

PORTFOLIO COMMITTEE NO. 2 – HEALTH

Wednesday 30 October 2019

Examination of proposed expenditure for the portfolio areas

MENTAL HEALTH, REGIONAL YOUTH AND WOMEN

CORRECTED

The Committee met at 13:50

MEMBERS

The Hon. Greg Donnelly (Chair)

The Hon. Lou Amato

Ms Cate Faehrmann

The Hon. Ben Franklin

The Hon. Natasha Maclaren-Jones

The Hon. Tara Moriarty

The Hon. Walt Secord

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 budget estimates supplementary hearing for the portfolio of Mental Health, Regional Youth and Women. Before I commence, I acknowledge the Gadigal people who are the traditional custodians of this land. I pay respect to the Elders past and present of the Eora nation and extend that respect to other Aboriginals present and those who may be watching on the internet. 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 they must take responsibility for what they 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.

Any messages from advisers or members' staff seated in the public gallery should be delivered through the Committee secretariat. I remind witnesses and officers accompanying them that they are free to pass notes and refer directly to their advisers seated at the table behind them. Finally, could everyone please turn their mobile phones to silent for the duration of the hearing. I remind all witnesses, with the exception of Ms Lourey, that you do not need to be sworn as you have been sworn at the earlier budget estimates hearings of this Committee.

CATHERINE LOUREY, NSW Mental Health Commissioner, affirmed and examined

MURRAY WRIGHT, NSW Chief Psychiatrist, NSW Health, on former oath

ELIZABETH KOFF, Secretary, NSW Health, on former oath

KERRY CHANT, Chief Health Officer and Deputy Secretary of Population and Public Health, on former oath

The CHAIR: As there is no provision for any witness to make an opening statement, we will begin our questions immediately. We will commence with the Opposition doing the first tranche of questions. Then we will move to the crossbench and then move back and forth over the course of the afternoon until we have exhausted either the questions or are physically exhausted and fall over—we will see which comes first.

The Hon. TARA MORIARTY: Ms Lourey, will you provide an overview of the Mental Health Commission of NSW?

Ms LOUREY: Sure. The Mental Health Commission of NSW was established under its own legislation, the Mental Health Commission Act 2012. Under that Act, the commissioner and the commission report directly to the Minister, which in our case is the mental health Minister. Under our legislation we have three key roles under an overarching goal, which is to work to improve the mental health and wellbeing of the community of New South Wales.

Those three particular goals are: To monitor and report on progress with reform of mental health, which is principally under the aegis of the Living Well mental health strategy of New South Wales; to review systemic issues to do with mental health, which is not individual services or facilities but around systemic issues such as housing, medications, those broad community supports et cetera; and advocacy, not only to bring the voice of lived experience further into the work in mental health reform across New South Wales but also advocacy for reform itself.

We are an agency of around 29 staff. We have a budget of over \$11 million. Within that budget we spend roughly \$4 million on grants to New South Wales mental health NGOs. Those NGOs include WayAhead; BEING, the peak consumer body in New South Wales; Mental Health Carers Australia, which is the peak body for mental health carers; and Beyond Blue. The Beyond Blue grant that we provide is part of the New South Wales Government's commitment under COAG when Beyond Blue was established. Every jurisdiction in Australia funds Beyond Blue.

The Hon. TARA MORIARTY: The major Government policy that you guys are responsible for is the Living Well strategy, the 10-year plan?

Ms LOUREY: The NSW Mental Health Commission was charged initially to develop a mental health strategic plan, which it did. However, we have no responsibility for implementing that. That is now Government's policy, it is not the commission's. Our role now is about monitoring progress with that.

The Hon. TARA MORIARTY: Just to clarify, the commission was responsible for drafting the plan?

Ms LOUREY: That is correct.

The Hon. TARA MORIARTY: You give it to the Government, the Government does what it will with it. I know that there is a review at the moment, which I will come to in a second. I acknowledge that you guys do not necessarily have anything to do with implementing the plan. Can you give us an overview of the plan, given that you guys drafted it?

Ms LOUREY: Living Well is a 10-year mental health strategy that looks at the domains of a person's life. It identified what those elements were, which are around care for all and having that whole-of-life—we are as interested in mental health as we are drug and alcohol and physical health outcomes. It is about having services closer to home that are accessible. It is about having quality care and ensuring access to quality care. It is around suicide prevention and looking at Aboriginal social and emotional wellbeing. It was really setting up a strategy that would bring those elements together.

That is the challenge of any comprehensive mental health strategy being a whole-of-government strategy, in that it crosses over a number of agencies. There is a NSW Mental Health Taskforce that is chaired by the secretary of Health. That also has its own particular responsibilities in terms of monitoring and reporting. However, in terms of the broad role of the commission when we were developing it—that was between 2012 and 2013 and then it was finalised in 2014—was that it was a very considerate strategy that was developed through a

lot of community consultation and a lot of agency engagement. Again, we have taken that model when we have been doing this midpoint review as well.

The Hon. TARA MORIARTY: I know you are at the halfway point and you are reviewing it and I have got some questions about that. However, are there any parts of the original plan from five years ago that the Government has not taken up, whether it has not done so yet or whether it is not going to?

Ms LOUREY: I think that is not really for me to comment, in terms of each of the particular agencies. I do not have a line of sight on that. As part of the review we have not received all the information, so at this point I really could not answer that question for you.

The Hon. TARA MORIARTY: I appreciate that you do not have a line of sight over all that, but are you aware of any parts of the original plan that the Government did not take up?

Ms LOUREY: It is not so much about whether the Government did not take something up, it is that times change. I think that is one of the main things when you look at Living Well. It was developed in 2013 and finalised in 2014. At that stage there was no NDIS. There were no primary health networks. There have been so many changes since it was written. From my observation, the Government has appropriately flexed during that. However, as I said, we are yet to receive a full range of data to inform us on that. That is what our role is at the moment.

The Hon. TARA MORIARTY: When did the current review start?

Ms LOUREY: We started the planning for the review about 12 months ago. There are two aspects to the way the Living Well strategy is being rolled out and monitored by government. One of those is by government, as the agencies which are responsible—again, that goes to the NSW Mental Health Taskforce. The role of the commission is around reporting on progress but also on outcomes. There are two parallel but distinct ways that the monitoring of Living Well has been structured.

In terms of the review that you asked me about, we started our pre-planning last year. What we are looking at is whether the key focus areas remain fit for purpose, whether they are still relevant given all the changes over the first five years—a few of which I have already alluded to—and to then really provide a focus for the next five years. Essentially, it is not rewriting Living Well. It is saying that it is still a very strong, relevant and well-considered document. But things have changed and we do need to make sure that we are responsive to the changing mental health environment that we are experiencing not only in New South Wales but, of course, also nationally.

The Hon. TARA MORIARTY: What was the reasoning for a 10-year plan in the first place?

Ms LOUREY: I was not around when the 10-year plan was written but as a planner I would say that you need to have a good horizon to be able to establish an initiative and embed that initiative and then have the last phase where your reform becomes business as usual. For that reason 10 years is not an unusual length of time for a plan. But the key—especially in the mental health area, where there have been so many changes and reforms—is that you keep it agile, relevant and meaningful. Having a review halfway through that 10-year period is just good practice.

The Hon. TARA MORIARTY: Fair enough. There have been so many changes in this space over the past couple of years—as you have talked about and as we all know—as awareness in this space increases and as specific things like the NDIS have come into play. You have the 10-year plan in place and you are doing the halfway point review. That is all perfectly reasonable. But how likely do you think it is that you will continue with the same plan? Are you going to make adjustments to the plan or make recommendations, presumably, to the Minister based on some of the things that have changed? I know you have said that it is not going to be completely rewritten but it could be, given the changes. How do you see that playing out?

Ms LOUREY: I will just give you a bit of an overview of what we have done so you can understand where our directions are. As I said previously, the initial plan was developed through a significant amount of consultation in the community. Over the past seven months I have visited 57 different communities in New South Wales and held consultations. We have had over 1,000 people engage with us face to face. We have had over 1,000 people respond to our online survey. We asked three key things in all those consultations. First, what has really worked well over the first five years? Second, what do you think the remaining challenges are? Third, what do you think the key areas are for focus over the next five years?

We are drawing upon the evidence from all of those consultations. We are also doing agency consultations. We have been speaking with professional bodies and groups to really get an understanding around

where that focus should be. From the feedback that we have got so far, the evidence would suggest that the community and organisations believe that the basic objectives and framework for living well remain relevant. But there are areas that need more focus or traction. That is the real key. When we talk to those communities we are asking if there have been improved outcomes for them in their lives across the domains of their lives and if there has been ease to get services, etcetera. It is about focusing that traction in the next five years.

The Hon. TARA MORIARTY: Can you give us examples of some of the issues that were raised through the feedback you have been getting from stakeholders in response to those three questions: what is working well; what are the challenges—

Ms LOUREY: What has really worked well has been the development of the peer workforce. The peer workforce has been seen as a great initiative not only in terms of providing people who have recovered from their own mental health issues with the opportunity to be able to go back into the workforce, build on that expertise and contribute to the recovery journey of people with mental health issues, but also around how we can change some of the cultural aspects of either a health service or other agency. We were very lucky to find out about a great service in Kempsey where they have a peer worker who is working across the local health district and the local Family and Community Services [FACS] office.

That has been a really wonderful initiative because the FACS workers are now understanding that a lot of their clients have mental health issues and they can better support those clients through a lot of those housing and other issues. Peer work has been a really important plus. The other benefits that have come out have been great local initiatives where there has been collaboration. That can be collaboration between a primary health network, a local health district, a community-managed service and a GP.

The Hon. WALT SECORD: In your preliminary remarks you said that you reported directly to the Minister.

Ms LOUREY: Correct.

The Hon. WALT SECORD: Is that the Minister for Mental Health, Regional Youth and Women?

Ms LOUREY: Correct.

The Hon. WALT SECORD: For how long have you been the Mental Health Commissioner?

Ms LOUREY: I have been in that position for 2½ years.

The Hon. WALT SECORD: How many times have you had sit-down meetings with the Minister?

Ms LOUREY: Across both—

The Hon. WALT SECORD: No, with the current Minister for Mental Health, Regional Youth and Women.

Ms LOUREY: We meet roughly once a month.

The Hon. WALT SECORD: How long do those meetings take?

Ms LOUREY: An hour.

The Hon. WALT SECORD: You meet the Minister for Mental Health, Regional Youth and Women once a month for an hour?

Ms LOUREY: Yes.

The Hon. WALT SECORD: What happens in those meetings?

Ms LOUREY: We talk about issues that are relevant to the Minister and to our work program.

The Hon. WALT SECORD: The Minister is responsible for Mental Health, Regional Youth and Women. You meet once a month. How many times have you met the Minister?

Ms LOUREY: I cannot tell you off the top of my head but I would be imagine it would be—

The Hon. WALT SECORD: A couple of times?

Ms LOUREY: It would be more than a couple of times. But I can get that information for you if you want a precise answer.

The Hon. WALT SECORD: Yes. Have you met the Premier?

Ms LOUREY: Formally in a meeting or informally?

The Hon. WALT SECORD: Have you briefed the Premier on mental health issues in New South Wales?

Ms LOUREY: No, I have not.

The Hon. WALT SECORD: Have you briefed the Deputy Premier?

Ms LOUREY: No, I have not.

The Hon. WALT SECORD: Have you briefed the health Minister?

Ms LOUREY: No, I have not.

The Hon. WALT SECORD: You have not briefed the Premier, you have not briefed the Deputy Premier and you have not briefed the health Minister but you meet with the Minister for Mental Health, Regional Youth and Women once a month for an hour?

Ms LOUREY: Correct.

The Hon. TARA MORIARTY: In terms of the review, can you tell us who you have met with and who has been giving you feedback throughout the process of the review?

Ms LOUREY: In our meetings at our regional consultations the people we have been speaking with have been from a range of groups, including local Aboriginal Medical Services, Aboriginal land councils, local groups, school principals and local service providers. There is a quite a range. We have visited Charles Sturt University, which runs an Aboriginal health training program. We spoke to students there who will be going into the mental health workforce. We have spoken with a range of organisations and we have an open invitation to speak to people, whether they be from the community sector or the public sector. We are interested in talking to services and people who support people with mental illness in their recovery. That can be anyone from a GP to a psychiatrist to a housing provider.

The Hon. TARA MORIARTY: How many people have you met with and how many submissions have you received?

Ms LOUREY: We have not had submissions. We have had an online survey. We have had over 1,000 responses to our survey. In terms of individuals, over 1,000.

The Hon. TARA MORIARTY: Meetings?

Ms LOUREY: No, 1,000 individuals.

The Hon. TARA MORIARTY: Who have completed the survey?

Ms LOUREY: No, sorry. In our consultations there were over 1,000 and over 1,000 responded to our online survey. In terms of individual meetings, I could get that information for you.

The Hon. TARA MORIARTY: Yes, just to give us an idea of what kind of consultation has taken place. Earlier you were talking about some of the things that have been found to have been going well. What are some of the challenges you are finding or getting feedback on?

Ms LOUREY: Some of the challenges that we are finding are no different to what is reported in other reviews into mental health. They would be around navigating and finding a way through services and people not understanding where to go when either their family member first becomes unwell or when they go to see a GP. They often do not understand that they could be entitled to psychological supports under the Commonwealth program. Or it may be that people do not actually understand when they are in distress where to go. You will find that people do obviously ring 000 or go to an emergency department. The whole navigation issue is one that comes up time and time again. That is also service providers who do not always necessarily know who else within their community or locality that they can refer their patients on to.

The Hon. TARA MORIARTY: As part of what you are collecting during the review now but also generally in terms of your role, just following up from my colleague's questions, the meetings that you have with the Minister, what kind of advice are you giving her generally or in relation to some of these issues that you are identifying?

Ms LOUREY: That advice can be in regards to what we find. If I go on a community visit I will advise the Minister on what we heard from that or any other issue or project that we are working on at that time.

The Hon. TARA MORIARTY: What kind of follow-up? I do not mean this to be a trick question but do you find that the Minister is responding to your advice, or just hears it and then you do not really get any follow-up? What happens?

Ms LOUREY: No, I think it is a very engaging conversation.

The Hon. TARA MORIARTY: I am sure the conversations are but I am talking about the follow-up afterwards.

Ms LOUREY: I would say that the conversations are engaged—which is different from engaging—but I think that the Minister understands, especially in regards to the Living Well review, that it is an ongoing process. Each of those conversations that I have with her are about updating her.

Ms KOFF: If I may interject and add, the effector arm of Living Well is through the government agencies and the Mental Health Commissioner did reference the task force. So, where issues arise that the Mental Health Commissioner raises with the mental health Minister the effector arm comes back through the Mental Health Taskforce. If I use the suicide prevention framework as an example, the design of the framework has been led by the Mental Health Commissioner with the support of the Ministry of Health. That document has been released and then the implementation of that occurs through the government agencies. It is quite a close relationship and partnership and issues raised by the Mental Health Commissioner to the Minister are then referred back to the Ministry of Health or the other relevant government agencies.

I think the effectiveness of the Mental Health Commissioner's advocacy has been highlighted in the allocation as a Premier's Priority of towards zero suicides for the State, which involves many, many government departments. That is how we get the closing of the loop on those issues that are identified.

The Hon. TARA MORIARTY: I was going to come to those questions, so we will come to them now. I am interested in getting some more information about how the task force works but, specifically, since you mentioned towards zero suicides, which I understand is one of the Premier's priorities, the commission does not directly engage with the Premier but presumably the department, the task force or the health department proper does?

Ms KOFF: For every Premier's Priority there is a lead Minister who is responsible and Minister Taylor is the Minister responsible for the suicide prevention program.

The Hon. TARA MORIARTY: What kind of work is being done on that, or what kind of advice are you giving the Minister in terms of meeting that priority for the Premier?

Ms KOFF: I would defer to our NSW Chief Psychiatrist Dr Murray Wright to discuss the suicide prevention strategy.

Dr WRIGHT: I think the towards zero suicides initiative is an extremely important initiative for this State. I should point out that it is completely consistent with national direction in mental health reform. The issues are represented in the *Fifth National Mental Health and Suicide Prevention Plan*. I note that it is the first time that the plan has been additionally called the suicide prevention plan. That is not mere window-dressing; I think it articulates the community's concern that we need to have a special whole-of-community and whole-of-government effort to reduce suicide. I think the things that have happened in the suicide prevention area over the last probably five years have all moved in the same direction and, at the risk of repeating things that have been said previously, I think it is important to see some of the architectural changes that have occurred.

The desire to have integrated, devolved, localised service planning between primary health networks and local health districts and other service providers is a pivotal part of suicide prevention both at a national and at a State level. It is because traditionally we have actually struggled to manage the gaps between the different tiers of government and how those services are provided. That is utterly crucial. When you look at documents like the *Strategic Framework for Suicide Prevention in NSW 2018-2023*, which was developed by Black Dog, it has developed the evidence-based initiatives which should go into a suicide prevention strategy and those are currently being trialled through Black Dog in New South Wales. But that same framework has also informed the development of other suicide prevention programs across the State. It also informs the towards zero suicides policy.

My point is that the towards zero suicides prevention initiative has not come out of nowhere. It is really a development of things that have been slowly gathering momentum and delivering results across the State but also nationally and internationally. It is a bold aspiration and I think that the Premier's Priority, which is a

20 per cent reduction in the suicide rate over the period, is something that is underpinned by a series of initiatives. That includes \$19.7 million being given to various projects over the course of this financial year and—

The Hon. TARA MORIARTY: Specifically, the Premier's priorities came after the last State election and she has decided to make this, quite admirably and importantly, a priority. You have helpfully just talked us through some general initiatives that have been happening over the last couple of years. What is the Government or the Premier doing specifically, or what has she asked you to do in relation to this now being a priority that is different?

Dr WRIGHT: It is \$19.7 million in this current budget for suicide prevention strategies. The range of initiatives includes expansion of Lifeline and expansion of the Kids Helpline, it is \$3 million in funding over four years for the Gidget Foundation, which is a not-for-profit organisation that aims at stopping maternal suicide. Those are some of the initiatives. There is an actual program called Towards Zero, which is an internationally recognised suicide prevention strategy that was initially developed in the US and has been taken up in parts of the UK and has also been adopted by Gold Coast Health's Mental Health and Specialist Services in Australia over the last few years. That is a whole-of-system transformation.

It is one of the reasons that I am very, very interested in where this takes us because those kinds of initiatives are not just about what happens between a clinician and a consumer who is experiencing suicidal ideation. The entire health system has to change the way in which it operates and manages people who are presenting in crisis. The vast majority of people who come into contact with our acute services have some degree of risk of harm, so suicide prevention is our core business. Those internationally recognised programs, which we are looking to adopt in New South Wales, are part of what the Premier's Priority is helping us to prioritise.

The Hon. TARA MORIARTY: Specifically, this money that you have just talked about—the \$19.7 million and, sorry, I have forgotten the figure for the Gidget Foundation; but the amounts that you have just talked about—is this new money as a result of this becoming a Premier's Priority? Or are these programs—

Dr WRIGHT: It is new money.

The Hon. TARA MORIARTY: —that were in place already in this space, given that it has quite rightly been looked at before that?

Dr WRIGHT: Things like Lifeline and Kids Helpline were already being funded, but this is an expansion of their capability.

The Hon. WALT SECORD: Dr Wright, in New South Wales how does NSW Health approach gender dysphoria? Given that transgender people are the most discriminated members of our society—I have seen a New South Wales Government report saying that—is it an area that involves mental health counselling? How does NSW Health respond to this?

Dr WRIGHT: I can tell you a small amount because, reflecting on your question, Mr Secord, I think that management and an approach to gender dysphoria is a whole-of-health issue. My area of responsibility is a small sliver of that. Specifically, gender dysphoria is an issue within the paediatric area—it is mostly around our paediatric and adolescent services.

The Hon. WALT SECORD: Yes, I know there are services at Westmead, from five years as shadow health Minister.

Dr WRIGHT: Mental Health has a role in that. It is not the lead agency there. Absolutely there is a mental health and counselling component, but there are other aspects to it that I cannot comment on.

The Hon. WALT SECORD: There are higher suicide rates. I have read studies from the previous anti-discrimination board that, in fact, they are the most discriminated members of our society. Can NSW Health enlighten me or educate me in this area, Dr Chant?

Dr CHANT: Sorry, Mr Secord?

The Hon. WALT SECORD: I wanted to know about the NSW Health approach to gender dysphoria: people who are looking at changing their gender or shifting their gender identity.

Dr CHANT: I think this is a complex area and I am not an expert in this area. It is not in my formal purview, so I would caveat any comment I made in that space. I think that the approach that our clinicians who are dealing with these issues take is very much on a case-by-case basis—very concerned about balancing the rights of the individual and the capacity to make decisions, as well as the evidence-based interventions that they

need along the pathway. I know this is a topic that has been raised by clinicians of all persuasions in that it is very complex to ensure that we have got good outcomes for the individuals.

Dr WRIGHT: Yes. It is a team-based issue that sits across both paediatrics, I think there is an element in the adult endocrinology world, and also in the mental health world. From my psychiatry colleagues, I know that there are a number of psychiatrists for whom this is an area of focus and interest, and they are very engaged. When I have spoken to the paediatricians who are involved in the area, again, it is a model of a multidisciplinary, team-based intervention. I do not think anyone underestimates the vulnerability of the population from a health perspective.

Ms CATE FAEHRMANN: I wanted to turn to the issue of suicide again and the specific target that the Government has set that the Hon. Tara Moriarty referred to, which is a 20 per cent reduction by 2023. Is that correct?

Dr WRIGHT: Yes, it is.

Ms CATE FAEHRMANN: The most recent data in relation to the number of suicides that are occurring in New South Wales is from 2017. Is that right, or have we had data from 2018?

Dr WRIGHT: The most recent data I have is from 2017, yes.

Ms CATE FAEHRMANN: Is there a reason why we do not have the data from 2018, firstly?

Dr WRIGHT: My data friends tell me that it takes a period of time to get verification of those kinds of figures. There is a difference between a presumed death by suicide and a confirmed death by suicide. The figures from the Bureau of Statistics are the confirmed deaths and that is the reason for the time lag.

Ms CATE FAEHRMANN: Does the 880—I think I have that down—from 2017 indicate a general increase from previous years? Is it moving up?

Dr WRIGHT: Yes, it is.

Ms CATE FAEHRMANN: The 20 per cent by 2023, are there milestones to be reached before 2023 in terms of seeing a downward trend in suicides in the strategic framework for suicide prevention? Does that set milestones before 2023 in terms of rates of suicide?

Dr WRIGHT: Before I answer that part of the question, I think I ought to say that 2023 is four years away. I think that there are a number of different markers or indicators that we would be looking at in monitoring people at risk of suicide, which I think would have more sensitivity in terms of being able to detect change. An annual figure such as the suicide rate is something that, if we were to implement the most perfect suicide prevention program today, may take a couple of years to see that change in something which is an annual rate. So we are very interested in some of the other indicators of people at risk, and those are things like presentations to emergency department with people who are presenting with suicidal ideation or people who are presenting with self-harm.

There are some particular populations who are of great interest to us to monitor, and we would also look at figures in some of those subpopulations, and there I am talking about young people and I am also talking about Aboriginal people. Those are populations where we are very keen to have specific improvements in some of those. As to whether there has been a setting of interim markers between now and 2023, I would have to take that on notice.

Ms CATE FAEHRMANN: I was just given that the suicide rate has unfortunately been increasing. To set a 20 per cent reduction target within four years is incredibly ambitious. It is good that the Government has set that, but the question was: When do you reassess as to how well you are going if, for example, the suicide rate after two years or three years is increasing?

Ms KOFF: If I could add, I think the most important thing to note is Towards Zero Suicides is an aspiration and an ambition which collectively everybody agrees with. We had an international expert out here last week from Mersey NHS health who has towards zero for suicide for their mental health services. Inherent in that discussion was the ambition itself must be stated and we must strive to do it. It is complex and it is difficult and we need to evaluate strategies along the way, but we must not resile from that ambition and we must endeavour to keep trying to achieve that.

We met with the Premier last week because part of, as Dr Wright explained, the suicide prevention framework—and that is a very, very broad framework that has a number of initiatives for implementation. Specifically, the Premier asked us what was ambitious, what was innovative, what is something different we can

do to shift the dial, because we collectively have an agreement that the dial on suicide needs to be shifted. We get the support in some of the Premier's Priority areas from the Premier's implementation unit located in the Department of Premier and Cabinet to assist us to develop strategies to do that.

The major ones we are focusing on as part of the Premier's Priority relate to peer workers and community-based support and a community-based approach for suicide prevention. Because some of the data indicates too that 40 per cent of people, if my memory serves me correctly, who commit suicide have not had a previous mental health engagement. So we are dealing with a population group outside of contact with the health system and our challenge is how we can engage or identify those groups earlier, and certain workforce populations are more prone to suicide also. I think the construction industry has a higher rate and we need to engage a number of work groups to assist in delivering that strategy.

Ms CATE FAEHRMANN: The suicide prevention programs that you have mentioned that the Black Dog Institute is running, which program were you specifically referring to, Dr Wright?

Dr WRIGHT: That is the LifeSpan projects. That is the four LHD—

Ms CATE FAEHRMANN: That are being trialled around New South Wales?

Dr WRIGHT: Yes.

Ms CATE FAEHRMANN: I have heard that Black Dog are very pleased with their trial. They are thinking that it is almost best practice. They feel quite confident in terms of what they are starting to achieve with that. Are you receiving their evaluation of those programs on a regular basis?

Dr WRIGHT: Each of those sites has one of the local health districts participating in it, so we are there through that. I have not seen their formal reports or evaluations but the information that I have received from the mental health services are that they believe it has improved things significantly, even by virtue of having better relationships and more regular relationships between the local health districts and the primary health networks and the other providers, just formalising that process around having a local suicide prevention strategy. That is a core feature of the LifeSpan project, having a suicide prevention plan in each of those sites.

Ms CATE FAEHRMANN: I understand that they have put a request in for funding from the Government to sustain their current four LifeSpan sites and for four new LifeSpan sites as well. Are you aware of that?

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

Ms CATE FAEHRMANN: How long do the existing LifeSpan programs go for?

Dr WRIGHT: My recollection is that it was a four-year project.

Ms CATE FAEHRMANN: When does that go to?

Dr WRIGHT: It was a staggered introduction. I think there was about an 18-month period from the first site to the last site starting. Some of them will be coming to an end. Can I just say that that is the part of the program which is, if you like, the research study. The local health districts were providing services there before LifeSpan, and they will be providing services there if LifeSpan moves on. The issues around developing integrated plans and suicide prevention plans in collaboration with the primary health networks, that is part of the Fifth National Mental Health Plan. We do not need LifeSpan in order to do those things.

LifeSpan has been a really important proof of concept because they have adopted a research methodology so as to try to demonstrate what of the eight evidence-based interventions make a difference. That has a beginning and an end. The services will be gradually developing over time. They will be informed by what we find from that research study and the other sort of initiatives that we have talked about in the suicide prevention framework will assist in us further developing those services. There is a difference between support for a research project and improvement in our services. The improvement task is ongoing.

Ms CATE FAEHRMANN: In relation to the target, the 20 per cent by 2023, does that incorporate targets for different vulnerable groups of people as well, or are their different targets, for example Indigenous suicide rates?

Dr WRIGHT: My information is that there will be an evaluation framework around the Premier's Priority. But I cannot tell you at this point whether there are, if you like, targets for particular vulnerable populations.

Ms CATE FAEHRMANN: I understand there is not a target to reduce Indigenous—

Ms KOFF: It is an aggregate target. As I mentioned, the Premier's Priority itself identifies the differences in some of the population rates, which then point to us to focus on those population groups

Ms CATE FAEHRMANN: Is there a reason why there would not be a target set to reduce the Indigenous suicide rate, for example?

Ms KOFF: They are one of the target groups.

Ms CATE FAEHRMANN: I understand Beyond Blue has recommended for a specific target to be set.

Ms KOFF: We have an aggregate target, and I feel most comfortable with an aggregate target and it is appropriate. But what we are doing then is delivering tailored community response packages for the priority groups. Those priority groups—as I said, men in construction are 1.8 times more likely to die of suicide than men in non-construction.

Ms CATE FAEHRMANN: Does it not make sense if you have programs for individual targeted groups, to then know how those programs are going, to set targets within your target groups?

Ms KOFF: I think they will be tracked and monitored but it is inappropriate to set a target collectively for individual sub-groups. Twice as many Aboriginal people die by suicide than non-Aboriginal people—

Ms CATE FAEHRMANN: Sorry, Ms Koff, could you explain to the Committee why it is inappropriate to set targets for suicide reduction for particular vulnerable groups, such as, for example, the LGBTIQ+ group or, for example, the Indigenous community? Why is it inappropriate?

Dr CHANT: I think Ms Koff is describing the fact that the macro target has been set as the priority. Once we get down into sub-populations we will obviously have to measure them as part of our program rollout and clearly everything we want to do. We look at whether there is ongoing disparity, particularly between Aboriginal and non-Aboriginal, so that is core. I think that Ms Koff was just referring to the Premier's Priority in terms of one target but for program rollout we will be looking at it, with the caveat that there is complexity in the data.

I think Dr Wright indicated this that we have to be careful that for some of our interim indicators we may actually see more recognition of self-harm or more presentations because we are actually trying to engage with groups that potentially would have not displayed those behaviours or health-seeking behaviours. We will have a programmatic response with indicators targeted at sub-populations and a combination of process indicators, which might be that we are seeing more presentations or we are having more effective engagement, as well as some of the outcome indicators.

Once we look at the data at a State level and start cutting it down into smaller, it will be very variable. One of the challenges for us is this will be a long journey, notwithstanding the time frame in the Premier's commitment, and we will need to be careful to not over-interpret within the bounds of the fluctuations of small, when we cut the data by smaller sub-groups. I think the point you are making is quite correct, we will be looking at segmenting the audience by age group. The issues that are affecting and perhaps driving the behaviours in younger people may well be very different from the over-80-year-old patients that may be choosing suicide.

Ms CATE FAEHRMANN: Considering that the rate of Indigenous suicide is so much higher than the rate of non-Indigenous suicide, has the department considered that higher rate and whether the department should actually increase its ambition when it comes to reducing the rate of Indigenous suicide in particular?

Dr CHANT: Having a focus on Aboriginal outcomes and disparity is a core to all of our programs. We have what is called an Aboriginal health impact assessment. That defines for all of the policies and programs that we rollout that we need to understand the disparities between Aboriginal and non-Aboriginal. For some it may be that, for instance, if we know ear disease is four times more likely in Indigenous populations we therefore want to see four times as many ear, nose and throat surgeries as non-Indigenous. So it is also having that lens throughout our policies. Dr Wright can probably talk about that, but that is a core element to developing the program of work in suicide prevention.

Dr WRIGHT: To add to that, going back to one of the principles of the suicide prevention framework, and in LifeSpan, is the importance of a local suicide prevention plan which is based on local data and an understanding of the issues. So there are and there will be differences based on the prevalence of vulnerable groups, but there will also be differences based on demography. We are aware of that. I think there is great versatility and strength in that local drive. In particular parts of the State where there might be a particularly vulnerable population they can have a targeted response to that.

Ms CATE FAEHRMANN: Can you expand on that a little bit? It leads into my next question in relation to Aboriginal communities, particularly in western New South Wales and far western New South Wales, with the drought and the impacts of climate change, but particularly towns running out of water. I visited Walgett a couple of months ago and that community is incredibly distressed. There are many other communities like that, because their rivers have run dry and they do not think they will ever be the same. I am assuming the suicide risk out there is higher as a result. I just wonder what the department is doing specifically in relation to that.

Dr WRIGHT: There is a mental health component to the drought relief.

Ms CATE FAEHRMANN: It is more than just drought relief.

Dr WRIGHT: I appreciate that.

Ms CATE FAEHRMANN: I get that from the Minister all the time.

Dr WRIGHT: I think that what works in the specifics of drought relief also works in the broader context because it is all part of the same issues. I think I may have said at an earlier estimates that it was in the drought around the turn of the century that we first introduced drought relief counsellors in mental health services when I was a director of a rural mental health service. It was towards the end of that drought that we began to appreciate that the issues that our counselling response was addressing had more to do than simply with drought. They had to do with the ageing population in rural areas—

Ms CATE FAEHRMANN: Yes, but can we get specifically to in relation to Aboriginal communities because my time is running out. This question is directed to anybody on the panel: What is the New South Wales Government doing to provide support for the mental health of those Aboriginal communities that have run out of water?

Ms KOFF: Generally I can state that in 2019-20 the Government is spending \$6.27 million on specific initiatives to improve the mental health and wellbeing of Aboriginal people and to prevent suicide.

Ms CATE FAEHRMANN: Could you repeat that?

Ms KOFF: Yes, I can—\$6.27 million.

Ms CATE FAEHRMANN: Over?

Ms KOFF: In '19-'20.

Ms CATE FAEHRMANN: In 1920? That is a long time ago!

Ms KOFF: The financial year 2019-20.

Ms CATE FAEHRMANN: Thank you.

Ms KOFF: There was \$2.18 million in grant funding¹ to 17 Aboriginal community controlled health services to support mental health service delivery, \$510,000 for statewide coordination and strategic projects to support development and growth of the Aboriginal mental health workforce. That goes to the heart of what we said earlier: we need to support the Aboriginal—

Ms CATE FAEHRMANN: Can I get a much more detailed breakdown of that provided to the Committee on notice, please?

Ms KOFF: Yes.

Ms CATE FAEHRMANN: What that money is spent on.

The Hon. TARA MORIARTY: Following up on that, whether it be Health specifically or otherwise, can I get an idea of how you go about providing advice to the Minister and the Government specifically in relation to mental health? Ms Koff, do you meet with the Minister to provide advice in the same sorts of ways on a regular basis? How does that work?

¹ In [correspondence](#) to the committee received 25 November 2019, the Hon Bronnie Taylor MLC, Minister for Mental Health, Regional Youth and Women requested a correction to evidence of Ms Koff by replacing the words '\$2.18 million in grant funding' with the words '\$2.19 million in grant funding'.

Ms KOFF: Yes, I certainly do. The prime carriage of the mental health portfolio resides with the Deputy Secretary Nigel Lyons. He was here at the first budget estimates. Unfortunately he is away overseas on leave, so he is not here today.

The Hon. TARA MORIARTY: Lucky him.

Ms KOFF: Yes. He is the deputy secretary responsible for the mental health branch in the Ministry. The mental health branch has an executive director of mental health services. Obviously the chief psychiatrist provides statewide leadership and advice on mental health issues. The mental health director and the chief psychiatrist meet at regular intervals with the Minister for Mental Health, Regional Youth and Women, as does the deputy secretary. I meet with the mental health Minister once a month.

The Hon. TARA MORIARTY: So you meet once a month. Can you give us an idea of what "regular" means? Is it at the request of the Minister?

Ms KOFF: No, regularly scheduled, usually at least once a week. At least once a week.

The Hon. TARA MORIARTY: So it is a standing meeting that you would have to provide—

Dr WRIGHT: For me it is once a fortnight, but that is the minimum.

The Hon. TARA MORIARTY: Is part of those discussions you providing updated information to the Minister? Is it the Minister requesting advice on particular projects? I am following up on my colleague's questions in terms of Indigenous suicide rates, for example. If the department felt that there should be more specific work done on that or if the Minister decided there should be more work done on that, how would that request or suggestion come about?

Dr WRIGHT: It can happen in many ways. The agenda for the meetings might be based on a response to your questions. That gives us the opportunity to speak to what is happening in that part of the mental health portfolio, what the issues are, what the opportunities are and any advice that we might have in relation to that. Sometimes the meetings will be to provide briefings on regular topics. So it is a mix of covering the territory of a diverse and complex portfolio or trying to get clarity around issues that seem to be causing concern, like drought and its impact on mental health or, in recent times, the suicide prevention strategy and things like that.

It is a busy agenda with many different topics. It presents issues around policy but also responds to clinical issues that arise from day to day, sometimes in response to issues that have been brought to the Minister via other members of Parliament or constituents. Lots of different ways.

The Hon. TARA MORIARTY: But in terms of ideas for how to deal with a particular problem of the day—obviously a really big problem is the statistics for Indigenous communities—I am interested in how we would encourage the department, the Minister or whoever else to do something about that. What would be the catalyst other than a newspaper story or whatever? Also, something that is a bit smaller, today there is an announcement—I am wondering if you have any information about it—in relation to sports grants for mental health. I think it is \$1.2 million. Correct me if I am wrong. I do not know what the figure is. I just read the media release before I came in. The sports Minister and the mental health Minister have announced some money for sports clubs to apply for grants to assist with mental health. What is that, and how would something like that come about?

Dr WRIGHT: I cannot tell you the genesis of that particular issue, but I think if I go back to your other example, if the Minister's office said we would like to discuss our concerns about the high rates of suicide in Aboriginal communities, then we have got access to a broad range of expertise, both within the ministry and within the mental health services and also in the research community. We would acquaint ourselves with the best advice and best practice and then proceed with the meeting if we felt we had reviewed what are the current approaches and what are some of the suggested initiatives that might lead to improvements and have those as a basis of a discussion.

The Hon. TARA MORIARTY: That is good if the Minister is requesting advice on a particular topic, which I expect would happen all the time, but what about the reverse of that? How would you go about pursuing an agenda, for example using the Indigenous health issue, which is quite a dramatic space, and getting the Minister or government to do more in that space?

Dr CHANT: I think also in terms of Indigenous health we are hearing very much from the community that they want to take a strength-based approach and also a very much healing approach. We need to understand the drivers for suicide within the broader context for Aboriginal communities. One of the lessons we have got to learn is very much a partnership. We have got to listen to the local communities. We would also be working

closely with our Aboriginal Affairs colleagues. There has been some particular initiatives in a solution brokerage where the local community has identified issues that the districts want to work on.

There would be a variety of different ways, but I would probably want to reassure the Committee that the health of Aboriginal people and the disparity is core to our thinking in how we CART the data for every particular issue that we are engaged with because as you know, whilst we have managed to close the gap in a number of areas, there is still significant disparity in many, many areas. Immunisation is probably a notable example, where Aboriginal coverage in some age points surpasses non-Aboriginal. I think we can do it, but we have got to work with Aboriginal people and in a cross-government way.

The Hon. TARA MORIARTY: Coming back to an example of something that is much smaller than that in terms of scale, for example this sports grant thing today, I understand you are not necessarily aware of it but is anyone else aware of it or can we get some information about it?

Dr CHANT: I will have to take that on notice.

The Hon. TARA MORIARTY: It is simply in relation to mental health, as to who would be implementing it or whatever else. You can take it on notice if you like.

Dr CHANT: I am happy to do that. The most important thing from our perspective is the Ministry of Health is there to support the Minister of the day and fulfil the Westminster functions. Our remit always, which we adhere to, is evidence-based policy and evidence-based decision-making. We put things forward to the Minister that we think are appropriate issues to pursue. She puts things forward to us that she would like some guidance, advice or support to initiate. It is a two-way relationship that we have. We want to provide the best care and that is at the heart of all the discussions that we have. Tracking and monitoring some of the implementation of the Living Well strategies, the last meeting I had with the Minister was about the suicide prevention framework. At the end of the day too, the Minister is ultimately held accountable for delivery of these things and she has a keen interest in knowing our implementation, how we are tracking and ensuring we are delivering.

The Hon. TARA MORIARTY: Is there any formal—I do not want to say relationship—work being done between the Government or the State health department and the Federal Government? I know the Federal Government have recently taken a big interest in mental health.

Dr CHANT: Yes, that they have. There are a number of mechanisms by which the State engages with the Federal Government. There is first of all the COAG Health Council. The COAG Health Council is the peak Ministers groups of States and Territories and the Commonwealth that meet regularly. In fact, it is meeting in Perth on Friday. Minister Hazzard is already on his way over there and I am here, at your service. That is the mechanism by which many national decisions are made and how we work collaboratively across the sectors. Also then the Australian Health Ministers' Advisory Council, which I chair², is the secretaries or directors-general from each of the States and Territories and the Commonwealth.

We discuss national policy issues for the health system at that meeting. There is a sub-committee of that, which is called the Mental Health Principal Committee. The Mental Health Principal Committee is the group that progresses many of the national strategies. Obviously, the Prime Minister's commitment to suicide is apparent to many with the appointment of a special envoy. Minister Hunt similarly has identified mental health as a priority for the whole of the country.

The Hon. TARA MORIARTY: Do you work towards coordinating any services or is it more sharing information?

Dr CHANT: No, it is a high-level policy framework. However, as Dr Wright described earlier, how these services fit together at the local area is the biggest challenge for all of us, because as the Mental Health Commissioner identified, navigating the system is part of the challenge for us to simplify because the Commonwealth funds general practitioners under the Medicare Benefits Schedule and funds significant amounts of money for mental health care in the community. The health system in New South Wales obviously funds hospital services in the community but also funds extensive community-based health care delivery in mental health.

² In [correspondence](#) to the committee received 20 November 2019, the Hon Bronnie Taylor MLC, Minister for Mental Health, Regional Youth and Women requested correction to evidence of Dr Chant to delete the words 'which I chair'.

We try to set the policy settings to make it easier for them to work but the practicality is it is about the relationship at the local level of how the GPs and the primary health networks work well with the health system. I think that is what the Mental Health Commissioner alluded to earlier with one of the examples up in northern New South Wales. There are quite a few layers to go through before service delivery but it is that relationship on front line delivery that is so crucial.

The Hon. TARA MORIARTY: This question is directed to anyone, but probably Ms Koff in particular. Mission Australia's recent report entitled *Can We Talk? Seven Year Youth Mental Health Report: 2012-2018* was released sometime in the last fortnight. Are you familiar with that?

Dr CHANT: No, I am sorry, I am not.

The Hon. TARA MORIARTY: It stated that in New South Wales between 2012 and 2018 the rate of young people suffering from psychological distress increased from 7.3 per cent to 17.3 per cent. We saw 20.9 per cent of young people suffering from psychological distress and they indicated in the survey that they felt they had no-one to talk to. Not being familiar with the report, that is okay, but is the Government doing anything in this space, particularly in relation to young people? These statistics are very bad.

Dr WRIGHT: Yes, there is quite a bit being done with young people but I am also conscious of the fact, relating to our previous conversation, that one of the things which we are aware of are the increasing numbers of young people presenting to our emergency departments in distress and with suicidal ideation. So I do not underestimate the challenge. There are clearly significant levels of distress. I point out that the peak age of onset for most mental health conditions is somewhere in the mid-teens to the mid-twenties. In some ways, it is not entirely a surprise that that is a peak period for resenting with distress—in particular, things such as anxiety, depression, first episode psychosis, substance misuse.

But also there are the life challenges of adolescence, which contribute to all of the above, such as the pressures to do with education, securing employment, relationships et cetera, et cetera. That means that anything we do to try and address that—picking up Ms Koff's earlier comment that a very large percentage of people who actually suicide have no contact with our health services, many of the initiatives that have been developed to assist young people are with that in mind. We have initiatives which we operate in collaboration with the NSW Department of Education. It is absolutely crucial that we have early detection of people in distress in all our educational facilities, right from primary school through to our universities.

There are some very good programs such as School-Link and the embedding of counselling services within our schools. We have got specific programs such as Getting On Track In Time, which is a targeted treatment for primary school-aged children with conduct disturbance. That is also done within schools and it is a combination between Health and Education. I think issues around homelessness or insecure housing are surprisingly common in that group and contribute to those sorts of things. One of the philosophies behind the creation of places like Headspace has been to destigmatise the front door, if you like, into the health system. We know that young people are a little bit intimidated by institutions.

If all of the health services sit behind an institution, then maybe those young people are going to be more reluctant to engage. Headspace has been a really important innovation. It has also been very influential in how we think about the way we create access to health services, not just for services around mental health but also substance misuse and general health services in the community. Those are just some of the things that are being done to try and improve access. There is a lot of importance placed on what we call gatekeeper training.

That includes mental health literacy amongst particular groups, such as teachers and people who are going to come into contact with young people, so that they can identify someone who is in distress or is particularly vulnerable and give them some advice and support into accessing services. I do think it is a significant challenge to try and help people feel confident enough to access those services when they are feeling quite overwhelmed. It is easy for them to lose heart and to lose confidence. To have them engage and stay in contact with our services is the next challenge along the way.

The Hon. TARA MORIARTY: And probably having enough services for people when they reach out is another challenge, but that is a comment rather than a question. Coming back to something you touched on there in terms of young people and the work that is being done in schools to identify young people who might be suffering, can you talk a bit more about how that works? There is a lot of responsibility being put on teachers who already have pretty full-on jobs. What other resources are provided to schools to identify this?

Dr WRIGHT: The caveat is that the school counselling is a significant part of that, but that is an initiative of the education department. School counsellors work for the education department and in schools.

They are obviously there to provide support to the teachers. It is one thing for the teachers to identify children who are at risk—that is the purpose of gatekeeper training—but it is very important that, having done that, they have got somewhere to seek professional advice. That is school counselling. My understanding is that the education department has invested significant amounts in placing counsellors within the schools.

The role of School-Link, which is the mental health contribution, is described in the title. It is really a coordination point between our mental health services—which are mostly community based but also include some inpatient services—and the embedded services within the schools. For instance, a lot of the issues that would become apparent in a school setting would be more than adequately managed by some advice and support from a school counsellor. However, there will be some individuals who require more ongoing or complex levels of care and that is when the school counsellor needs to have good linkages into the local mental health system. That is the role of School-Link, to make sure that those pathways are well understood and are working well between the mental health component of the service and the school component.

The Hon. TARA MORIARTY: Are there counsellors in every school in New South Wales? I understand that it is an education question but do you know?

Dr WRIGHT: What I can recall is that there was an enhancement to the funding for school counsellors in New South Wales this year, but I cannot answer that.

The Hon. TARA MORIARTY: In fact, there was an election commitment from the Government that it would provide every public school with two dedicated mental health experts. Do you have any idea where that is up to?

Dr WRIGHT: No, I do not.

The Hon. TARA MORIARTY: The language that was used in terms of that commitment was that it would be "mental health experts"—that does not necessarily mean school counsellors. Are you guys providing any advice on how that works? Is there any input or is it purely through the education department?

Dr WRIGHT: I can take on notice what advice the children and young people's unit is providing. If I can be pedantic for a moment on the difference between an expert and a counsellor, "counsellor" is not necessarily a professional term either. You can be a psychologist or a social worker or a mental health nurse or a psychiatrist. A counsellor is someone who provides counsel. I am not sure there is a significant differentiation between a counsellor and an expert.

The Hon. TARA MORIARTY: This is the Government's language, not mine. The Government has committed—in terms of when I have asked about preventative care or rapidly and dramatically increasing bad statistics facing young people, one of the responses was "counsellors in schools". I am interested to know how many there are who are specifically counsellors. But the Government has committed to provide "mental health experts"—whatever that is—two of them in every school. I am interested to know where that is up to.

Ms KOFF: If I may reiterate, the New South Wales Government is investing \$88.4 million over four years to provide every public high school with full-time school counselling support on site. Up to 100 additional school counsellors or psychologists and an additional 350 student support officers will be employed, making it easier for students to access support for mental health and wellbeing.

The Hon. TARA MORIARTY: Just to clarify, is that 100 now and 350 now or is that what is proposed?

Ms KOFF: As was indicated, up to 100 additional school counsellors or psychologists and an additional 350 student support officers. I think what came through strongly in discussions is that the stigma attached to students going to visit school counsellors is also a barrier. We had the discussion with Minister Taylor and the Premier. The comment was if you want to go and see the school counsellor they fill out a bright red piece of paper and say, "Go and present it to the school counsellor". Everybody knows where you are off to: You are there to visit the school counsellor. I think that dedicated titles as to what they are could be, in some instances, a disincentive for children in schools to access these people. The most important thing is that we have the support networks students can access and that if there is further clinical support needed it can be brought in to support the students.

The Hon. TARA MORIARTY: That is fine. I do not necessarily care what they are called; I care about the service that they provide and the commitment that has been made. Just to clarify, are these the 100 counsellors that exist in schools now or is this what is—

Ms KOFF: My advice is up to 100 additional school counsellors or psychologists.

The Hon. TARA MORIARTY: In what time frame are they going to be provided?

Ms KOFF: The funding goes over four years. The commitment starts from 2019-20. It will be over that period.

The Hon. TARA MORIARTY: Have any of the 100 been put in this financial year?

Ms KOFF: Education is running with that implementation.

The Hon. TARA MORIARTY: But you guys do not know? There has been a commitment of 100 but we do not know—and I accept that it is under the remit of Education—if any of them have been put in place?

Ms KOFF: We can take that on notice and ask Education.

The Hon. TARA MORIARTY: I would appreciate that. Then there are the 350 student support officers. I have the same question. Are they new resources that have been proposed?

Ms KOFF: Yes. An additional 350 student support officers will be employed, making it easier for students to access mental health and wellbeing support. That is what I meant about the navigation process. How does somebody who has an issue know where to go and who to ask? The student support officers will be more skilled—

The Hon. WALT SECORD: What will the base minimum qualification be for the 350 student support officers?

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

The Hon. WALT SECORD: Will the 350 student support officers be providing face-to-face counselling or will they be administrators and bureaucrats? Will they be providing face-to-face assistance?

Ms KOFF: We can take that on notice. As I said, Education is responsible for the implementation of that commitment.

The Hon. TARA MORIARTY: But do you know what they are? Do you have any description of what student support officers will do?

Ms KOFF: Yes. That is what Dr Wright was saying in terms of qualifications and titles. I think the main thing is that they have the skills and capacities to support students when they have mental health issues.

Dr WRIGHT: Borrowing from other parts of mental health, I think one of the things that has come through quite consistently in some of the studies into supporting people in distress is that there is clinical support and intervention, which requires a certain set of skills, and that is generally attached to people like psychologists, social workers, mental health nurses and psychiatrists. But then there is non-clinical support and psychosocial support. That is something we are much clearer about now than we have been in the past and it is actually just as important. When you are thinking that the young person in distress, they may have an emerging mental health issue but the stress might have been precipitated by something that requires pragmatic support. A support officer will provide that support. It might be linking someone up to some kind of social benefit, helping with housing issues or—

The Hon. TARA MORIARTY: Is your understanding that these 350 support officers will not necessarily be qualified in this space but instead will be administration people who can point students in the right direction?

Dr WRIGHT: I do not know that I would say that they are not qualified. I think that understates the skills that are required to provide that kind of support. In the health system we sometimes refer to those people as navigators. They are people who help to coordinate—

The Hon. TARA MORIARTY: Sorry to interrupt you but this is really important and I am going to run out of time. My question is: Are these people likely to be counsellors of some description—we can get into the details and you can take it on notice in terms of what the specific qualifications are—or, if I follow your language of navigators, will they be in an administrative role that can point people to outside services? There is quite a difference between the two. It is not what the Government committed to, so it is particularly important that we get the right information.

Dr CHANT: I think this question is best directed to Education. We will follow up with Education. But I think it is dangerous for us to speculate. Obviously the members on this panel just do not have that detail. I am sure there are officers within the ministry who have been working closely with Education—

The Hon. WALT SECORD: Can the Mental Health Commissioner shed any light on this? Are they qualified?

Ms LOUREY: I cannot shed any light on that.

The Hon. WALT SECORD: Were you consulted on or involved in the formation of the delivery of this policy?

Ms LOUREY: No, we were not.

The Hon. WALT SECORD: Would you expect to be consulted on something important like this?

Ms LOUREY: I would say that the Department of Education and the commission do meet formally. We do have conversations about the broader issues.

The Hon. TARA MORIARTY: Have you had conversations about these 350 school support officers?

Ms LOUREY: No, not specifically.

The Hon. TARA MORIARTY: Have any of you had any consultation with the Minister or anyone else? We have acknowledged that this is in the Education space and that part of this will be taken on notice. I will raise the issue with the Education department. But have any of you been consulted? Have any of your departments been consulted or involved in the set up of this or the commitment of this in any way?

Ms KOFF: I am confident that there would have been discussions. If it is an election commitment, we would provide evidence-based advice on what is appropriate to support youth in schools. Then it becomes a ministerial decision as to which policies are supported. We would have had some contribution to it and we will take it on notice with regard to the questions around qualifications that you are asking.

The Hon. TARA MORIARTY: If possible, can the Committee also be provided with whatever advice you might have given in this space, whether it has been taken up or not? Clearly that is not something that you guys are aware of. But something has been taken up. Can we get information about what advice you provided?

Ms KOFF: If it is available and able to be shared, yes. I do not know whether it was Cabinet-in-confidence or any mechanism of briefing that—

The Hon. TARA MORIARTY: I think the Committee can determine that.

The Hon. BEN FRANKLIN: No, the Government determines what is Cabinet-in-confidence, not the Committee.

The Hon. TARA MORIARTY: I am not specifically talking about Cabinet-in-confidence.

The Hon. BEN FRANKLIN: That is literally what she just said.

The Hon. TARA MORIARTY: No, she said a few other things before that.

The Hon. BEN FRANKLIN: No, with respect, the witness just said that that information may be covered by Cabinet-in-confidence and she may not be able to release it. Then you said, "The Committee can determine that." I said, "The Committee cannot determine that. It is for the Government to determine whether it is Cabinet-in-confidence." They were the last three comments.

The Hon. TARA MORIARTY: I have been asking questions about this for about 10 minutes.

The Hon. BEN FRANKLIN: I understand that. But I am referring to exactly what you just said.

The CHAIR: Order!

The Hon. TARA MORIARTY: I have asked for the advice and I have been told that I may be able to be provided with it. That is on the record.

The Hon. BEN FRANKLIN: Absolutely.

The Hon. TARA MORIARTY: Either way I will pursue the matter. But I have run out of time.

(Short adjournment)

Ms CATE FAEHRMANN: What research is the department doing in relation to the impacts of climate change on mental health?

Ms KOFF: Dr Chant looks after the research portfolio, so I will hand it to her.

The Hon. WALT SECORD: I did not know that you did research. I should have peppered you with questions before.

Dr CHANT: Okay.

The CHAIR: That is called a Hail Mary pass, Dr Chant.

Dr CHANT: I am not aware of specific research. The ministry tends not to fund specific research. We tend to maybe support research programs or areas of research where we partner around key areas but there are a number of grant programs that we run which would be open for researchers to undertake research around the mental health facts of climate change. Some of those programs include the PhD scholarships we have put out and also the Early-Mid Career Fellowship grant. Just as an example, there has been \$1.56 million in Early-Mid Career Fellowships and 13.5 per cent of the total funding went to mental health related research. Of our Translational Research Grants, which are probably less suitable for the question that you are framing, 10 per cent of the funding went to mental health. Of our PhD grants—

Ms CATE FAEHRMANN: Do you mean climate change when you say mental health?

Dr CHANT: I think you said the impacts of climate change on mental health.

Ms CATE FAEHRMANN: Yes.

Dr CHANT: They would come in under—I suppose what I am highlighting is that if you had the research question of the mental health impacts of climate change, that could be the subject of your PhD scholarship, it could be the subject of your Early-Mid Career Fellowship, so there are general schemes. I suppose the point I was trying to highlight is that a proportion of that funding has actually gone to fund mental health. I am not saying the specific question you have raised. Also, Black Dog and Neuroscience Research Australia received \$55 million in the period 2011-2012 in our Medical Research Support Program, which provides infrastructure support if they are successful with grants and capital within National Health and Medical Research Council [NHMRC] and others. Obviously you are aware that there has been significant investment in Federal funding as well in the area.

Ms CATE FAEHRMANN: That was just very broadly in terms of mental health research.

Dr CHANT: In the broad area of mental health and then within that. I am aware that there are particular strengths in climate change research within the New South Wales research universities. We would encourage them to actively seek grant funding through some of these programs, but noting that the NHMRC is still the largest source of funding for specific project-based grants.

Ms CATE FAEHRMANN: What about the Mental Health Commission? What are you doing specifically in relation to what is increasingly being reported as the mental health impacts of climate change?

Ms LOUREY: We do not have any specific project currently on that topic. In regard to research or support, we have a very small budget. Our research is actually very targeted and very small. Our research is currently investigating the coronial data into the physical health causes of death because of mental illness and we have also been doing some research in the forensic area, but not in the particular area that you have mentioned.

Ms CATE FAEHRMANN: Dr Wright, are you aware of the increasing rates of suicide on hotter days and the way heat affects mental health? Are you aware of research in that field?

Dr WRIGHT: I am aware of some of the research and the way I would capture it is that there are vulnerabilities arising from extreme heat. Some of those are vulnerabilities basically on a physiological basis, particularly as many of our consumers are quite socially isolated and can find challenges in responding to periods of extreme heat. In relation to that, over the last five to 10 years in New South Wales when Dr Chant's branch put out warnings about extreme weather there is a specific component related to the mental health response. It is actually addressing those vulnerable individuals.

I would say the risks are more broad based than suicide. We certainly did have some cases that I can recall from more than a decade ago where it was issues as tragically straightforward as dehydration and being unable to address issues of being in an enclosed space which heated up to a dangerous degree.

Ms CATE FAEHRMANN: One is health impacts and deaths and the other is mental health issues, potentially suicide, as a result of extreme temperatures. Do not confuse the two in terms of the questions I am asking you.

Dr WRIGHT: I am not confusing them because I think that the issue is that—and it is not just on days of extreme heat—there are pressures on people with mental illness brought about by being exposed to not just extreme weather events but the risk of extreme weather events. The way I understand it is that if someone is struggling to manage because of the burden of a mental health concern, if you introduce another significant and ongoing stress, such as the stresses that are associated with extreme weather, including prolonged heatwaves, that takes their risks up to another level.

Ms CATE FAEHRMANN: Have you, the department or the Mental Health Commission been asked to provide advice to government in relation to the potential impacts of climate change on mental health?

Dr WRIGHT: I would have to take that question on notice. I have been part of a number of conversations around this issue and I have certainly met with some of the individuals from the University of Sydney and the Australian National University, who have a research base in this area, so I do not want to confuse the answer. Whether we have formally provided advice to government on this, I cannot answer off the top of my head.

Ms CATE FAEHRMANN: Dr Chant or Ms Lourey?

Dr CHANT: In terms of the analysis, our environmental health team has looked at all-cause mortality following heatwave events. I will just have to follow up with the team whether they cut it by any characteristics. They certainly did it on age and other demographics, so whether they had sufficient data to look at pre-existing mental health issues. Obviously we have provided general advice around the climate change impacts and acknowledge the impact of mental health impacts but it is actually multifactorial and the context is multifactorial because mental health patients, as I think Dr Wright was commenting on, are also at risk from the general adversities around heatwave because of cardiovascular and other risks as well.

Ms CATE FAEHRMANN: It does sound like some of your responses to some of the questions from this afternoon do seem to indicate that you like to keep up to date, Dr Wright, on emerging issues and trends within the mental health space.

Dr WRIGHT: Yes.

Ms CATE FAEHRMANN: Would you agree that one of those emerging trends is the anxiety and depression as a result of people's fear around climate change and what is happening to the environment? Are you across that?

Dr WRIGHT: Yes, I am.

Ms CATE FAEHRMANN: New research?

Dr WRIGHT: Yes. As I said, I have met with and heard presentations from a group based at the University of Sydney—

Ms CATE FAEHRMANN: What is that group?

Dr CHANT: Tony Capon's group. There was actually a meeting a couple of days ago. I could get you the details of that group.

Ms CATE FAEHRMANN: Thank you. Yes, please.

Dr WRIGHT: There is a psychiatrist attached to that group, who is also based in the Australian National University. I have met with her and discussed the international research evidence on the relationship between climate change and mental health issues.

Ms CATE FAEHRMANN: As Chief Psychiatrist, is it your responsibility—and possibly yours as well, Dr Chant—to proactively discuss these emerging trends with the Minister? Or do you need to wait for the Minister to come to you and say, "Please give me a brief on the potential impacts. Are there any impacts? What do we need to do in relation to climate change and mental health?"

Dr WRIGHT: I think that the issue relating to climate change takes the challenges for people vulnerable to a mental illness to another level. There is an across-the-board impact on individuals, which, as I said before, can be both physiological and it can be related to a perception of stress as to the impact for the future in climate change. The issue for me is what does that mean in terms of the development of our mental health services? I do not see anything in the guiding strategies and plans that we are doing which is not going to be responsive to those sorts of things, because it is not about particular kinds of emerging mental health problems; it is about the

prevalence of mental health problems and the levels of mental health distress and the likely impact on demand for our services across a range of conditions.

So when I listen to those individuals, I am obviously concerned about the impact on increasing prevalence, but what I see in terms of our services is that we are trying to grow our services. We are trying to respond to increasing demand and we are trying to make our services work better together across the State- and Commonwealth-funded services. So I do not see that there is an imperative, from where I sit, to do anything specific and different, other than try to make our services more reliable and more efficient and to be able to meet any increases in demand.

Dr CHANT: Probably just two things I would like to note. The centre at the University of Sydney is the University of Sydney's Planetary Health Platform. It is headed by Professor Anthony Capon and I know that we have had engagement with them at a branch level from environmental health out of Health Protection NSW. I am just reading some information. Clearly, the ministry is aware of the connection between mental health and climate change and those reports. But, interestingly, whilst it did show that concerns around declining agricultural production and livelihoods, changed environmental outcomes, reduced employment, the impact on rural communities, migration and separation for families as people might have to separate to come to work, and the actual physical harms to physical health—but one of the evidence checks has shown that some of our general strategies are as relevant for people experiencing anxiety from this cause.

I defer to Dr Wright, but things like psychological treatment programs, mental health outreach and care coordination, online and telephone support, health literacy programs and mental health first aid and training support. So I think our role in Health is to understand the literature, be across the literature, reflect that in our briefing to government around when we are considering to make sure we codify the full range of the impacts that climate change may have, and therefore inform government policy around mitigation strategies or the focus we should have on addressing climate change—noting it is a global issue, but also looking at the literature where it tells us how we might have to incorporate this or embed this in our training for our staff, just to increase awareness about this issue and also how it would fit into our existing programs. Dr Wright, did you want to add anything?

Dr WRIGHT: No, I think that covers it. But if I can just pick up the point that we provide a broad range of services and if we work together with the primary health sector and the specialist sector, I think that the issue that Dr Chant is referring to is that conditions—it is not difficult to understand why anxiety is a response that can occur in response to climate change concerns. My point previously was that there are not any specific and uncovered mental health issues that come up as a result of the impact of climate change on our community.

It is a very significant stressor in a variety of different ways, and that stress can have an impact on the mental health of the population. What we need to do is to continue to monitor demand and also to continue to monitor the adequacy of our response to that demand, not just within the publicly funded services but at a community level as well, because some of the impacts are about the degradation in other parts of community-based services. That can obviously have a knock-on effect as well.

Ms CATE FAEHRMANN: Thank you. Would you expect to see, then, with the expected increase in extreme weather events like we are seeing around the world but also here in New South Wales—bushfires across the State, towns running out of water, rivers running dry—that we are going to see more anxiety, more depression and potentially higher rates of suicide as a result?

Dr WRIGHT: One of the things that we have learnt in Australia over the past 40 years—and there has been very robust research in response to some of the catastrophic events that have occurred over the past 40 years, notably bushfires, and some of that is internationally recognised research. One of the things that we have learnt from that is where the attention needs to go following those events. If you take that paradigm and look at more frequent extreme weather events or a case where there is a risk of that much of the time, the truth of the matter is still that the people who are most at risk are the people who we already know. They are the consumers that are already part of our services, because what happens as a result of some kind of catastrophic event is that those individuals are cut off from their regular support.

Ms CATE FAEHRMANN: They are consumers but it is the compounding factor that I think you were just referring to, in terms of the increased frequency of events and one event after the other and potentially more people in New South Wales being impacted by extreme weather events like, for example, places around the Gondwana rainforest near Dorrigo, which has burnt and which should never have burnt and has not burnt before. Communities are experiencing these events and it is affecting them psychologically.

Dr WRIGHT: I know; I appreciate that. I am not diminishing the impact on communities and individuals.

Ms CATE FAEHRMANN: I suppose the question is, therefore, what advice is the mental health Minister receiving in this regard?

Dr WRIGHT: Can I change that? My framing of a response to that is that you have described a couple of discrete events. I think that we certainly have learnt of the importance of providing support and access to support on a cross-government basis following those kinds of individual events. We have also learnt to take the medium- to long-term view, because quite often individuals or communities in response to some kind of catastrophic event actually pull together quite well in the short term, and it is only over the weeks and months following that event that the impact of that event becomes apparent and then the impact on their mental health. Working together with both the first responders and also the recovery resources in the local communities is very important.

That is something that I think our mental health and health services do quite well, with our other government and non-government colleagues. I do think the challenge is the frequency and the sustained nature of some of these events means it is not a rare event in some instances, it is something which is having a cumulative effect. We monitor the demand for our services all the time. If there is an increase in demand, and if there is an increase in demand in a particular area, for any reason—whether it is related to climate change or some other event—we would have to respond to that and to address it. We would address it in collaboration with some of the other services that might be there.

For instance, the primary health networks or other government and non-government agencies. In our experience the best kind of response is a community-led response. Again, I think I mentioned a couple of examples at a previous estimates hearing, and it is not unrelated. Initiatives such as the Healthy Clarence on the north coast of New South Wales, which was not directly related to climate change but the principles hold the same—and I have had this conversation with some of the climate change experts—it is about building cohesion within the community, led by the community. It is not led by Health or Mental Health. That is actually quite important because, unfortunately, there is still a stigma attached to mental health services.

The issue in the Clarence was led by local government and joined everybody in trying to have a more cohesive and positive approach within that particular vulnerable community. That is something of a template for how local communities can address how—not just climate change but all the knock-on effects of climate change can make some of those communities very vulnerable. You mentioned Wilcannia recently. Those sorts of quite isolated and vulnerable communities. There are ways in which I think all tiers of government can work together within the community to help create that cohesion and that is a community-based way of mitigating somewhat against the potential for the mental health repercussions of climate change.

Ms CATE FAEHRMANN: I have one more follow-up question. You just mentioned that if there were a change on the ground of people experiencing mental health issues, for example from climate change, that that would go through the local health districts and you would find out and develop a response to that. That is not as eloquent as you put it.

Dr WRIGHT: Yes.

Ms CATE FAEHRMANN: What monitoring is in place for you to be able to ascertain what issues are affecting people's mental health and how quickly does that happen?

Dr WRIGHT: We collect lots of information and it does actually help us to identify—

Ms CATE FAEHRMANN: Can we use, say Wilcannia, as an example, or Walgett?

Dr WRIGHT: I prefer to use an unnamed, small, rural space. We have got fairly extensive community-based mental health services and they collect data on the occasions of service. They tell us how many people they are seeing and each health facility or hospital emergency department [ED] collects data on the number of emergency presentations, including down to mental health presentations or self-harm presentations.

Ms CATE FAEHRMANN: In terms of what issues people are presenting, as in why, when you are saying mental health presentations?

Dr WRIGHT: It is a question of how you use data. If you saw an increase in presentations for mental health reasons, that does not answer the question of why, but it poses the question and we would see that. We would see that at a State level and I would expect that the local health district would see that and that they would ask the question. You then have to drill down on the individual cases. We also collect information on incidents, the incident reporting system, all the way up to critical incidents. That is monitored at all levels in the system. We collect information on the number of admissions and separations from hospital, the length of stay, the

readmissions. That information is actually a pretty good barometer and can give us an early indication. For instance, one of the triggers when the Healthy Clarence initiative was developed was in response to concerns about suicide amongst young people.

There were a series of follow-ups to this to try to understand what is the nature of this problem and try to understand what the causes might be. Was it something that was out of step with what was happening in other parts of the State and other parts of the community? And the answer was: yes, it was. That then precipitated the whole of the community coming together to try to do something about it. We certainly track the kind of information that would be an alert to us that there could be a problem in a particular community. I would be very hesitant about saying that that information tells us precisely what is going on, but it would raise a level of concern.

I think some of my colleagues would refer to it as like a smoke alarm. A smoke alarm does not tell you exactly what is going on but it tells you that you had better do a quick investigation and take some urgent action. A lot of that sort of data occurs within our mental health services. I think we have got pretty good coverage and I think we have got a fairly responsive system around those sorts of issues.

The Hon. TARA MORIARTY: I have some technical questions to wrap up. How many mental health beds are there in New South Wales?

Ms KOFF: The most recently available data that we have from 2017-18 was 2,785 average available mental health beds in the system.

The Hon. TARA MORIARTY: How many mental health beds are there in each local health district? I acknowledge you might have to take that on notice but I cannot get the answer out of anybody.

Ms KOFF: No. To be brutally honest, counting beds is not the way we manage services. It is a very antiquated and old-fashioned way of measuring because we use activity-based funding. Activity-based funding is about a level of activity that is achieved within a hospital. Counting beds is not traditionally the mechanism by which we measure metrics. Also, care substitution for care in the community that we provide is counted as activity too and it may be a substitute for inpatient mental health care also.

The Hon. TARA MORIARTY: I acknowledge the answer and I understand what you mean but it does make it difficult then for me or anyone to try to be holding the department or the Government to account. If we do not have actual numbers to measure this stuff by, how do we know if it is working? There is a figure for total beds. If possible, I would like to get as accurate a picture as I could of what the breakdown is across the different local area health districts?

Ms KOFF: Yes. We can report on separation numbers, which will give you a track of the activity, because a hospital episode is measured by separations—that is, when they are discharged. We have very good metrics around discharge from hospital for mental health patients.

The Hon. TARA MORIARTY: Sure, but that is a different question.

Ms KOFF: Sorry, I am just explaining—

The Hon. TARA MORIARTY: I understand.

Ms KOFF: —to assist both of us in progressing to find the information on notice.

The Hon. TARA MORIARTY: Sure. Then the further breakdown. Again, I acknowledge what you said but I do want to get as close to the accurate figures for beds as I can. I want the numbers of beds in each local health district but also in each facility. If I can get whatever breakdown you have that would be useful. This is not tracked, on the basis of what you have said. You just said that in 2017-18 there were 2,785 beds. In terms of what I have been able to find in the statistics that are available on your website, there is a figure in 2018-19 of 2,744 beds. That is a drop. Again, I acknowledge that you will have to take this on notice, but I would like to get an idea of why that is the case and if that is accurate or not. That is a 40-odd beds difference, so if the figures are going down I would like to know about it, or if that is not correct.

Ms LOUREY: Could I just make a point here?

The Hon. TARA MORIARTY: Sure.

Ms LOUREY: We spoke earlier about Living Well—the mental health strategy for New South Wales. One of the key directions of that strategy was to rebalance the level of investment in mental health beds with community and other options. So I could say that that is a good finding. If there are appropriate services in the community for people—going to Ms Koff's point about substitutability of care—that could be a good finding. The

ministry, under Living Well, has made great efforts on a program called Pathways to Community Living, which is taking very long stay patients—we are talking about years or decades in hospital—and appropriately transferring their care into the community or nursing homes or what is appropriate.

We all acknowledged that beds are not necessarily the right metric—and I do absolutely take your point about accountability—but there is a bigger picture here around what a good mental health service looks like. It is about community-based mental health care and it is about appropriate in-patient care but it is all about early intervention and prevention.

The Hon. TARA MORIARTY: I can hear what you are saying but I can tell you that anecdotally, as the shadow Minister in this space, I hear daily from people who say there are just not enough services and there are just not enough beds at the times that people need them. I understand that you might want to record things in different ways but when I hear from people who use this service that they do not have enough services I need to be able to figure out whether that is true or not. I understand that there is a push towards more community services; I think that is great. You guys are more expert in this space than I am. But I know that there are certainly ranges of care that people need, and community care is appropriate for some and acute care is necessary for others.

It is my job to try to figure out whether the services are provided and available. That is why I need the statistics. So I get it, but you have to be able to measure this. We have to be able to know and I have to be able to communicate to the people who are raising these issues directly with me. They are saying that they cannot get the services they need, particularly the acute stuff, when they need it. The only way to do that is to track the actual figures, not, "Yes, we're doing more in the community generally". Do you know what I mean?

For example, waiting times in emergency—again, you might want to take this on notice—do you know on how many occasions in the past year patients have waited over four hours in emergency due to there being no mental beds available? I understand that emergency is, again, a different space and you would not necessarily have a mental health bed available specifically in an emergency department, but I hear every day that people present to emergency and cannot get the urgent assistance that they need in a timely manner. I need to get some information as to why that is happening. You may well have a great explanation, but I need to understand that.

Dr WRIGHT: Can I just make a comment? We certainly do keep figures on how long someone spends in the emergency department, and we separate, for the mental health patients, the time spent in the emergency department for those people who are admitted and for those people who are discharged into the community. Interestingly, compared to the broad health area it is often the time taken in the emergency department for people who are subsequently discharged which takes longer. That is because, in my view, it is often a more complex matter to ensure that you have a very robust and workable treatment plan before you discharge someone into the community. That often takes time. It takes a fair bit of consultation.

I guess I am saying that the interpretation of those figures is actually quite important. I am not sure that we collect and separate out delays on the basis of bed availability beyond four hours. What we do track very closely is the percentage of people who wait more than four hours. So we can tell you that from month to month and facility to facility, but we do not necessarily identify those because there are complex medical resuscitation issues, which cause them to delay in the emergency department, whether it is a delay in the assessment for one reason for another—sometimes those are facility driven; sometimes they are patient driven—or whether it is the availability of a bed. So I just want to give you fair warning that it might not answer the specific question.

The Hon. TARA MORIARTY: That is fair enough. I guess the next series of questions is more numbers based. Beds is one way of measuring it; time is another way. I heard what you just said in terms of varying reasons—it could be the person presenting or what is available in the hospital—but if someone does present to an emergency department with mental health issues, what is the process that follows? I am particularly interested in whether or not there are clinical psychologist services available and whether that causes delay. The original question is: What happens if someone presents to emergency now?

Dr WRIGHT: There are some variations based on the size of the facility and the population it is serving, but we have mental health services embedded in our emergency departments. That is something which is quite an important part of the responsiveness of the system. So if someone presents to an emergency department, allowing for the individual differences, they are triaged, as would anybody be. If the triage indicates that someone most likely has a primary mental health concern as their reason for being there then there would be an early contact with the mental health resource—if I can use that term. That could be anyone, from a junior medical officer to a clinical nurse consultant or some other mental health clinician. There would be an early contact for that person.

The model varies a little bit. The ideal is that there is a simultaneous assessment by the medical officers in the emergency department and the mental health services, and that they work together to conduct an assessment

and to develop an immediate treatment plan. Because of the fact—we did not design the system this way—that a majority of patients present for the first time in an emergency situation and in an emergency department, we have had to adjust the way our resources are allocated. Thirty years ago it was not like that, but that is how it is now in this country and in many Western countries around the world. So we have got those resources.

That is also why we also have psychiatric emergency care centres [PECCs] in most of our larger hospitals, because we recognised the importance of having somewhere which was at a slightly lower acuity compared to our acute in-patient units, where people who are presenting are often in a short-term crisis, do not need to be in an acute mental health in-patient unit but need to be within a mental health facility for a short space of time and benefit from the structure and support that can be provided there. That is why the PECCs evolved.

The reason I am going into that is because I think, again, our system has evolved and developed in response to those changing patterns of presentation to our services over that period of time and will continue to do so. We are very interested in New South Wales in looking at some of the alternative models of how to respond in emergency departments. We are certainly not resting on our laurels in relation to how we engage and support people in the emergency departments. The duration of time that they spend in the ED is one of the factors but it is not the only one. I am pretty interested in what the outcome is and what the level of satisfaction is of the consumer on the basis of that experience.

We have got other figures that we collect, such as readmissions to mental health services because if that figure is creeping up, then that tells us something about our discharge processes. It is still an evolving area, but I do think that for the majority of our services, particularly the larger services, we do have a resource on site which is available to respond fairly quickly in most instances.

The Hon. TARA MORIARTY: This is quite a technical question. If you know the psychologist on site in an emergency department, what is the process to determine if a person is required to be sectioned?

Dr WRIGHT: The Mental Health Act is fairly clear that, for instance, a registered medical practitioner can write a schedule, a form 1 under the Mental Health Act, and that can allow a person to be detained for further assessment. That initial assessment and that initial decision requires either a registered medical practitioner or an accredited person and there are a variety of accredited persons. Many individuals who ultimately become involuntary patients come on a police schedule; a smaller number under an ambulance schedule. So they are already detained under the Mental Health Act. Then there is a process of further review.

If the first form is completed by a non-psychiatrist then a psychiatrist needs to review that person within a period of time. The first assessment is purely whether someone should remain for further assessment then there is, if you like, checks and balances within the system to either ratify or change that decision, for reasons which I am sure you would understand. The point I am making is that the presence of a psychiatrist should not be considered a rate limiting step for that process, because in some instances there is not a psychiatrist on site at the time, sometimes there is a junior medical officer—which might be a psychiatrist in training—but in some places, particularly in rural areas, it is a decision of the emergency staff.

I should add that a fellow of the Australian College of Emergency Medicine is very experienced and quite capable of making those initial decisions, as are most experienced senior medical officers. The initial decision does not require a psychiatrist, but I think the psychiatrist review at the earliest opportunity is an important part of not just ratifying that decision, but really consolidating the initial treatment plan. It is not simply about should this person be in hospital or not but it is about ensuring that we have got a comprehensive and appropriate treatment plan for that person.

The Hon. TARA MORIARTY: During the last estimates when you were here we discovered that there is a facility, Birunji Adolescent Mental Health Unit at Campbelltown, which was without a clinical psychologist from October 2016 to June 2019. Would you agree that that is against best practice?

Dr WRIGHT: I am not familiar with precisely the range of programs that are offered within that facility.

The Hon. TARA MORIARTY: You can take it on notice if you like.

Dr WRIGHT: As I say, I am not completely familiar with their staffing profile because I think we do have to be adaptable in our health services. If we cannot fill a particular position, sometimes we need to identify an alternative workforce. I do not know what solutions they have provided there. We could certainly take that on notice.

The Hon. TARA MORIARTY: I am happy for you to take it on notice but I do want to get to the bottom of a couple of things that happened there. A follow-up for that is what psychological care people were

provided with during that period. It is quite a long period. It is October 2016 to June 2019 that the position was not filled. What was the psychological care that was provided? You can also come back to me in terms of whether the department looked into why the position could not be filled in that period of time—why it was vacant, why it could not be filled. I assume you want to take that on notice as well to confirm for the record.

Ms KOFF: From the note that I have received, a part-time clinical psychologist is employed as part of a comprehensive multidisciplinary team. That is the nature of mental healthcare delivery. There are psychiatrists, social workers, occupational therapists, diversional therapists and nursing staff, of course, that all come round to provide the comprehensive care level required. Another clinical psychologist was due to commence in September 2019 but withdrew from the position. That was part of the decision of the employee. It is still being progressed for advertisement, was the last update that I received.

The Hon. TARA MORIARTY: Obviously in terms of employing people things happen, but this is quite a long period of time and a position that I would have thought would be pretty important did not exist in this facility for two years. If you can see what happened during that period and come back to me?

Ms KOFF: Certainly.

The Hon. TARA MORIARTY: Also, how many other inpatient care units are there in New South Wales that should have a full-time clinical psychologist or a clinical psychologist of some description that do not at the moment? I expect you will have to take that on notice, but I want to get an idea if this has happened in whatever period of time in other facilities.

Dr WRIGHT: Can I clarify the question because that is quite a complicated question? In our inpatient facilities, what you are asking is those facilities which have a clinical psychologist in their staffing profile that they are unable to fill?

The Hon. TARA MORIARTY: It does not have to be that they are unable to fill. Are there any other facilities that have not fulfilled it for whatever reason.

Dr WRIGHT: Vacancies?

The Hon. TARA MORIARTY: Sure, but this is two years. So I just want to get an idea of whether this is the best—

Dr WRIGHT: I appreciate that, but we—

The Hon. TARA MORIARTY: The normal vacancy, if that is the case when you look into this. I am sure that will be the answer, but if there are supposed to be clinical psychologists in other facilities and there are not, I would like some information about that and the length of time.

The CHAIR: Thank you very much. We appreciate it very much. Thank you all for coming for the hearing. We have finished the questioning. As I indicated earlier, we have the 21-day turnaround period for the questions on notice.

Dr CHANT: Understood.

The CHAIR: I am sure we will be able to work our way through those supplementary questions. Thank you all very much. I appreciate all the effort in coming for the first hearing and for this one. I appreciate the information you have been able to pass on to us. Thank you for the great work you do for the citizens of New South Wales.

(The witnesses withdrew.)

The Committee proceeded to deliberate.