Transcript pages 2-3

Impact of COVID-19 on women

The Hon. PENNY SHARPE: Thank you. Minister, I wanted to just start off by asking you about the impact of COVID on women. Obviously there has been a lot written about this and the impacts on women in terms of job loss, dropping out of the labour force altogether, have been massive. Can you tell me what action you have been taking to address this issue?

The Hon. BRONNIE TAYLOR: Yes, and I thank you very much for your question. You are absolutely correct—as I would have no doubt on a women's issue that you would be—in the fact that women have been adversely affected in terms of what has happened with COVID. We knew that, because we do have a higher proportion of women that work in service industries and those industries like hospitality, like child care, all of those things have been greatly affected. Obviously it is my job to advocate for all women. But can I just start by saying as well, Ms Sharpe, that there were multiple programs across the Government as a whole, not specifically under the Women's portfolio—when we look at the New South Wales JobSaver program, when we look at the COVID-19 micro-business grants, the COVID-19 business grants, payroll tax support, tenancy support, support for the creative arts sector, and we have had supports for the travel industry. So I think when we look at that we have to incorporate all those. Now, specifically—and I know that you—

The Hon. PENNY SHARPE: Sure and I agree with that—they have been extremely important, particularly given the Federal Government was not so great in coming to the table on those. Are you able to give us a breakdown, though, of those programs in terms of the uptake that women have had as a result of those programs?

The Hon. BRONNIE TAYLOR: Specifically for each program, if you wanted to look at the uptake and have that data divided, I do not have that with me, Ms Sharpe.

The Hon. PENNY SHARPE: Are you okay to take that on notice?

The Hon. BRONNIE TAYLOR: I am happy to take that on notice, with the caveat, if I may, if it is possible to collate that data in terms of male or female, because I really honestly do not know if that has been collected. I could ask—may I just refer to Ms Smyth, to see if—

The Hon. PENNY SHARPE: Find out whether we can. That would be great.

The Hon. BRONNIE TAYLOR: Ms Smyth, would you mind answering that?

Ms SMYTH: We could check with each agency if they have that data, but I am unaware if it is available.

ANSWER:

I am advised:

In October 2021, in response to the Delta COVID-19 outbreak, the NSW Government announced a $2.8 billion package[1] to support recovery from the pandemic.

The recovery and support package covers a range of measures for victim-survivors of domestic and family violence (DFV), including 75 new and upgraded fit-for-purpose refuges for women leaving DFV. This is the single biggest investment in responding to DFV in the state's history.

This investment comes on top of the existing 2021-22 NSW Budget commitments for DFV, which included $687 million over four years (including an $80 million Commonwealth Government investment) to reduce DFV re-offending and support victim-survivor safety through continued early intervention initiatives and perpetrator interventions.

Women also continued to benefit from the $10 million Return to Work Program, as it solely focuses on women. 1,417 women have received a grant to date.

The NSW Government has monitored the impact of the COVID-19 pandemic and recovery on women across indicators such as workforce participation, caring responsibilities and mental health outcomes. We will use this information to inform future policy and program development.

By early 2022, the NSW Government will continue supporting women's workforce participation and empowering women by improving childcare settings, ensuring greater workplace flexibility, and reducing gender segregation within industries and occupations will also be essential in supporting the future of our state.

[1] https://www.nsw.gov.au/media-releases/28-billion-package-launched-to-turbocharge-nsw-recovery-from-covid-19-pandemic

Transcript page 6

NSW Women's Strategy

The Hon. PENNY SHARPE: Maybe we will go to Ms Smyth, if she could explain to me the interdepartmental operation of how the women's strategy is delivered.

The CHAIR: Ms Smyth.

Ms SMYTH: Thank you. We have an interdepartmental committee, which has recently met, last month. That is to guide and monitor the implementation of the NSW Women's Strategy [disorder]—
The Hon. PENNY SHARPE: Thank you. Ms Smyth, would you be able to provide to us the members of that committee?

Ms SMYTH: Yes. There are other members of the Department of Communities and Justice in addition to Women NSW; Treasury; Department of Premier and Cabinet; Public Service Commission; Ministry of Health; Transport for NSW; Planning, Industry and Environment; Create NSW; the NSW Small Business commissioner;
Multicultural NSW; Education; Primary Industries; Office of Sport; Aboriginal Affairs; and Customer Service.

The Hon. PENNY SHARPE: Thank you. Would you be able to provide the Committee with the level— you can take this on notice; I do not need it now—of the departmental representation that comes to those meetings, please? You can take it on notice.

Ms SMYTH: In terms of the seniority of the membership?

The Hon. PENNY SHARPE: Yes, please.

Ms SMYTH: Yes. Generally, it is—

The Hon. PENNY SHARPE: Could you also—

The Hon. WES FANG: Point of order: I just think what we need to do is, when we are asking questions of the people on Webex, just pause slightly, just to allow the delay in the digital, because what we are seeing is people talking over each other. It is going to make it very difficult for Hansard to be able to record it.

The CHAIR: We know how to proceed. Ms Smyth, were you going to respond to that question about the seniority?

The Hon. PENNY SHARPE: I am happy for you to take that on notice.

The Hon. BRONNIE TAYLOR: She is trying to respond, to be fair.

Ms SMYTH: Generally, it is at a director level. But we also have executive directors that attend and, in some cases, managers. But I am happy to provide information about who is the delegated officer for those departments.

The Hon. PENNY SHARPE: Could you also provide me with the list of the number of times the committee has met?

Ms SMYTH: No problem.

ANSWER

I am advised:

The membership of the NSW Women's Strategy Interdepartmental Committee (IDC) consists of departmental representatives from the following NSW Government agencies:

- Aboriginal Affairs
- Create NSW
- Department of Communities and Justice, including Youth Justice NSW
- Department of Customer Service
- Department of Education
- Department of Planning, Industry and Environment
- Department of Premier and Cabinet
- Department of Primary Industries
- Ministry of Health
- Multicultural NSW
- NSW Small Business Commissioner
- NSW Treasury
- Office of Sport
- Public Service Commission
- Transport for NSW

Representatives vary up to Executive Director level.

Meetings of the IDC are held at key decision points for the development and implementation of the NSW Women's Strategy 2018-2022 actions. The IDC communicates and meets regularly.

Transcript page 15

Pru Goward review into ministerial offices

The Hon. BRONNIE TAYLOR: I have had one meeting with Ms Goward about that for an update that is happening. Obviously, the Government is committed to improving the prevention of and response to workplace sexual harassment, but any questions relating to the implementation of the recommendations need to be referred to the Department of Premier and Cabinet. As soon as I have an update or I am told about that, I am happy to share that with you, Ms Sharpe.

The Hon. PENNY SHARPE: Is there going to be a public update and when is that coming?

The Hon. BRONNIE TAYLOR: I can take that part of the question on notice and get you a timeline on that when I speak to the committee.

ANSWER

I am advised:

This is a matter for the Premier.

Transcript page 16

Acute Mental Health Units

The Hon. ANTHONY D'ADAM: How many specialised acute mental health units are there, Dr Wright?

Dr WRIGHT: We have got—sorry.

The Hon. ANTHONY D'ADAM: You do not know at the top of your fingers?

Dr WRIGHT: No, because there is a large number. We have got—

The Hon. ANTHONY D'ADAM: Would it be in the vicinity of 46?

Dr WRIGHT: Acute inpatient units? No, significantly more than that.

The Hon. BRONNIE TAYLOR: In terms of units or beds?

The Hon. ANTHONY D'ADAM: I am talking about units.

The Hon. BRONNIE TAYLOR: Units.

Dr WRIGHT: While I am trying to find the actual number—

The CHAIR: That is okay.

The Hon. BRONNIE TAYLOR: We can take that on notice and get back to you by the end of today

ANSWER

Dr Murray Wright responded to this question later in the hearing. Refer to page 17 of the transcript - 'Just to go back to your earlier question, there is 167 declared inpatient units across the State'.

Transcript page 18

Morriset Hospital

Dr WRIGHT: At the moment, the New South Wales target for percentage of mental health episodes of care with at least one episode of seclusion is below 4.1 per cent.

The Hon. ANTHONY D'ADAM: Do you have at your fingertips the benchmark for Morriset Hospital: Where is it in the terms of its performance?

Dr WRIGHT: The other benchmark figure is the number of episodes of seclusion per 1,000 bed days. That target is 4.5 episodes per 1,000 bed days. The figures have moved around during the course of the last 12 to 18—

The Hon. ANTHONY D'ADAM: Can I just bring you back to Morriset? Dr WRIGHT: Yes.

The Hon. ANTHONY D'ADAM: Do you have a figure for Morriset?

Dr WRIGHT: I do not have the figure in front of me. I would have to take that on notice. But I think that there are some services that have struggled to meet- well, there are services that are not meeting those benchmarks. That is why one of the reasons that we have invested in the Mental Health Patient Safety Program through the Clinical Excellence Commission, which is intended to assist-

ANSWER

The Morisset Hospital benchmark for acute seclusion applies only for the 12-bed neuropsychiatry unit acute unit at Morisset, Kaoriki Lodge.

According to the most recent reporting quarter, Kaoriki Lodge had a seclusion frequency of 15.4 per cent. This figure resulted from only six seclusion events in that quarter.

Caution is advised with interpretation as the unit has a small bed base, usually with a low occupancy rate of 70 per cent or less. Acute facilities with episodes of care with at least one event of seclusion may be greatly affected when there are low total episodes of care.

Hunter New England Local Health District is committed to reducing and eliminating the use of seclusion in inpatient units and continues to work on numerous strategies for reduction including the Safewards program, the Violence Prevention and Management program, and enhancing therapeutic environments.

Transcript page 20

Child Protection Practitioners

The Hon. EMMA HURST: That is fine. You also recently announced a $3 million expansion of caseworker wellbeing checks to provide support for thousands of child protection staff across New South Wales. Did that come from any kind of concern that there has been a decline in mental health in child support caseworkers?

The Hon. BRONNIE TAYLOR: Ms Hurst, for us it was more a recognition that it is a difficult job, what those caseworkers are doing, and that if we can support them in any way that we can, that was really necessary. In terms of their particular mental health, that would be something that I am sure—Dr Wright, could you talk to that, or would that be Mr Pearce? Mr Pearce, would you be able to comment further on that in terms of caseworkers and their mental health?

Mr PEARCE: Yes. That was a program that DCJ is leading—$6 million over two years to build the capacity of caseworkers and casework managers to provide support to child protection practitioners. DCJ is leading that program [inaudible].

The Hon. EMMA HURST: Was that actually related to concerns around a decline in mental health for child support caseworkers? Did that trigger this?

Mr PEARCE: Not so much a decline but a recognition that they do need support.

The Hon. EMMA HURST: Can I also ask what sort of tailored mental health services these caseworkers will have access to?

The Hon. BRONNIE TAYLOR: Ms Hurst, as Mr Pearce said, that will be led by the Department of Community and Justice. If you want absolute information on the more detailed aspects of that program and how the funding will be spent, I am very happy to take that on notice for you and get that to you. If, indeed, that is in progress, we can update you on a regular basis.

The Hon. EMMA HURST: Thank you. I guess my question—and I am happy for you to take it on notice—is if what they will have access to will actually be tailored for their specific workplace?

ANSWER

Staff who are involved in child protection casework will have access to individualised wellbeing checks. The frequency of checks and the extent to which they are mandated will vary dependent upon actual or likelihood of exposure to trauma in the workplace. The check consists of a one hour one-to-one session with a trauma informed specialist. The program aims to prevent workplace psychological injuries by enabling staff to identify and seek help for any early indications of a mental health concern.

Transcript page 26 - 27

Concord Hospital

Dr WRIGHT: Could I just comment on the target because I do not want it to be misunderstood. What we are trying to do is eliminate seclusion. We would rather see no seclusion and zero hours, but in order to improve practice, the target is four hours at this point.

The Hon. ANTHONY D'ADAM: Of course. I understand that in terms of the performance against that target, there are a number of hospitals that exceeded it by a significant amount. I want to raise a question, Minister, about Concord. In terms of the recent data, its average period of seclusion was 24 hours and 45 minutes. That is significantly higher than your four hour target, isn't it, Dr Wright?

Dr WRIGHT: Yes.

The Hon. ANTHONY D'ADAM: So I am assuming, Minister, when you got your briefing on the BHI, that one stood out quite dramatically. What did you do in relation to that target as it pertained to Concord? What questions did you ask?

The Hon. BRONNIE TAYLOR: In that particular one, Mr D'Adam, as I said previously, an internal process takes place. I allow that internal process to take place and I allow explanations to be given for that. I also say that—

The Hon. ANTHONY D'ADAM: Minister, I draw you back to the question.

The Hon. BRONNIE TAYLOR: I really need the opportunity to answer this, Mr D'Adam, or else I cannot give you the context for it. I am really concerned when we look at lines of questioning that say that there are definitely those outliers. You are right. But the staff are absolutely—

The CHAIR: Order!

The Hon. ANTHONY D'ADAM: Minister, what I am trying to probe is how you respond to specific circumstances that are drawn to your attention. That is what I am trying to get at. **The Hon. WES FANG:** Point of order—

The Hon. BRONNIE TAYLOR: Mr D'Adam, I very clearly said to you, with all due respect—

The Hon. ANTHONY D'ADAM: I want to try to get an understanding of how you approach those.

The Hon. BRONNIE TAYLOR: I am answering that question. If it not what you would like me to say, I am sorry. All I can do—

The CHAIR: Order! I think there is a point of order.

The Hon. WES FANG: Chair, my point of order is this: The Minister, in particular in the area of mental health, has to provide context around her answers. She is trying to do so. I ask that she be given a bit of latitude to be able to do that because the context is sometimes more appropriate than just a single answer.

The Hon. ANTHONY D'ADAM: I have specific questions to which I am seeking answers. If I need to get context, I will ask the Minister to elaborate.

The Hon. WES FANG: Again, the answers may not be specific. The answers may require some level of detail which the Minister is trying to provide.

The Hon. ANTHONY D'ADAM: No, they do not.

The CHAIR: Please, everyone. The question was very specific. Minister, you indicated essentially that you understand the question. You then moved on to give some context. The question was specific in regard to Concord hospital. Either you have a specific response to that or you do not. That is essentially the position. If you have no specific comments about Concord hospital, so be it. But that was the question.

The Hon. BRONNIE TAYLOR: Yes, Mr Chair. What I was trying to explain—I beg your pardon if that was not coming across clearly to the honourable member—is that there is a process in place each time the seclusion and restraint data is released. We look at those areas that are outliers. The member previously referred to the forensic ward at Morisset, he referred now to Concord and he was also talking about Shoalhaven. What I said in that answer was that I am briefed regularly. I understand where those rates are at times higher than others. The process is—which stands for all things, whether it is Concord or whether it is Morisset or wherever it is—that we internally look at the reasons that are behind that increase in seclusion and restraint. I wanted to preface that answer by saying that what I am really concerned about, as I tried to explain, is that often there are one or two episodes of patient care that require that most extreme level of care. That will then make those numbers look like they are higher than normal if we look at a large number of people. That is why we have this whole process in place. I want to say as well that the mental health staff feel so proud about this now that they put it up within the ward so everybody can see it.

The Hon. ANTHONY D'ADAM: I have limited time, Minister. I am after specific answers. I have given you a lot of latitude—

The Hon. BRONNIE TAYLOR: I understand that, but there are good people out there that I need to protect.

The CHAIR: Order!

The Hon. ANTHONY D'ADAM: I have given you a lot of latitude to give some context. Now I want to come back to the specifics. The specific question was about Concord. You advised in your previous answer that, when there is an outlier, you write to the local health district, with a "Please explain". Concord is clearly an outlier. The data was presented in, I think, June. So you would have had a briefing in June or perhaps early July. You would have written. What came back in relation to that specific outlier at Concord? What information was provided to you?

Ms KOFF: If I may, the Minister does not intervene personally in operational issues of performance such as that. The Minister, obviously, has a responsibility of oversighting and understanding delivery of the policy. But it is then the Ministry of Health that has responsibility. There are two mechanisms by which the ministry and Health monitor those agreements and performance indices. We have collective service level agreements with every single district. The local chief executive—

The Hon. ANTHONY D'ADAM: Can I just clarify, Ms Koff? Is it your evidence that the Minister does not need to oversight this kind of issue?

Ms KOFF: No, she does. I did not say that. It is reported to the Minister. She has responsibility for the policy direction. She has responsibility for setting the strategic—

The Hon. ANTHONY D'ADAM: That is what I am trying to get at. Thank you, Ms Koff.

The CHAIR: Order!

Ms KOFF: But in terms of operational implementation, it is up to the Ministry of Health then to hold the district accountable for that delivery. I do not know why the Concord number was so high. I am happy to take that on notice to find out because I think we need to explore it because it does look an outlier in the BHI report.

ANSWER

During the period of April to June 2021, Sydney Local Health District Mental Health Service experienced a spike in average duration of seclusion. During this period, three acutely unwell and clinically complex consumers were admitted to Concord Centre for Mental Health from other tertiary mental health facilities.

All consumers had diagnosed serious and enduring mental illnesses and significant behavioural disturbance including violence and aggression towards mental health staff. Treatment for these three complex consumers required multiple and extended episodes of seclusion to manage their risk of violence and aggression to self, others and staff, as well as input from family and a variety of therapeutic interventions.

These three consumers accounted for 53 per cent of seclusion duration in the April to June 2021 quarter. Excluding these episodes reduced the average duration of seclusion from 24.75 hours to 13.79 hours.

The Mental Health Service acknowledges this duration of seclusion remains above target and is focussed on strategies to reduce restrictive practices. The initial impact of these strategies is reflected in a decrease in seclusion events at Concord Centre for Mental Health, reducing the rate from 15.1 seclusion events per 1000 bed days in October to December 2020, to 8.9 events in April to June 2021.

Transcript page 28

Emergency Hospital Admission – Psychiatric Treatment

The Hon. ANTHONY D'ADAM: Minister, on 17 October you said, "If you require an emergency hospital admission in New South Wales for an acute exacerbation of your mental health illness, you will get that admission." On notice, if you do not have the data available, in the past 12 months how many patients seeking admission for a psychiatric treatment have waited for more than 24 hours in the emergency department before a psychiatric unit bed was available? Do you have that data on hand?

The Hon. BRONNIE TAYLOR: I will be able to give you that data by the end of this, Mr D'Adam, because it is somewhere and I have read it, but I understand that less than 1 per cent have waited for longer than 24 hours.

The Hon. ANTHONY D'ADAM: I am after a headcount number, if possible.

The Hon. BRONNIE TAYLOR: Okay, Mr D'Adam. I will ascertain to have that to you by the end of budget estimates today.

ANSWER

NSW Health reports the number of people with a mental health or drug and alcohol condition who have waited in an emergency department for more than 24 hours.

In 2020-21 there were over 3 million emergency department presentations in New South Wales. From 1 January to 31 October 2021, there have been 1,840 presentations with a mental health or drug and alcohol problem where the person spent more than 24 hours in the emergency department. People with mental health or drug and alcohol presentations to emergency departments often have complex needs or physical comorbidities. They then may require time for comprehensive assessment, or the care of urgent medical problems such as severe intoxication or self-harm, which could mean they need to remain in emergency for more than 24 hours so that a full assessment can be undertaken. Developing a plan for care may also require communication with carers and other services to gather information and develop care options. Not all people staying more than 24 hours in an emergency department are required to be admitted to hospital, with some discharged from the emergency department after assessment and treatment.

NSW consistently outperforms other jurisdictions in the proportion of mental health-related emergency department presentations seen within clinically recommended timeframes.

Transcript page 29 - 30

Housing and Accommodation Support Initiative

The Hon. ANTHONY D'ADAM: Can I ask about the Housing and Accommodation Support Initiative?

The Hon. BRONNIE TAYLOR: Yes, HASI.

The Hon. ANTHONY D'ADAM: How many community living supported places are funded this year?

The Hon. BRONNIE TAYLOR: I would have to take that on notice, Mr D'Adam, so I can give you an accurate number. I do not know off the top of my head, I am sorry.

The Hon. ANTHONY D'ADAM: Can you also provide us with the details of how many were funded last year?

The Hon. BRONNIE TAYLOR: Yes, I can. If I am allowed to elaborate, that has been a really fantastic, well-respected and well-thought-of program.

The Hon. ANTHONY D'ADAM: Is there a waiting list for community supported living places?

The Hon. BRONNIE TAYLOR: HASI places?

The Hon. ANTHONY D'ADAM: Yes.

The Hon. BRONNIE TAYLOR: I would have to take that question on notice to make sure. I certainly have not been made aware of that waiting list.

The Hon. ANTHONY D'ADAM: If there is, can you give us details about the numbers?

The Hon. BRONNIE TAYLOR: Yes, most certainly.

The Hon. ANTHONY D'ADAM: Are you also able to provide us details in relation to the average waiting time for placement?

The Hon. BRONNIE TAYLOR: Could you be more specific? In placements to the HASI program?

The Hon. ANTHONY D'ADAM: If someone need a placement within a community living supported facility.

The Hon. BRONNIE TAYLOR: The reason I am asking is are you specifically referring to housing and accommodation or are you referring to the HASI program?

The Hon. ANTHONY D'ADAM: I am referring to community living supported places. As I understand it—perhaps you can elaborate on these facilities—these are actual places where people are transitioning.

The Hon. BRONNIE TAYLOR: What usually happens is that if they have been in an inpatient facility or if they have been somewhere, they will be in housing, whether that is social housing or that is housing of their own. Then we implement a HASI program which is really intensive wraparound support for those people to make sure that we can transition them.

The Hon. ANTHONY D'ADAM: So this is the accommodation dimension of that? Perhaps Mr Wright can elaborate on the nature of the service.

Dr WRIGHT: Are you speaking of the Pathway to Community Living Initiative [PCLI] or the HASI initiative? Sorry to bamboozle you.

The Hon. ANTHONY D'ADAM: The HASI initiative.

Dr WRIGHT: Okay. Can you restart the question, sorry?

The Hon. ANTHONY D'ADAM: I am wondering whether there is a wait time for placement in community living supported places.

Dr WRIGHT: I think we would have to take on notice if there is a wait time for the HASI places, unless Mr Pearce can add anything.

The Hon. ANTHONY D'ADAM: Are you able to break down the data to reflect the number of places by local health district—

Dr WRIGHT: Yes, we can describe the number of HASI places by district.

The Hon. ANTHONY D'ADAM: —and the demand in each local health district?

Dr WRIGHT: Not so much the demand.

The Hon. ANTHONY D'ADAM: If there is a waitlist—

The Hon. BRONNIE TAYLOR: Because it is a transition program, so people are transitioning. There is always going to be people who are waiting to go and be able to go onto the HASI program to then transition.

The Hon. ANTHONY D'ADAM: Does that mean that there is the possibility that people are not able to transition into the facilities because they are not available? How is that managed?

The Hon. BRONNIE TAYLOR: Mr D'Adam, we have amazing success rate with our HASI program and the outcomes that we get. They are quite phenomenal, and that is because it is a really robust system, a really robust service. Why do we not take your question on notice and then what we are able to—

The Hon. ANTHONY D'ADAM: I suppose the core of my question is about how is the demand managed for this program, whether there is demand that exceeds the available supply of places. If you are able to provide relevant data for that, that would be—

Dr WRIGHT: I think that we will take on notice and provide a description of what the HASI program is, where the beds are and what the process is to identify those people who are getting the most benefit from that accommodation and how it is—

The Hon. ANTHONY D'ADAM: Presumably someone is identified for entry into the program, and at that point there is a timestamp there, and then there is the question of how long it takes from the time that they are identified to the time that they get put into a place to enter the service.

The Hon. BRONNIE TAYLOR: To be fair too, Mr D'Adam—and I am not trying to skirt around your question at all—there is no timestamp because obviously sometimes someone may be told to say, "Look, we predict that in another fortnight or in another two weeks that this person will be ready to transition into the HASI program", and then transition through all those steps. But that can change depending on the nature of the person and how they are tracking. We will make every attempt, I assure you, to answer your question exactly as you have asked it. We will take it on notice.

The Hon. ANTHONY D'ADAM: A final question on that: Are there plans to provide any additional places under that program?

The Hon. BRONNIE TAYLOR: Of HASI? As I said, we have numerous HASI places and things, but in terms of additional programs, my understanding is that the need is being met and we are doing that, but I am very happy to take that part of the question on notice as well.

ANSWER

In 2021-22, the NSW Government is investing $91.2 million in NSW Mental Health Community Living Programs, supporting more than 1,900 people with severe mental illness to live independently in the community.

This includes:

- Housing and Accommodation Support Initiative (HASI)
- HASI Plus
- Community Living Supports (CLS) program
- Mental Health Community Living Supports for Refugees (MH-CLSR) program.

Details of these programs are published on the NSW Health website.

The HASI Plus program provides accommodation along with psychosocial and clinical support. HASI Plus is a high intensity transitional program, specifically designed to help people recover and then transition to a more independent life in the community. Once accepted into the program, participants move into one of eight community accommodation sites located across NSW. These are either self-contained apartments or a modified house with shared cooking facilities and living areas.

There are 70 HASI Plus packages located across the eight locations, and referral and intake processes are managed at the local health district level. Participants of the program are not automatically allocated to the next available place. Several variables are considered when reviewing priority including urgency of need, suitability, and services required.

To ensure that people with high needs are prioritised, benchmarks for the number of clients that require more than five hours of support a day have been set for each local health

district. Benchmarks have also been set for the number of Aboriginal clients. HASI services are exceeding benchmarks for delivery of services.

Transcript page: 32

Aboriginal Mental Health and Suicide Prevention Workforce

The Hon. EMMA HURST: Thank you. I also have some questions about First Nations populations. In October you announced $21 million in funding to expand the Aboriginal mental health and suicide prevention workforce, specifically to recruit 18 Aboriginal care navigators and 18 Aboriginal peer workers. What consultation was conducted with the First Nations community in respect to funding these new roles?

The Hon. BRONNIE TAYLOR: In regard to the funding—I know that you asked me specifically about the second announcement—can I quickly say in the Towards Zero strategy we have a section there that is solely for First Nations peoples. We have run a bit behind in implementing that program but that is because we were adamant that that had to come from Aboriginal community-led organisations. I am pleased to say that last Friday I saw someone from one of those organisations who said that it is working very well and they are really excited about where we are going. In regard to your specific question about the peer workers and the Aboriginal coordinators that are going into those 18 LHDs, I will ask Mr Pearce to comment directly on that part of the question.

Mr PEARCE: We released our Aboriginal Mental Health and Wellbeing Strategy earlier in the year, which was a product of extensive consultation with Aboriginal communities right across the State. In terms of this specific funding, that is consistent with that strategy. Each local health district, in consultation with its Aboriginal communities, has been requested to develop implementation plans by the end of this calendar year. These are additional resources that go into delivering on those implementation plans. We have emphasised to each local health district that they have flexibility around the way in which job descriptions are framed. So, really, our immediate challenge is issuing the dollars to support the LHDs and the Aboriginal communities, and they have the flexibility to tailor those job descriptions to roles that meet the need of those specific local communities.

The Hon. EMMA HURST: Thank you, Mr Pearce. If you do not have on hand the names of any organisations, et cetera, that were used in consultation, can I put that on notice?

Mr PEARCE: Yes, I will take that on notice.

ANSWER

Building and sustaining the Aboriginal mental health and wellbeing workforce is a Strategic Direction of the *NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025.*

The Strategy is developed through extensive consultation with Aboriginal people and communities, local health districts and specialty health networks, the Aboriginal Health Medical Research Council and Aboriginal Community Controlled Health Organisations, which have identified the need to:

- increase the number and type of Aboriginal workers across all levels and positions in the mental health workforce

- build and support the Aboriginal peer workforce through the development and implementation of the NSW Peer Workforce Framework.

Funding for the Aboriginal Mental Health Care Coordinator and Aboriginal Mental Health and Wellbeing Peer Worker positions will directly respond to this community-identified need.

The Aboriginal Mental Health Care Navigators will be responsible for supporting Aboriginal people and their families to connect with the most appropriate service within and outside the local health district. They will also provide ongoing support and contact with these individuals and families.

The Aboriginal Mental Health Peer Workers will be embedded within public mental health services and are responsible for providing culturally sensitive support, particularly in emergency settings. They will also link people to other supports, such as suicide prevention services, drug and alcohol services, and Aboriginal community services.

Transcript page: 39

New Horizons

The Hon. ANTHONY D'ADAM: In the arrangement with New Horizons, what is the data reporting agreement between Health and New Horizons?

The Hon. BRONNIE TAYLOR: Why do I not take that question on notice and get you an exact detail of the reporting requirements for the Youth Aftercare service?

The Hon. ANTHONY D'ADAM: If you can take that one on notice, that is fine.

The Hon. BRONNIE TAYLOR: Do you want it both for Coffs Harbour and Blacktown?

The Hon. ANTHONY D'ADAM: Yes. For both, if you could. Obviously, if there is any data available, if that could be provided as well.

ANSWER

New Horizons is required to submit biannual and annual program reports, which contain data of referral numbers, client numbers, support hours provided, length of engagement, outcome measures, client satisfaction feedback, minimum data set, and all data about co-production and young people's involvement. In addition, New Horizons shares de-identified data with the evaluators.

Data below has been provided by New Horizons and extracted from the most recent program report:

	Blacktown – Western Sydney	Coffs Harbour – Mid North Coast
Referrals received	23	19
Referrals accepted	13	12
Number of clients	13	10
Clients exited	0	2

Referrals not accepted were due to the following factors:

- child or young person refused service
- not contactable / parent disengaged
- relocated outside the catchment area
- presenting issues not appropriate for service
- in crisis presentations.

Transcript page 40

Aboriginal Care Workers

The Hon. EMMA HURST: Minister, in our last allocated time, we were talking about the Aboriginal care workers and we were talking about a review of the program. Do you have any specific time allocated for that review?

The Hon. BRONNIE TAYLOR: As that was announced recently, what you are talking about—

The Hon. EMMA HURST: Do you have any idea about when you would review—yes, sorry. The two sets of workers.

The Hon. BRONNIE TAYLOR: That would all be in place in the strategy and what we do. As I said, it was announced about a month ago, if that. In an evaluation process I presume that is structured within it, but I am really happy to take that on notice and get back to you with that time frame. Mr Pearce, we can do that, can we not? Unless you have an answer now on that.

ANSWER

The *NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025* was published in December 2020. The Strategy was developed through extensive consultation with Aboriginal people and communities, local health districts and specialty health networks, the Aboriginal Health Medical Research Council and Aboriginal Community Controlled Health Organisations.

Building and sustaining the Aboriginal mental health and wellbeing workforce is a key Strategic Direction of the Strategy. The recently announced Aboriginal Mental Health Care Navigator and Aboriginal Mental Health Peer Worker positions align to this Strategic Direction.

NSW Health has engaged an Aboriginal organisation to conduct a comprehensive evaluation of the Strategy that includes in-depth community linkage analysis across NSW with regular reporting. Commencing in 2022, the evaluation will build evidence of what works, determine outcomes, and inform future strategic planning and resource allocation.

The implementation of Aboriginal Mental Health Care Navigator and Aboriginal Mental Health Peer Worker positions at the local level will be captured and reported against through this evaluation process.

Transcript page: 42-43

Recommendations from Victorian Mental Health Commission

Ms CATE FAEHRMANN: Thank you, Chair. Minister, have you had a chance to have a look at the recommendations from the Victorian royal commission into mental health?

The Hon. BRONNIE TAYLOR: Yes, I have.

Ms CATE FAEHRMANN: Do you agree with most of those recommendations?

The Hon. BRONNIE TAYLOR: I think that is an accurate summation. Not all, but most.

Ms CATE FAEHRMANN: Recommendation 55 is about compulsory treatment. I have spoken with you both about this before. I will just read a little bit out from it:

The Royal Commission recommends that the Victorian Government:

1. act immediately to ensure that the use of compulsory treatment is only used as a last resort.

2. set targets to reduce the use and duration of compulsory treatment on a year-by-year basis …

I just wanted to check what happens in New South Wales. I know that you have both assured me that it is used as a last resort. We will probably talk about that. Is there a target to begin aiming to reduce the use of compulsory treatment orders within New South Wales? Dr Wright?

Dr WRIGHT: The short answer is no. The broader answer—I think context is important—is that the application and administration of community treatment orders [CTO] is under the monitoring by the Mental Health Review Tribunal, which has an autonomous function, to ensure specifically what you are asking: that any application for a CTO is the least restrictive form of care. The whole principle of least restrictive form of care plays to your point about it being a last resort. That is the function of the Mental Health Review Tribunal. I can say confidently that they exercise that responsibility very robustly.

Ms CATE FAEHRMANN: Thank you, Dr Wright. Do you know what the general trend has been, therefore, say, over the past five years or something in the application of community treatment orders? Has the rate of those increased or decreased?

Dr WRIGHT: No. I would have to take that question on notice.

ANSWER

The number of Community Treatment Orders issued by the Mental Health Review Tribunal are in the Tribunal's Annual Reports, which are publicly available at: https://www.mhrt.nsw.gov.au/annual-reports.html. The trend over the past five years can be ascertained from these reports.