JACKSON: Are you able to answer any questions around women's health outcomes, for example, waiting times for access to trauma counselling for women?

Ms NORTON: Again, that would be an issue for the health Minister. Within the Women's Strategy, I think you are referring to, there are some health—

The Hon. ROSE JACKSON: The entire section 2 is entitled Health and Wellbeing.

Ms NORTON: Yes, in the Women's Strategy, that is right, with a range of different projects and programs that Health is undertaking, but we do not have that information in terms of things such as waiting times.

The Hon. ROSE JACKSON: Are all of the programs and priorities and goals for women's health and wellbeing through the NSW Women's Strategy delivered by Health, not anything to do with the work that you do?

Ms NORTON: The role of Women in New South Wales is across government function to work with other agencies to deliver outcomes for women. I think you will see there in the strategy that we identify which agency is responsible for delivering those. You will see that that is the Ministry for Health. We do not necessarily deliver programs directly ourselves. Our role is around coordinating other government action and working with agencies outside of Government as well as identifying opportunities to increase women's economic opportunity, health and wellbeing, and participation.

The Hon. ROSE JACKSON: If there are problems, for example, with the delivery of these programs or meeting these goals, even though they are directly identified in the Women's Strategy, you are not accountable for them at all?

Ms NORTON: I guess it is a two-way function. For any of the actions in the strategy, each of those agencies will have its own internal processes around how it monitors the implementation of those things.

The Hon. ROSE JACKSON: Are they consistent? Do you ensure that there is at least some consistency there, in terms of agency level monitoring?

Ms NORTON: In addition to that we also have a process where they report through us to the Minister for Women. And you will notice at the front of that Women's Strategy we have an update on the year 1 action plan, which is, in effect, the result of that information they provide us about progress on those actions.

The Hon. ROSE JACKSON: I think, from what I could see, the most recent was the year 2 action plan.

Ms NORTON: That's right. That's correct.

The Hon. ROSE JACKSON: And, yes, there was a series of nice ticks and on track, but it is very difficult for us to dig into what is actually behind those nice graphics if we are not able to even discern through you that there are at least consistent benchmarks across each of the various departments that are reporting in under the strategy.

Ms NORTON: You will notice both in the year 1 and year 2 action plan a number of the strategies will have specific targets or activities that they have identified. So that summary you have there at the beginning of the year 2 action plan about the outcomes of year 1, show you which ones are complete or on track. That would be in line with what they had committed in the year 1 action plan.

The Hon. ROSE JACKSON: Can I ask you, for example, about—

Ms KOFF: I was just going to add some information about the women's health centres, if it is appropriate now. NSW Health provides funding to 20 women's health centres through its non-government organisation program, so that is the mechanism by which we fund them. In 2019-2020, $11.7 million was provided to those women health centres. It is done by a ministerial grant that are given to those. It is important to understand also there is a peak body—Women's Health NSW—that provides an oversight of the work of all the women's health centres. That is dedicated specific initiatives that go towards funding dedicated services for women by the health centres. I think the other important thing to understand in our broad diversity of health service delivery, is we have specialist services for women in terms of maternity, gynaecology services and a range of services appropriate to the needs of women.

The Hon. ROSE JACKSON: That conveniently leads me on to another line of questioning I was hoping to pursue in relation to some of those specialist health services that are available to women, which, in particular, relate to women's access to reproductive health in rural and regional New South Wales. What work in particular is being done to ensure that women in rural and regional New South Wales have equal and equitable access to reproductive health services? I suspect you are going to tell me, "I cannot answer that question."

Ms WALKER: We think that that question is best at the Health estimates, which is due at the end of this week.

The Hon. ROSE JACKSON: Perhaps you might be able to answer a question about the Illawarra Domestic and Family Violence Trauma Recovery Centre, which I understand is a first in Australia, a community-supported initiative that is delivering very specific and best practice care for women who are experiencing domestic and family violence.

Ms WALKER: This question was raised yesterday with the Attorney General, as the Minister for the Prevention of Domestic Violence, and I am not aware of that program.

The Hon. ROSE JACKSON: I think part of the frustration that we have is that we have this Minister for Women, there is an Office for the Status for Women, but yet in order to discern any actual information about

the position of women and the situation of women in New South Wales we have to go to each and every department and dig down in each and every line item. Do you do any work that pulls all of that information together so that there is in fact, in actuality, a whole-of-government monitoring and response of the situation of women in New South Wales?

Ms WALKER: I think, as Melinda Norton mentioned, the action plan and the summary in the action plan are our monitoring of the commitments made by the agency. If you think about the year 2 action plan, there are 49 actions that are led by 15 different government agencies. I think the positive thing about that is actually what we have is a whole range of government agencies that are identifying specific funding for women inside their portfolios and making the commitment that there will be a coordinated approach. So I think it is fair to say that the whole is greater than the sum of its parts and that is why we need the coordination function. Part of the other reason for Women NSW to keep influencing this space is that we want to make sure that we continue to raise the profile and the needs of women, and ensure their prosperity.

The Hon. ROSE JACKSON: Perhaps to try again, another particular issue that women in New South Wales are facing right now is an increasing number of women being incarcerated. For example, the number of women in custody is increasing at a higher rate than the number of men in custody, percentage wise, obviously not in real terms. What programs is the New South Wales Government implementing to address this increase in the number of female prisoners?

Ms WALKER: We do have a range of information about the reoffending rates and the targeted work about Aboriginal offenders who account for 34.3 per cent of the female prisoner population. In the Department of Communities and Justice, we work broadly about offender and reoffender strategies, especially with diverse groups including Aboriginal populations, women and people with disability. That is a core part of our working function. I can get you more information about that if you would like. For example, to manage the growth in the numbers of corrective services, Corrective Services overtook and reconfigured the Juniperina Juvenile Justice Centre into the Mary Wade Correctional Centre for women in 2017. In 2018 the Berrima Correctional Centre was reconfigured as a women's prison. The Dillwynia Correctional Centre for women will be expanded to 248 beds in mid-2020. What that does not get for you is what we are doing to stop the incarceration of women or to reduce it. We can put some information together for you on that.

The Hon. ROSE JACKSON: That would be wonderful. One of the things that I particularly would be interested in is that I understand that there are some innovative services in relation to particular programs that allow women in prison to have their children with them, which, I understand through a range of different research, has been demonstrated to have a significant impact on not just the experience of women in prison but also their likelihood of reoffending if they develop proper familial connections with their children. What programs is the New South Wales Government putting in place to expand the availability of those specialist services so that women in prison can have their children with them?

Ms WALKER: We will take that on notice. Absolutely there are some programs, particularly for minimum-security women inmates where their children can be with them to a certain age. We will get you the detail on that and any planned expansion.

The Hon. ROSE JACKSON: I might ask a couple of more questions to follow up our line of questioning earlier about mental health services for young people in rural and regional New South Wales. Minister Taylor has said on the record that one of the reasons that she was enthusiastic about taking on both the particular portfolios of Mental Health and Regional Youth is that there is quite a lot of overlap in that one of the biggest problems that regional youth are experiencing is mental health problems. I wanted to follow up what specific programs the New South Wales Government is funding to ensure availability of specialist mental health support for rural and regional youth.

Dr LYONS: To start off with, the specific targeting of youths as a component within our mental health services is a component of the child and adolescent services and young adult services. We have talked about some of the specific areas in investment that we are making to support improvements, particularly in self-harm and suicide prevention, which is a major focus. There are not a lot of other specific investments in regional youth mental health services; it is more a general investment in the mental health services that will be available for the whole community with the youth as a component of the community.

The Hon. ROSE JACKSON: Even the secretary herself acknowledged that the part of the planning that the Department of Health does is to segment the community because their needs are quite different. What I am putting to you is that, yes, there are a range of mental health services available generally in rural and regional New South Wales, but the needs of young people in rural and regional New South Wales for mental health services

are quite different to just the general mental health services that are available. Are there no specific programs dedicated to that cohort even though it has been identified as a priority by the Minister herself?

Dr LYONS: I have another couple of comments. In rural services, the more you segment down and specialise the services, and the narrower the role and function of them, the more difficult it is to provide a service with that specific remit and target.

The Hon. ROSE JACKSON: Is it also not more targeted the more you segment it down?

Dr LYONS: It is more targeted but you have usually smaller populations because the populations are less in those environments and also they are very dispersed populations. As we go into those environments our approach is usually to provide more generalist services and backup for the generalists by access to those highly specialised services or access to specialised knowledge to support the care that is provided in those settings. That is why our focus is to get the services available on the ground and then connect those in with highly specialised services to provide advice, backup and support for the practitioners who are on the ground providing that service. That is the general model for providing services in rural and regional environments rather than going into specific segments and having highly specialised and targeted services. It is much more difficult to maintain and much more difficult to recruit to.

The Hon. ROSE JACKSON: I appreciate that it costs more; I accept that.

Dr LYONS: It is not about the costs; it is about the fact that, as we have talked about the challenges of recruiting people into regional and rural environments, the more specialised you get around the knowledge set you ask for, the less likely you are to recruit a person into that role. This is about a very practical and pragmatic decision that we have made, which is: Let's have generalist services wherever we possibly can but make sure they are backed up and provided by support with detailed and specialist knowledge where it exists in the State.

The CHAIR: The crossbench members have left the building, so to speak. One has a medical appointment and the other one, I think, is not that far away but they have informed me that they are ceding their time to the Opposition to continue. The Opposition members may continue. There is one caveat: Ms Abigail Boyd is potentially coming down but if she does not come down, she does not come down. Please continue.

The Hon. ROSE JACKSON: I might ask one more question or, depending on your answers, a set of questions before I hand over to my colleagues. I want to phrase it in the right way. What percentage of young people in rural and regional New South Wales seeking critical mental health support, which presumably cannot be offered via video or telephone, have to travel more than five hours from their place of residence in order to access that support?

Dr LYONS: That is a very specific question. We will need to take that on notice.

Ms KOFF: I was going to say the most important thing is planning. The structure that we have in the health system about districts and devolved planning and management is that services are developed in conjunction with GPs, local providers, local community groups et cetera. I think part of what makes the health system strong is developing services according to local needs and priorities. I think that was identified earlier in the suicide discussion up on the North Coast that we had earlier in that there was a cluster and they worked comprehensively with the local community to initiate some things in response to that. I think the other critical element, as Dr Wright touched on with the National Mental Health Program, is that the primary health networks and the GP services are absolutely critical elements of how mental health is managed in rural and regional areas because the GPs are really the primary carers in understanding mental health needs. Both levels of government are fully supportive of development of mental health services to respond to local community needs in partnership with each other. I think the NGO funding that comes from the Commonwealth is indicative that the primary health networks are seen as commissioners of services to respond to local health needs.

The Hon. ROSE JACKSON: The specific example that I was interested in and drawing from was Dubbo, which is a relatively large regional centre; it is hardly very remote. It is really at the coalface in terms of some of the drug and alcohol crises that we have talked about earlier in the day. The ice crisis there is extreme. There is quite high youth unemployment. There is a range of stresses, if I could pick up on that language that was used, that are experienced by young people in Dubbo. In order to access critical mental health support, young people are having to travel, for example, six hours away from Dubbo, away from their family networks and their friendship networks. I suppose it would be of concern that young people in a centre like that are having to travel six hours away to access critical mental health services, and that is likely to be even worse for young people who are living in more remote communities. That is not really a question, I suppose, but is there is any reflection on that?

Dr LYONS: We will take it as a statement if that is okay.

The Hon. TARA MORIARTY: A follow-up to that, my colleagues asked some great questions about the need for specific, targeted help for people in regional communities. I hear the answer, I understand what you are saying but where we are coming from is the broader consequences for people suffering from mental illness in these regional communities are greater than in the city, and I do not just literally mean the need for immediate urgent acute services. If you are suffering from a mental illness and you are having trouble participating in society it makes it harder to hold down a job and in regional communities there are not that many jobs to start with. I understand that you guys are from Health but is there any work done on coordinating services across the government? We have talked a little bit about that today—people who fall through the gaps if they are in the prison system or if they come to the attention of different parts of the system but is there any coordination across departments for how to assist people before it reaches a crisis point, particularly in regional New South Wales where it is a bit more of a pressing issue because there are not a lot of options?

Ms KOFF: A couple of things I will say at a statewide level. Part of the response to the Living Well strategy is the Mental Health Taskforce. The Mental Health Taskforce is the New South Wales Government's response to a whole-of-government response to mental health care. I chair the Mental Health Taskforce, which has representation from Stronger Communities, Education—representations from all the clusters that potentially have input and impact on mental health service delivery and responding to the Living Well guide. At the local regional level there is quite a strong relationship with other government agencies because of the recognition—as was touched on earlier with some of the suicide prevention—that one agency cannot do it alone. In local districts there are very strong relationships with FACS and Mental Health, with Education and Health, and that is where we develop the programs locally that are the local-designed response to some of the initiatives that are special requirements for those geographic regions.

Mr ORR: If I could just add a little bit more, and this is not necessarily about mental health but broadly. The teams which we have in regional New South Wales play a whole-of-government coordination role and that could be on a whole range of different topics, be it about a particular response in a certain place where an industry may be shut down and we need to bring a whole heap of effort to providing support to those people who may have lost their roles, be it about a particular issue in a certain community—refugees or whatever the case may be. There are existing structures within government whereby we work collectively together on certain issues, whatever they might be. There is a regional leadership executive structure which exists within each one of the regions, and that is representatives from all the agencies sit around the table on a regular basis to talk about priorities, what is going on and how responses may need to be managed.

Dr LYONS: If I can add, from my experience, and I have worked in regional and rural New South Wales for a large part of my career, it actually occurs at a whole range of different levels. At the local community level—and I think this is where rural communities by necessity drive innovation in healthcare delivery and demonstrate collaboration across agency boundaries—they do it because they need to, to provide supports to their communities, and it happens at the local town level, the community level, and then it goes up to the local health district level. We have actually had arrangement of the Family and Community Services boundaries to reflect the local health district boundaries to support that occurring across the State. Then, as the Secretary has also said, at the ministry level and across agency level we have a range of different groups. So it happens at a number of different levels to reinforce and support the need for that to occur. But where it really counts is where it is as close as possible to where care is delivered in communities and that is where most of it actually happens.

The Hon. TARA MORIARTY: That is good and I think that that kind of coordination is important. It sounds like that is done on an as-needed basis or an issue basis rather than actual sustained coordination around these issues. It is not necessarily a problem.

Dr LYONS: I would say it is actually more sustained. It is actually about how the services operate in relation to the things that they do and what they are responsible for for the populations that they care for and provide services to and it becomes the way that they do business at the local level. Certainly in the services that I have been involved in in the past, rural and regional, it is very much an active part of what they do. It goes across into local government and it includes people who are working in private practice often; it goes into the community-managed organisation sector. The extent to which local groups come together around solving problems at the local level, ensuring that they are closing as many gaps as they possibly can with the resources they have available, it is the way they do business.

The Hon. TARA MORIARTY: I accept that that is true and that is kind of an essential way to do this. I guess where I am headed with that is who is ultimately responsible? It is coming back to what we were talking about earlier this morning—people do fall through the cracks. We talked this morning, and I am not raising it

again now, about some extreme examples that occur when people fall through the cracks. So it is good that there is some coordination and FACS acknowledges that that is something that is ongoing. But coming back to the regional issue or whatever else, if people fall through the cracks there are not a lot of options for them. Ultimately the Government is responsible for the welfare of everyone in New South Wales. Should there be some ultimate responsibility for how the coordination of these services works, particularly when it comes to mental health? If you have an illness but again not acute enough to need emergency care but you lose your job and cannot find one, there are housing issues that come from that and all the things that flow on from that. Should someone be responsible for that?

Dr LYONS: Absolutely, and I think our services take a lead in that but they work in partnership with the Primary Health Networks, which are the Commonwealth groups that provide support for the services the Commonwealth is responsible for. I know across our State that at the Primary Health Networks and local health district level they are doing joint planning and doing the needs assessment and thinking about what services they duplicate because sometimes there is duplication as well as gaps. So how do they refine the service delivery models to reflect the needs of the community, how do they look at what resources they have got available, how do they configure those to get the best outcomes for their communities? They are factors but, as you rightly say, someone is to be held accountable.

I would say in my experience in the system for many years that most often that is the health system in relation to everything that is provided for a local community, whether that is a responsibility of the State or not. I think our services take that responsibility very seriously and look for solutions. Even sometimes when it is not their direct responsibility they get actively involved in supporting and resourcing. I know examples where we have jumped in to solve aged care for a community because there is a need. We have many examples. General practice, finding a GP for a town, these are things that are not directly NSW Health's responsibility but just pragmatically when it comes to finding a solution to a community and making sure they have got access to health care we get involved.

The Hon. TARA MORIARTY: This is probably a question that would have worked better at the start but it fits in here now. Probably to Ms Koff, but anyone can take this question, can you paint a picture for us about how mental health—it is not a standalone department—fits into the health department? Obviously you have all got specific roles and you have talked to those today, but can you paint a picture of how it fits in broadly? There was an answer earlier in terms of a staff survey that there are 50-odd employees in the department. Who answers to who? How do things fit in health?

Ms KOFF: Certainly. I have confirmation on those numbers in terms of the mental health branch at the ministry; it is 54 headcount and 35 full-time equivalent positions, and that represents primarily the policy and planning arm for mental health services across the whole of the State. Mental health has always been a discrete unit in itself because of the complexity of mental health, the specialisation of mental health and the need for us to keep a greater oversight over mental health service delivery. That is the same in most jurisdictions. They have mental health branches within their central Ministry and most of them have a mental health commissioner. There is a national Mental Health Commissioner and one for each State and Territory. I think that reinforces the importance and the prioritisation of mental health within the health system delivery.

In terms then of our governance structure, we have the devolved structure with local health districts and specialty health networks. We have two specialty health networks, the Justice and Forensic Mental Health Network and Sydney Children's Hospitals Network—and not to forget St Vincent's, which is often left off as a specialty network because it is a different sort of structure, an affiliated health organisation. Then apart from the districts, we have 15 regionally based local health districts. The structure of the districts, as was mentioned, is geographically based and attempts to align with the other government service deliveries there. In the devolved management structure, I think some of the recommendations in the seclusion and restraint review, as identified by Dr Murray Wright, reiterate and strengthen the importance of the mental health director being part of the executive team or reporting to the chief executive within the district. That was an attempt—and I believe a much needed mechanism—to make sure that mental health was a priority for each and every local health district.

The way we measure the performance of the districts is via the service level agreements. Annually the Ministry of Health negotiates a service agreement with each district which outlines the budget it will receive and the performance expectations around the delivery of services for that budget allocation. It has the usual things of emergency department performance and surgical performance, which are the two big ones that always grab people's attention. But I think it is important to understand that we have expectations around mental health service delivery also within those service agreements. There is safety and quality criteria for which we measure the performance. It was touched on earlier about the follow-up within seven days of discharge. There are a number

of other key clinical criteria and we also monitor what we call sentinel events. In mental health a sentinel event relates to suicide in an inpatient unit. We have a rigorous mechanism of monitoring the performance of the districts around mental health. The mental health branch in the Ministry brings the mental health directors from across the State together regularly to discuss policy issues and co-design what we need as priorities of the health system and assess its performance.

The Hon. TARA MORIARTY: Thank you, that is useful. In terms of understanding how clusters work, ultimately the health Minister is responsible for the health department. Regarding how the department interacts with the mental health roles, specifically the Minister for Mental Health compared to the Minister for Health, how does that work? How often would you engage directly with either Minister? Are there set scheduled processes for briefing?

Ms KOFF: Yes, Minister Hazzard is the senior Minister of the cluster.

The Hon. TREVOR KHAN: Fairly hands on.

The Hon. TARA MORIARTY: Okay.

The Hon. WALT SECORD: Some people would give other descriptions.

The Hon. TARA MORIARTY: Please elaborate.

The Hon. WALT SECORD: Sticky fingers everywhere.

The CHAIR: Don't be distracted, Ms Koff.

Ms KOFF: No, thank you. Minister Hazzard is the senior Minister and has legislative responsibility for the whole of the portfolio. Minister Taylor fulfils the role as the Minister for Mental Health. The main points of contact for Minister Taylor is with Dr Lyons as deputy secretary, who has responsibility for the Mental Health portfolio, and Dr Wright in terms of the Chief Psychiatrist. That is where the facilitation and engagement around most of the mental health issues occurs.

The Hon. TARA MORIARTY: Given that you two are the ones who are engaged with the mental health Minister most often, how does that work? Is there a regular briefing or is it needs based?

Dr LYONS: Yes, regular meetings with the Minister and her staff. The other person who has a key role is the executive director of the mental health branch. The relationship is very close and the briefings are very regular around a whole series of policy areas but also around holding us to account in terms of service delivery, government priorities and informing appropriate policy to be implemented across the State. But it is also thinking about what are the other issues we need to be thinking about across agencies and other portfolios and how we can influence in that regard as well.

The Hon. TARA MORIARTY: Do you have set regular meetings or is it based on what you need?

Ms KOFF: Yes.

The Hon. TARA MORIARTY: I am sure it is very regular but is it—

Dr LYONS: It is very structured. In the early phases of the Minister being appointed we went through a whole series of briefings around the components of the mental health system. They were scheduled weekly or fortnightly. We will move into a more regular pattern, probably fortnightly meetings with the executive director of mental health in the usual pattern. Then there is a monthly meeting with the secretary and myself as well.

The Hon. TARA MORIARTY: Ms Koff, what kind of interaction would you have? I assume you would have way more interaction with the health Minister. But what kind of interaction if any do you have regularly with the mental health Minister?

Ms KOFF: On the regular meetings as Dr Lyons outlined, progress updates on Living Well, feedback on the mental health taskforce are the sort of initiatives that I report back on to the mental health Minister and obviously any issues that have been brought to her attention then by any of the NGOs or the College of Psychiatrists. It is a development of an agenda that meets the needs of both parties and seeks information and advice from the Ministry.

The Hon. TARA MORIARTY: Is that kept separate in terms of the mental health part of the Ministry or would the health Minister be briefed on all of this and somehow engaged in all of this?

Ms KOFF: I think the issue is we bring other executives in as necessary. So talking about, as Mr Minns mentioned earlier, some of the psychiatrists numbers when Minister Taylor had been approached by the head of

the College of Psychiatrists, having the conversation as to how we can enhance psychiatrist training—definitely Mr Minns was there as part of that conversation. While there is the main key contact point, the Minister still has at her disposal all the other portfolio areas in the Ministry, be it finance, workforce, risk management or any of those other portfolios as necessary.

The Hon. WALT SECORD: Ms Koff, I would like to follow up in response to an answer you gave earlier to my colleague the Hon. Tara Moriarty. You mentioned sentinel events involving mental health patients. How many sentinel events involving mental health patients and mental health issues occurred in 2016-17, 2017-18 and 2018-19?

Ms KOFF: We can give you the exact numbers when Dr Lyons finds them. I think one of the most important things to emphasise about sentinel events is that Australia wide the Australian Safety and Quality Commission has been doing some work on sentinel events.

The Hon. WALT SECORD: I have been following that.

Ms KOFF: In other places they are described as "never events" that should never occur in hospitals. The Government policy from the Federal level now is penalisation for sentinel events. Health services do not get reimbursed Commonwealth funding for when there is a sentinel event. For mental health, as I said, the sentinel event is death in suicide in an acute mental health facility. We are looking at the numbers.

The Hon. WALT SECORD: When you say a department or a government wouldn't get funding, would that discourage people? Would that discourage jurisdictions from properly disclosing or describing them? Has there been a redefinition of sentinel events in New South Wales?

Ms KOFF: The National Safety and Quality Commission has refined the sentinel event because part of the process with the funding associated at a national level was a redefinition of the sentinel events.

The Hon. WALT SECORD: So a sentinel event in New South Wales is the same as a sentinel event in Tasmania, Queensland or Western Australia?

Ms KOFF: That's exactly right.

Dr LYONS: So we have data up till 2016-2017 for sentinel events, based on the national sentinel events data. So for New South Wales, the number of sentinel events for 2014-2015 was 15. For 2015-2016, it was nine and, for 2016-2017, it was four. The suicide of an inpatient is what the sentinel events are, under the national definition.

The Hon. WALT SECORD: Thank you for that. I would like to return to some questions asked of Mr Orr earlier. I wrote it down, but I want to make sure that I am correct. You mentioned that unemployment in regional areas for youth would be 13 to 14 per cent. Is that correct?

Mr ORR: It is around 12 per cent. It is 12 to 13 per cent. On average, it is a few percentage points higher than in metro areas.

The Hon. WALT SECORD: I just want to give the context. So what is the definition of employment? So that 12 to 13 per cent, is that someone working 35 hours a week or is that someone working 12 hours a week or one hour a week?

Mr ORR: We get the numbers from I think it is the Australian Bureau of Statistics [ABS]. As for how it defines that, I cannot give you a specific answer in terms of—

The Hon. WALT SECORD: Does your colleague know?

Mr ORR: —what the actual definition is and what the ABS' methodology is in terms of how they actually go about sourcing those numbers. So I cannot give you a specific answer about what the statistics are and what the methodology is behind how they do that, but those are the numbers which we work with.

The Hon. WALT SECORD: Earlier there was some discussion about the Office for Regional Youth. It was announced in February that, if re-elected, the Berejiklian Government would set up an Office for Regional Youth. How much has been allocated to do that in the budget?

Mr ORR: I answered the question previously.

The Hon. WALT SECORD: Yes. How much was it? I am giving you a follow-up question.

Mr ORR: In terms of what was in the budget papers, if you look through and try and find the Office for Regional Youth, there is not an allocation in terms of the Office for Regional Youth.

The Hon. WALT SECORD: Zero.

Mr ORR: However, there are a couple of other things, one of which is on page 4-2 of *Budget Paper No. 3*. You will find the Stronger Country Communities Fund. Of that, $50 million is allocated towards regional youth. And then as I mentioned previously—

The Hon. WALT SECORD: Okay. Let us scroll down.

Mr ORR: Yes.

The Hon. TREVOR KHAN: By the way, he did not say "zero." He said there is not a line item for it, Walt. You said "zero".

Mr ORR: Yes.

The Hon. WALT SECORD: Did I say "zero"?

The Hon. TREVOR KHAN: You said "zero".

The Hon. WALT SECORD: Did I say "zero"?

Mr ORR: Yes. And in terms of—

The Hon. WALT SECORD: I'm sorry, who said "zero"? I said "zero"? Okay.

Mr ORR: I don't know. But in terms of—

The Hon. ROSE JACKSON: It was not Mr Orr.

The CHAIR: Order!

The Hon. WALT SECORD: No, no. Mr Khan has picked up a very important point because as the shadow Treasurer—so you are not saying "zero"? That is why I am—

Mr ORR: So what I am saying—

The CHAIR: Order!

The Hon. WALT SECORD: Sorry, that is why I am revisiting these questions.

The CHAIR: Indeed. And it is important to do so, but Mr Orr can answer the question himself.

Mr ORR: So I was sort of working through the answer.

The Hon. WALT SECORD: Stop being fair, Chair.

Mr ORR: So there is money in terms of the Stronger Country Communities Fund. There is $100 million there, and $50 million of that goes to youth. I mentioned previously the mechanism by which that occurs. And then in terms of the Office for Regional Youth, there are currently 11 staff working on youth matters. We have not tallied up what the actual budget would be for all of those staff. We could do that if that was useful for you. But it would be over a million dollars which is being spent on the Office for Regional Youth based on the activities of those staff.

The Hon. WALT SECORD: Those 11 staff, how do they fit in the context of the Treasurer announcing that there will be 2,500 job cuts? Are they frontline or back-office staff, those 11?

Mr ORR: I think the policy position of the Government has been made reasonably clear about jobs in regional New South Wales. It is not my role to reiterate that.

The Hon. WALT SECORD: I understand.

Mr ORR: Those positions are a blend of people who exist within Sydney, and there are people based in regional New South Wales. I can go through and say who they are and where they are located if it is helpful, but those people—

The Hon. WALT SECORD: How about if I get on notice just where the 11 staff are based?

Mr ORR: Sure.

The Hon. WALT SECORD: Thank you very much. I am not sure, but I think it was Ms Koff who referred to the mental health branch having 54 head and 45 FTE for planning and policy. Are they determined as part of the Premier and Treasurer's announcement that there will be 2,500 job cuts? The mental health branch

staff, are they front line or back office? Because I think they would answer to you if they were drawn on an organisational chart.

Ms KOFF: Yes, that is right. They do.

The Hon. WALT SECORD: So do you determine those 45 FTEs to be front line or back office?

Ms KOFF: No, they are not counted as frontline services.

The Hon. WALT SECORD: They are back office? So you cannot guarantee that they will not be affected by the 2,500 staff cuts?

Ms KOFF: In terms of the Health budget, we had an increase in the Health budget as was documented, with a 4.5 per cent budget increase. Our commitment is to no reduction in frontline clinical services and no reduction in rural and regional roles, and we are committed to doing that as a process of continuously ensuring we are efficient and provide appropriate services. We, as a ministry, always assess our staff profile to ensure that it is optimising its support for the health system.

The Hon. WALT SECORD: But as you said earlier, they are not frontline staff. To you, Ms Koff—though you may want to direct it to another person—Aboriginal health workers, the classification and designation of an Aboriginal health worker. How many are there in your department? Mr Minns, is this your area?

Mr MINNS: I will take it on notice, but my memory is there are more than 100.

The Hon. WALT SECORD: Around 100 is what I have heard.

Mr MINNS: I am thinking 120, 130? Somewhere like that. But it is a question to formally take on notice and provide an accurate answer.

The Hon. WALT SECORD: Have there been discussions about reclassifying or expanding the definition, the scope of duties involving an Aboriginal health worker in New South Wales?

Mr MINNS: There is a conversation that has begun and it was raised at the most recent Aboriginal workforce summit within Health. So there is a kind of complex award-related matter that we are investigating whether that historical award position is operating as a barrier to these roles being created in the New South Wales health system. Queensland, for example, has engaged in some reform around this area. So my understanding—

The Hon. WALT SECORD: Is it narrowing the scope or broadening the additions?

Mr MINNS: I think you would say it is broadening. My relevant staff are engaged in planning a visit to Queensland to understand exactly what Queensland has done, because it has been successful in achieving a higher level and a fairly rapid level of growth in those positions.

The Hon. WALT SECORD: So what did it do to change the position? Was mental health one of those areas? Because if you look, from memory, there are about eight different areas of responsibility that an Aboriginal health worker could have. Mental health is one of those, but I just wanted to know if there was a scope or an expansion to go into areas where there is a dearth of mental health workers.

Mr MINNS: I think, as we will all be here again on Thursday, I would be quite happy to gain some detail on that and provide a comprehensive answer on Thursday.

The Hon. WALT SECORD: Thank you.

Ms KOFF: If I could add, we had discussions at the COAG Health Council specifically about Aboriginal health workforce nationally, and there was representation from each of the clinical groups: medical, nursing, allied health and Aboriginal health workers. What became apparent from that discussion is there are quite different qualifications and scopes of practice for Aboriginal health workers across the whole of the country. There were quite useful discussions on how we can harmonise that to ensure they can work at the top of their practice level, because it seems to be quite different according to jurisdiction to jurisdiction, the roles and responsibilities undertaken by Aboriginal health workers.

The Hon. WALT SECORD: There was some discussion in this session about the proposal for an Aboriginal drug treatment centre in Dubbo. I know that Federal conservative members of Parliament, conservative State members of Parliament and the Opposition have expressed concern. Has the Government done any work or any modelling involving the Dubbo drug treatment centre? Also the council—the council has been quite active in that.

Ms KOFF: I think I will go back to paper next time. In terms of the calls for drug courts and drug centres in Dubbo, Western NSW Local Health District participated in discussions led by Dubbo Regional Council.

The Hon. WALT SECORD: That was what I was referring to.

Ms KOFF: And was supporting the drug court and drug centre for this region. The Commonwealth did announce a funding commitment of $3 million over two years to establish the residential service and the district then is providing a range of services to actually support that program including counselling, diversion programs, substance use in pregnancy, opioid treatment and the hospital consultation liaison services that occur in conjunction with that. I reiterate, the responsibility for programs for drug and alcohol resides with the Chief Health Officer and if you require any further information I am sure she could give you more detail.

The Hon. WALT SECORD: I will revisit that on Thursday. You made mention of a suicide cluster on the North Coast. Without being specific are there other suicide clusters in New South Wales?

Dr WRIGHT: It is actually a difficult question to answer because I think there is very poor definition around what that actually means. It is quite an emotive term. I would go back to basics. I think any suicide is a tragedy and for every single suicide that we become aware of if the individual had any relationship with our services we look very carefully to try and understand what is happening. If there is more than one happening in a short space of time from a local region obviously we do get concerned about the risks of contagion, and that is particularly within certain subgroups. That is what motivated some of those local communities to really get together and to try to create a response which took the community away from that kind of despair.

My approach to these things is that if there is a concern that this seems to be happening more commonly in any part of our system that we look very carefully to understand is that some kind of tragic aberration or does it go to something which is happening within the community? I mentioned two other areas in one of my answers and that was because there were concerns locally that there might be something happening particularly amongst some of the young people. We did not answer the question of whether that is a cluster or is it not. It is more a case of if you have that concern why don't you look at this sort of a community-based whole-of-government whole-of-community response and try and see if you can build some more resilience within your community.

Dr LYONS: If I might add, I have a note here that the NSW Ombudsman released its *Review of suicide clusters and evidence-based prevention strategies for school-aged children* report in June of this year and noted that, as you have highlighted, suicide clusters, however you define them, are more likely to occur amongst people aged under 25. That review found that there are comprehensive activities and guidelines for prevention and postvention amongst school-aged children and they have been adopted across schools in New South Wales.

The CHAIR: There are no further questions. Thank you for your appearance today.

(The witnesses withdrew.)

The Committee proceeded to deliberate.