LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING

(Reference: Inquiry into ACT Budget 2021-22)

Members:

MR J DAVIS (Chair)
MR J MILLIGAN (Deputy Chair)
MR M PETTERSSON

PROOF TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 20 OCTOBER 2021

This is a **PROOF TRANSCRIPT** that is subject to suggested corrections by members and witnesses. The **FINAL TRANSCRIPT** will replace this transcript within 20 working days from the hearing date, subject to the receipt of corrections from members and witnesses.

Secretary to the committee:
Mr A Snedden (Ph: 620 50199)

By authority of the Legislative Assembly for the Australian Capital Territory

APPEARANCES

Privilege statement

The Assembly has authorised the recording, broadcasting and re-broadcasting of these proceedings.

All witnesses making submissions or giving evidence to committees of the Legislative Assembly for the ACT are protected by parliamentary privilege.

"Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committees and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution.

Witnesses must tell the truth: giving false or misleading evidence will be treated as a serious matter, and may be considered a contempt of the Assembly.

While the committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 20 May 2013

The committee met at 11.45 am.

Appearances:

Davidson, Ms Emma, Assistant Minister for Seniors, Veterans, Families and Community Services, Minister for Disability, Minister for Justice Health and Minister for Mental Health

Canberra Health Services
Peffer, Mr Dave, Interim Chief Executive Officer
Mooney, Mr Colm, Acting Deputy Chief Executive Officer
Rea, Ms Katrina, Acting Executive Director, Adult Acute Mental Health Services Central Management, Mental Health, Justice Health and Alcohol and Drug Services
Riordan, Dr Denise, Acting Director of Clinical Services, Mental Health, Justice Health and Alcohol and Drug Services
Ogden, Mr Paul, Chief Financial Officer, Finance and Business Intelligence

ACT Health
Cross, Ms Rebecca, Director-General
Culhane, Mr Michael, Executive Group Manager, Policy Partnerships and Programs
Lopa, Ms Liz, Deputy Director-General
Moore, Dr Elizabeth, Coordinator-General Mental Health, Office for Mental Health and Wellbeing
Garrett, Ms Cheryl, Executive Branch Manager, Mental Health Policy

THE CHAIR: Good morning, guys, gals and non-binary pals. Welcome to the second public hearing of the Standing Committee on Health and Community Wellbeing into budget estimates for 2021-22. We will be examining expenditure proposals and revenue estimates within the responsibility of the Minister for Mental Health and elements of Justice Health within the Health Directorate and Canberra Health Services, in relation to budget statements C.

On behalf of the committee, I would like to acknowledge that we meet today on the land of the Ngunnawal people. We respect their continuing culture and the contribution they make to life in this city and region.

Please be aware that the proceedings today are being recorded and transcribed by Hansard and will be published, and the proceedings will also be broadcast and webstreamed live. Should anyone take a question on notice today, it would be useful if witnesses could say, "I will take the question on notice." That will help our secretary and witnesses to confirm those questions in the transcript.

In this first session today, we will hear from the Minister for Justice Health and officials. I remind all witnesses of the protections and obligations afforded by parliamentary privilege, and draw your attention to the privilege statement. When you first speak, I remind you to acknowledge that you have read and understood the implications of the privilege statement.

We have decided to forgo opening statements today, so we will proceed straight to questions. Minister, it is a bit of a life-in-the-day question, but I would appreciate getting a bit of context around the life of an alcohol and other drugs nurse at the AMC. What does their day look like at the moment? What would an AOD nurse at the Alexander Maconochie Centre be responsible for?

Ms Davidson: Before I hand over to officials to answer that in more detail, we have made some really good investment in justice health in this budget—making sure that we are looking after people's mental wellbeing, which is often linked to alcohol and other drugs as well. There has been some really good work done in justice health. The staff there are people who care about their work and see that they are doing something very meaningful in the community. I will hand over to officials to talk a bit more about what their typical day is like.

Mr Peffer: Chair, thanks for the question. It is a great question to receive. There are a very broad range of activities that our nursing workforce undertakes at AMC. The person best placed to talk you through those different activities and what that might look like would be Katrina Rea, our exec director.

Ms Rea: I acknowledge that I have read and understood the privilege statement. Thank you for the question. Our alcohol and drug health services team at the AMC are part of a multidisciplinary team that work in conjunction with our mental health team and our primary health team.

On an average day, they would see current detainees who require their services, whether that be for medication rounding, or dosing for methadone or Buvidal. They take on any new inductions, as part of their assessments of whether or not they require their services, as well as any new referrals. They assess and triage those referrals and, on average, they receive about two additional referrals each week. There is no current waitlist to be seen by the ADS team. They work in conjunction to provide that care in a holistic way, as I mentioned, with the rest of the MDT.

THE CHAIR: I have a follow-up to a question that you might recall me asking at the last estimates. I am interested to see where the work is up to around smoking cessation. I know that the alcohol and other drugs nurses in particular would be working with what many in the community would see as being those big-ticket items, but I am interested in whether we keep a record of how many people come into AMC with a tobacco addiction, and what work those alcohol and other drugs nurses do to introduce them to smoking cessation programs.

Ms Davidson: The AMC is not currently a smoke-free facility, but there are programs in place to support people who would like to go through a quit smoking program. I will pass over to the officials in a minute to talk in more detail about that process. It requires justice health working together with corrections officers to make sure that this is all working smoothly. Certainly, people who would like to quit smoking are well supported to be able to do so. I will hand over to officials to talk about that.

Mr Peffer: I did not acknowledge the privilege statement last time I spoke, but I have read and acknowledge that. We recently completed a pilot program in partnership

with Corrective Services. We had 15 participants go through that program—11 males and four females. That program occurred over a 12-week time frame, assisting those participants to cease smoking. We have some work underway at the moment with those participants to evaluate the effectiveness of the program and any feedback that they might have to help guide future work in that area.

THE CHAIR: If the review of that program is still ongoing, would you be comfortable taking that on notice and providing to the committee at a later date some of your interim findings?

Mr Peffer: Yes, we can do that.

THE CHAIR: I appreciate that. I will pass over to the deputy chair, Mr Milligan.

MR MILLIGAN: Minister, are you aware of many problems with the outdated facilities at the Hume Health Centre, as well as the prison medical centre? Some of those issues are that there is no separation between detainees and staff while they check in and while they wait, space shortages between two medical practitioners using the one medical appointment space, and administration staff being housed in a very small administration facility section.

Ms Davidson: Thank you for the question. Before I hand over to officials to talk in a bit more detail about the physical space requirements at the Hume Health Centre, I would like to acknowledge that, while they are working under what may be less than ideal conditions for delivering health care, because there are security restrictions that have to be in place in that environment, they have been doing a fantastic job with the services that they have been able to deliver. If you look at the vaccination rate for people in the AMC and compare that to other jurisdictions around Australia, they have clearly been able to get a lot done there.

Also, they have been able to deliver those health services to the level where we have had multiple COVID-positive cases in the AMC and, instead of the numbers going up and spreading throughout AMC, the numbers have actually reduced. Even with the restrictions on space in the facilities, they have been able to provide some really good quality health care to people. I will hand over to officials to talk a bit more about the space and how that is working.

Ms Rea: There are some challenges with space that you have acknowledged. The team work really collaboratively with corrections to support the effective use of those spaces, based on the demands of the detainees and their healthcare needs. There has been a lot of work this year with both the justice health team and our corrections colleagues to identify any of those risks around space. They have completed appropriate risk assessments and identified for each location what mitigations may need to be supplied or provided to ensure that there can be safe delivery of care in those environments.

There have been ongoing discussions with corrections around what future expansion requirements might look like in the health setting, acknowledging that the number of detainees in the muster has increased over time, and access to the infrastructure may not have increased in line with that. Certainly, we are clear on what we would like to

continue to achieve over time and we are working actively with corrections to identify how we might do that in the short term and how we might look towards master planning in the longer term.

MR MILLIGAN: You mentioned that you have done an assessment of the space. When is it expected that this space will be increased and meet the needs of the prison and its staff?

Ms Rea: I am not aware of an immediate time frame to increase those spaces at this point in time.

Ms Davidson: It would be subject to a budget process.

MR MILLIGAN: As part of the budget process, I have here that there is at least $5 million being funded to the prison for improvements in infrastructure and wellbeing over the next two years. Is any of this money going to the expansion of the justice health premises there?

Ms Davidson: There would be a process by which we would take the results of the review, discuss what is possible, work out some time frames and go through that process before we could commit to how much it will cost.

MR MILLIGAN: How long could they be expected to wait for any progress on or updates to these facilities? Isn't it urgent at this stage, right now?

Ms Davidson: I think it is really important, when you are going through a process like this, that you take the time to adequately look at what the review has found and consult with stakeholders in the community. We have an active group of stakeholders in the community who are really interested in justice reinvestment, and good health care is a big part of that. I would want to be having conversations with them about that before we commit to decisions.

MRS JONES: Minister, currently there are two medical staff in one medical treatment space in every single office in the medical centre at the Hume Health Centre, and administrative staff are sitting less than half a metre apart from each other in the administrative wing. Is this something which to you seems urgent to resolve?

Ms Davidson: I think this is part of the entire justice reinvestment policy and process that we need to go through, all of which is incredibly important in reducing the number of people who end up in the AMC and in making our community safer.

MRS JONES: What about for the staff? What about for the staff at the moment, the conditions that they are working under right now? You would not accept it in a GP clinic; you would not accept it in a government clinic.

Ms Davidson: We are working through a process on that.

MRS JONES: What is your time frame?

Ms Davidson: I could take that on notice. I do not have that at hand.

MRS JONES: You do not have a time frame for resolving this difficulty? You do not say, "I want to have it in the next budget"?

THE CHAIR: Mrs Jones, the minister did say that she would take that question on notice. We will get an answer to that question in due course. I will move to Mr Pettersson now for a substantive.

MR PETTERSSON: I thought I would take the opportunity to ask about MindMap, as it was released yesterday. Minister, I was hoping you could inform the committee as to the purpose of MindMap.

Ms Davidson: This is a really exciting project that actually came from young people in the first place. Back around 2018, I think it was, young people in the ACT were talking about the need for better support to navigate our really diverse and comprehensive mental health system of different services that we have here. When you are a young person who is realising for the first time that you actually need a bit of help with your mental health it can be quite overwhelming to try and find the right service at the right time.

This project that was launched yesterday will support more young people to connect with the right service at the right time and with the help of youth navigators. But I can hand over to Dr Elizabeth Moore from the Office for Mental Health and Wellbeing to talk in more detail about how it works.

Dr Moore: I acknowledge the privilege statement. As the minister has said, this actually came out of the Youth Assembly and we have had the Youth Advisory Council and many other stakeholders involved. We commissioned it with Marymead, who are the successful procurement operator of MindMap.

It has two functions. One is to give children and young people the ability to look for services that they think they need and also for parents and carers to see the number of services available. When we did the children and young persons review we found that there were over 176 services in the ACT for various service needs for children and young people but people were not aware of them. The second part of MindMap is that, as the minister said, there are navigators. These are both non-clinical and clinical navigators to help the young person, if they so wish, to support them whilst they find a particular service.

It was launched yesterday. We have asked people to give us frank and fearless advice on whether or not it meets the bill. It did go through quite a deal of young person testing and we are hoping that over the next two years, which we have funding for, we will see whether or not this is a useful addition to our armamentarium.

MR PETTERSSON: I had a quick look at the website when it went live yesterday. I was wondering how the wait times are updated on the website.

Dr Moore: The wait times are updated from the individual organisations. That is their responsibility to do.

MR PETTERSSON: They will get in touch when things either increase or decrease in time?

Dr Moore: Correct; yes.

MR PETTERSSON: Is there a risk that, when a young person uses this website and they see right in front of them quite long wait times to access these services, that might act as a deterrent to them actually trying to follow that path?

Dr Moore: One of the things that young people wanted was an accurate representation of wait times so that they could look at alternatives. If there is a long wait time, what else is available that they might use? There are actually a lot of digital mental health strategies as well, a lot of programs available that people are unaware of. So eMental Health, RACGP, is the overarching digital platform from the commonwealth and there are many individual apps and websites for young people. The ones that I usually recommend are things like ReachOut and Emerging Minds, which of course is one of our locally based websites.

Many young people have said that perhaps in the first instance they do not want to speak to anybody. They always have an option to speak to a clinical navigator or a non-clinical navigator. But many of our young people have said, "No, we want to actually learn more about what we are going through, actually define it, and define it for our friends as well."

MR PETTERSSON: You mentioned that some of the youth navigators were clinical and some not. I was wondering if you could maybe differentiate what role they would have. When you call the hotline is there a random chance which you get assigned to or is there some delineation?

Dr Moore: Initially there is not a delineation, but obviously if the person needs more clinical care—and we are yet to have calls—what young people have said is that, basically, they just want somebody to talk to. It might be a different level. The non-clinical navigators can refer to the clinical navigators if there is a greater degree of distress.

MR PETTERSSON: In terms of the website, I noticed that there are a couple of different age brackets that people can identify with. Does the website change in any way if someone wants to identify as, let us say, a six-year-old or a 24-year-old? Does the website present in the same way or is it just the results at the back end that you would see would change based on the age?

Dr Moore: The young people were very clear that they actually wanted it a little like internet shopping. You put in your various things: you are 12 and you have anxiety and depression. What is most likely to be best for you? It was a bit like internet shopping. "I want a pair of shoes, women's size 6, red." It was very much a similar concept. They did not want to have no way of navigating the system.

MR PETTERSSON: Should the language and design of a website that a seven-year-old would use be the same language and design that a 23-year-old would potentially use?

Dr Moore: It really is designed for 12 and up.

Ms Davidson: I can point out that it can also be used by parents and carers or friends. They might be looking up information to help a younger person that they are supporting.

MR PETTERSSON: How does MindMap interact with some of the other services that already exist? I know that the commonwealth have—what is it called?—HeadtoHelp and then there is also a hotline service that exists through ACT Health at the moment. There is some guidance on the best first point of entry for young people?

Dr Moore: Young people wanted options for the best point of entry. They can already go to websites like ReachOut or Emerging Minds, but actually what they wanted was what was available in the ACT in terms of services. The commonwealth are looking very closely at MindMap because they are wanting to do a HeadtoHelp for young people as well. It has been a confusing area. The option there with MindMap is go to MindMap and actually see what is available for you in the ACT.

MR PETTERSSON: Are all the services that you would be directed to through that Access Mental Health phone line replicated through MindMap?

Dr Moore: MindMap is not an emergency service and it very clearly states that. It states on the front page, "If you require that sort of help, you need to go to the logins that are below, including Access Mental Health."

THE CHAIR: I have got a quick supplementary, if you would not mind, at the risk of spending much too much time on MindMap. I will say that my first anxiety when I saw MindMap come out, as wonderful as the program is, is getting to young people, actually promoting it. I was wondering if you could talk me through what the government strategy is to make sure that every Canberran, every young Canberran, knows about this program and knows how they can access it.

Dr Moore: Yes, multi-strategy. We have the children and young persons community of practice very heavily involved. We have also a media campaign going out to promote MindMap. We have had the education department closely involved and they are sending out details of MindMap to children and to parents. It is multi-strategy. Marymead have also included some very innovative things. The Canberra Rocks that people are going to find has MindMap on it.

THE CHAIR: That is a good takeaway. I will remember that next time I am on a walk around Lake Tuggeranong.

MR PETTERSSON: The press release that went out yesterday says that MindMap was co-designed by the ACT government, Marymead, the Australian National University, the ACT Youth Coalition and the ACT Youth Advisory Committee. Were clinicians involved in the design?

Dr Riordan: Yes, they were. Clinicians are part of community of practice, and the community of practice was part of this as well.

MRS JONES: Minister, you have had nearly a year in this role now, and we have some statistics that the clinical end of the spectrum, the more acute end of the spectrum, has its problems in the ACT. The proportion of mental health related emergency department presentations, as I am sure you know, being seen on time is fewer and fewer every year. The last reported data is that 38.4 per cent of mental health presentations to EDC were on time. The care-giving community—carers and parents and so on—as I am sure you are aware, have lots of dissatisfaction with our mental health system at the more acute end.

My question is: what legislation do you, as the Minister for Mental Health, administer? What powers do you have as the Minister for Mental Health to change the system?

Ms Davidson: That is an interesting question. I am pretty sure the admin arrangements are publicly accessible if you wanted to check what pieces of legislation I am responsible for. But if what you are wanting to talk about is what is happening with demand in the acute mental health system—is that what you are really wanting to explore a bit more?

MRS JONES: I have a supplementary question, but the first question I really wanted to understand is: what levers can you pull, as the Minister for Mental Health, as opposed to the Minister for Health?

Ms Davidson: Great question. There are two things going on there. First of all, with the demand for acute mental health services—and I will hand over to officials to talk a little more about what direction, what kinds of trends we are seeing and where that is headed at the moment—we have actually got some budget measures in place in this year's budget to increase the number of beds available in the acute, high-dependency unit and subacute care in hospital. But, really importantly, we are delivering quite a lot more services in the community in early intervention and prevention and for people with mild to moderate symptoms, including having an increased number of step-up, step-down services in the ACT.

The reason why that is so important is that it helps to reduce the number of people who end up in acute care need. We would like to keep on doing that work while still meeting the acute care needs that already exist. I can hand over to Dave to talk a bit more about where the demand levels are going.

Mr Peffer: Thanks for the question. This is not something that is unique to the ACT in terms of this growing demand. There has been quite a lot of media attention over recent months, particularly the last week or two, about what hospitals across the country are seeing. And mental health is obviously a key driver in that respect.

In the budget this year some quite significant investments have been made around acute mental health—

MRS JONES: Can I just get you to go to the presentations, whether there have been increased presentations in our hospital system?

Mr Peffer: There have been growing presentations—

MRS JONES: During the lockdown?

Mr Peffer: We have seen sustained growth over the last couple of years. Since the lockdown has commenced we have seen a reduction in emergency department presentations. This is what we observed last year, as well, when we had a lockdown. Then what we experienced, coming out of the lockdown and as life—

MRS JONES: Was an increase?

Mr Peffer: An increase in that demand. But going to the specifics of where we saw those increases and how we are also working across the system between the emergency department and mental health, I might ask Ms Rea just to talk about some of the initiatives that we have got in place.

Ms Rea: Yes, we have absolutely seen sustained increase in demand over a long period. As Dave has accurately reflected, throughout COVID we have seen a reduction or plateau in emergency presentations, and that has been the same for our mental health acute inpatient demand as well.

What we have seen over the more recent period is quite a reduction in our very long waits in the emergency department. However, there is still an ongoing increase in occupancy and our inpatient units, an increase in bed days year on year. And our average length of stay has increased, which actually is a good thing in this environment. I think that, historically, the pressure has been so significant on inpatient units that we have seen actually a reduction in length of stay—not to an unsafe rate, because we have not seen that change in terms of the re-presentation rate. We have not seen any deterioration in that number.

MRS JONES: Going to those statistics that you just referred to, can you take on notice to provide me with the last two years of data, with those statistics on the length of stay and the number of long presentations?

And just to go back to the original question, Minister, in 2016-17 only 57.9 per cent of our mental health emergency presentations were seen on time. In 2017-18 the figure went down to 43 per cent. In 2018-19 it went down to 38.4 per cent. The trajectory is in the wrong direction. What are you doing in this budget to change that trajectory? That is really the issue at heart here. What will change that trajectory in the ACT? We are far and away the slowest performer, by tens of percentage points, behind every other state and territory.

Ms Davidson: I am not sure that I agree with you that we are that far behind other states and territories. We are actually delivering some really good—

MRS JONES: Sorry, Minister. Going to the 2018-19 data, New South Wales sees 75 per cent on time, Victoria 68 per cent, Queensland 65 per cent and WA 55 per cent. We see 38.4 per cent. Nobody is anywhere near as low as those statistics indicate. Unless you have updated numbers that are better than that, we are heading in the wrong direction.

Ms Davidson: Before I hand over to Dave to talk a bit more about the numbers, I want to return to the conversation about early intervention and prevention and care in the community. We are delivering quite a number of—

MRS JONES: I understand your desire to pivot the question to a different topic, but I am talking about people who, for example, have slashed their wrists and are at emergency. Or people who fear they will hang themselves and are at emergency. They are not being seen anywhere near on time.

THE CHAIR: Mrs Jones, you have had three goes to rephrase the question before the minister has had an opportunity to answer. I will let the minister answer now, if that is okay.

Ms Davidson: Yes. Before I hand over to Dave to talk a bit more about the numbers in more recent years, I want to talk a bit about what we are doing to manage the demand on acute services and people presenting at emergency. Sometime in the next couple of weeks we will be opening the first Safe Haven Cafe in the ACT. It is going to be co-located near a Head to Health commonwealth mental health club. It is going to be a really warm, welcoming place where people can go if they are experiencing distress, to be connected to the right kind of mental health services for where they are at at the time.

What we are hoping will happen as a result of this is that people will feel comfortable going in and asking for help at an earlier state in their condition so that things do not get to the acute level of need before they are asking for help and before they can be connected with the right services.

Also, it is a really beautiful example of the commonwealth and ACT working collaboratively to achieve really good outcomes for people in our community. I am really looking forward to seeing those services launched soon.

I will hand over to Dave, who can talk a bit more about the numbers of presentations.

Mr Peffer: We acknowledge that more needs to be done to drive performance within the system, but I caution against thinking about it as an emergency department problem; it is not. It is a system-wide effort that is required to support patient flow.

Let me come to your particular question about emergent patients presenting. If we have patients present through the emergency departments here in the territory—true emergent patients—100 per cent of them are seen within a clinically recommended time frame. As we move through to lower acuity categories of patients presenting, we need to do some work to bring up those numbers.

MRS JONES: But the other categories include urgent and semi-urgent, as you well know. Yes, if someone is dying because they are bleeding out, they are seen immediately. But the very next category is urgent. I urge you to produce some numbers in this discussion that show that we are not still going downwards as to the number of people seen on time. So far, nothing has been presented in this discussion.

Mr Peffer: As I was saying, this is not solely a discussion about the emergency department; it is a discussion about the system. The minister has been drawing your attention to the fact that it is the performance of the system that ultimately will determine the numbers and the performance.

MRS JONES: My final supplementary to you both is this: if these changes will reduce the demand on the system, where is the data that shows that that has either started or will be measured now? We are now in a situation where, as we come out of lockdown, the needs for mental health services are going up, as we all know. This is why New South Wales has put a stack of cash into it. But what is happening when they come to the emergency department? If our stats are so bad, yet we are doing all these things to keep people out, then it is even worse than it seems.

THE CHAIR: Mrs Jones, there is a fair bit in there. I am going to ask the minister to answer that question; then we are going to end this line of questioning and I will move to Mr Braddock for a substantive.

MRS JONES: Thank you.

Ms Davidson: This is one of the reasons why we recently announced funding for a second PACER team, which also massively impacts on the number of people who end up having to present to emergency. It is not just on the day when they are making the call and the PACER team is going out but for 14 days afterwards that we see they are having reduced presentations to emergency.

That ability to have an urgent care response that goes out to see people in the community and takes a mental health clinician with them to get them connected to services in the community is having a really positive impact on the number of people that end up having to present at emergency and—

MRS JONES: But how can you show that in the numbers, Minister? Nothing that anyone has said today shows any change in the numbers in the ED.

Ms Davidson: Would you like me to take on notice to provide you with data about the reduction in emergency presentations as a result of PACER?

MRS JONES: Yes, and how that is affecting the waiting times, please.

Ms Davidson: I will do that.

MRS JONES: Thank you.

MR BRADDOCK: I would like to inquire about the relationship between justice health and the corrections service in terms of the need for the corrections service to help justice health achieve its objectives and improve detainees' health. How does that work?

Ms Davidson: Before I hand over to officials to talk in more detail about how the relationship works, I want to acknowledge that delivering good health care to people in the AMC does require a good working relationship with corrections officers to

make sure that people are escorted to and from the health centre and to make sure that wellbeing is supported. Quite a lot of work goes into making sure that all of that is working as smoothly as possible. I will hand over to officials to talk about how that works.

Mr Peffer: I might ask Ms Rea to expand on how that works day to day.

Ms Rea: There are a number of ways it occurs day to day. The team on the floor, in terms of corrections officers, as well as our health team, work incredibly collaboratively. At least in my forums, the team continually comment on how collaborative those relationships are.

The important thing is the governance arrangements locally that are established. Our justice health team have clinical and corporate governance structures, and corrections have their own governance structures. The teams also have a shared meeting where they come together to discuss key issues from either party and ensure that both parties are aware of the consequences for their respective services as a result. Any of those issues are then escalated through our MHJHADS clinical governance committee—the Mental Health, Justice Health and Alcohol and Drug Services governance committee—from a health perspective. That has multidisciplinary representation in terms of all our operational and clinical directors as well.

From there, we can appropriately escalate to the relevant forum and advocate as needed. Equally, those resolutions can go back down the team and feed back what we are doing at organisational levels to support in that frame.

MR BRADDOCK: Have there been instances where, for example, a detainee has not been able to access a health service due to corrections not having enough staff to assist with that?

Ms Rea: Not that I have been made aware of, other than recently in some of the COVID outbreak work where we have worked very closely with corrections. There has not been an issue in terms of accessing health services; it is just that the way we have delivered health services has required augmentation to respond to the number of corrections staff that were furloughed as a result of some of the outbreak management.

In conjunction with that team, we were sharing communication and information with a number of incident response teams that were established, in terms of the number of staff impacted and how that would respond to services. We condensed some of our daily medication rounds to single day rounds to ensure that everyone still had appropriate medications. We were still, of course, able to provide for any urgent or priority appointments, but it was a challenging time for all teams to prioritise health appointments.

An additional burden in that situation was the additional COVID monitoring that was required and the additional reviews required of each individual. Corrections supported us to ensure that that could occur and, equally, supported us to ensure that we could resume vaccination clinics in a timely way to protect all detainees in that environment.

MR BRADDOCK: So there were no detrimental impacts to detainees' health during

the COVID crisis?

Ms Rea: No issues of deterioration that were flagged; correct.

THE CHAIR: Minister, I want to ask about the justice health services community contact. The note to strategic indicator g says that the justice health service community contacts shown in table 19 have been discontinued. Can you explain why this is and how you measure the accessibility of health services to people in the prison?

Ms Davidson: Before I hand over to officials to answer that in more detail, I would like to say that maintaining social contact has been really challenging for our whole community during COVID. Within our justice system, there has been a lot of effort made to try and ensure that people at least have AV link contact with family and friends, and with other services outside, wherever possible. I will hand over to officials to speak a bit more in detail.

Mr Peffer: I might start off and then hand to Ms Rea. The change in this indicator came following an Auditor-General's report into the full breadth of indicators that were used across government directorates to measure activity and performance. Some of the feedback around those indicators suggested that some indicators were more useful than others.

For a health service like ours, simple activity numbers often do not tell the story about what is going on. If numbers go up and down, is that necessarily good or bad? A lot of our focus needs to be on the quality of the services we are providing and the impact they have for those accessing services. I might hand over to Ms Rea to expand on how we measure performance there.

Ms Rea: The indicator did not necessarily give us enough information on the efficiency, effectiveness or quality of care for those services, particularly in the justice health space, but also the alcohol and drug health services space.

There was the introduction of new medication such as Buvidal and the impact that has had, in that the number of occasions of service has reduced over time. It is an indicative number of the quality of care that we are providing or the positive impact for those individuals in terms of having to potentially access services monthly rather than daily.

It was not necessarily supportive of how we could articulate that. In the AMC environment the team continued to record any occasions of service, and we will continue to do that, ongoing. They also record any referrals to the team, based on triage categories, and they monitor that closely and will continue to do that. From a mental health perspective in that environment, anyone who needs urgent follow-up receives it immediately, or within two hours, and those targets are certainly met.

Some of the other key targets we are retaining in these metrics are things like physical health assessments in AMC within 24 hours. At the moment, we achieve 100 per cent of that target. That is really important when we look at the whole person and their whole physical and mental health care.

THE CHAIR: Thank you.

MRS JONES: When I was last in the Hume Health Centre, I promised that I would talk about not only the problems but the good things too. On that note, given that you have mentioned the injections which are now being administered, do you want to tell us about how many people have been transitioned to buprenorphine and how that has changed health care? I believe we may be the only prison in the country that has achieved what we have.

Ms Rea: Thank you so much for that question and I really appreciate you acknowledging the team. That is really appreciated, thank you.

At the moment, of those detainees receiving care in the AMC, there are 86 receiving OMT-type care, and 63 of those are on Buvidal. That is a significant portion, as opposed to methadone, that is being administered within the unit. We continue to try and titrate to Buvidal if that is clinically appropriate for an individual and, equally, if that individual can be cared for over a sustained period of time.

As you mentioned, that is a really positive thing for our detainees, both in this setting and in the community setting, where we have also employed that strategy for individuals who are wanting to take on that clinical management pathway. Obviously, it reduces diversion, which is really important, as well as reducing any stigma associated with them having to have daily doses.

MRS JONES: Yes. For those who have watched me in these hearings, I have talked a lot about methadone over the years, and it really is a big change in how people's lives are lived, both inside and outside the facility. So good job.

Ms Rea: Thank you.

MR MILLIGAN: I am hoping you can hear me okay; my internet is a bit scratchy.

MRS JONES: Yes.

MR MILLIGAN: During the Ninth Assembly, the education and youth affairs committee handed down its report on youth mental health. There were some 66 recommendations. This was handed down in August 2020. I am wondering how many of these recommendations you have actioned.

Ms Davidson: Before I hand over to ACT Health to talk more about the detail of how many have been actioned, I want to note the huge investment in youth mental health in this year's budget. We are investing $7½ million in youth mental health programs, in addition to having just launched the youth navigation portal MindMap and a number of other pieces of work. We have a real focus on trying to provide some good services in that area. I will hand over to ACT Health to talk about the recommendations.

Ms Cross: I acknowledge and understand the privilege statement. I might see whether Dr Elizabeth Moore, or one of the team in Woden, has the exact number of

recommendations that have been responded to.

Mr Culhane: I acknowledge the privilege statement. We do not have the number of recommendations that have been implemented; we will have to take that question on notice.

MR MILLIGAN: When do you expect the recommendations you have actioned to be completed?

Ms Davidson: That probably depends on the recommendations. When we can come back with the full list of recommendations in progress, we will be able to give you the expected completion dates as well.

Ms Rea: Our apologies; we had not included that in our briefing packs because I do not think it was specifically in the budget papers this year. We can certainly go back and check that for you.

MRS JONES: Is there any funding in the budget from an ongoing line item or a new line item for the implementation of the vast 66 recommendations of this report into youth mental health?

Ms Davidson: As discussed earlier, I will be able to give you an answer to that once we can come back with the list of the recommendations—which ones are still in progress and when they are due to be completed. We will also be able to tell you what funding has been allocated to each of them. We will take it on notice.

MRS JONES: Thank you.

MR PETTERSSON: I have a question about the Safe Haven Cafes. I note that they were flagged in one of the previous answers, but I was wondering if you could provide an update to the committee on how the program is progressing.

Ms Davidson: Yes. The Safe Haven Cafes are one of my favourite topics. We are very close to launching our first Safe Haven Cafe in the ACT. I will hand over to officials to talk more about the time line and progress towards that in a minute, but I just want to note that this entire process has been a really great example of working with the community to co-design a new service, to pilot that and to look at how we can link that into the rest of our landscape of mental health services in the ACT.

When the opportunity came up in the recent mental health package that was announced during COVID to co-locate that with one of the commonwealth Head to Health hubs, we took that opportunity to have an even better integrated mental health service system in the ACT.

I am really looking forward to this service starting and being able to provide people with an alternative to having to turn up to emergency to seek help when they are in distress or waiting for things to become that acute. For people to be able to go and talk to a peer mental health worker at an earlier stage and feel comfortable asking for that help and getting connected to the right place is going to make a huge difference to them.

I will hand over to ACT Health to talk about the detail and the time line.

Ms Rea: To reiterate what the minister has said, the collaboration with Capital Health Network in setting up this joint approach has been extraordinary, and if we can do more of that in the future, we will have better services in the community.

Progress in terms of the opening is going very well. We are expecting to be doing a soft launch of the service in early November. Doing a soft launch will allow providers and stakeholders to see the service, see the site without any people there receiving the service. That is what is recommended with these sorts of facilities. We will be doing a soft launch early in November and then in November we will be opening for service provision.

MR PETTERSSON: I was wondering why the Canberra Hospital location was ruled out.

Ms Davidson: There are a few reasons why we have chosen Belconnen as the location for the first Safe Haven Cafe. One of the reasons relates to the PACER data for call-outs for people who are experiencing distress. That is an area, geographically, where there is demand. I can hand over to Health to talk more about why Belconnen was chosen.

Ms Rea: I might see whether one of the team in Bowes Street wants to go to the process that we went through in looking at the Canberra Hospital and how that fits with the ongoing plans around the Canberra Hospital new critical services building. I am not sure whether Michael or Cheryl is able to provide the history.

Ms Garrett: I acknowledge and understand the privilege statement. The initial plan was to pilot two Safe Haven Cafes, but the master planning process for the Canberra Hospital expansion is being progressed, and consideration for a hospital-based Safe Haven Cafe will progress as part of that plan.

In terms of the location at Belconnen, we have a very engaged governance committee with local service providers and people with lived experience. The decision was made to base it in the Belconnen region. It has the advantage of the growing population in Belconnen, access to the Gungahlin areas, relative proximity to the inner north and city areas, being close to the community health centre there, and being supported by all of the stakeholders through the governance considerations.

MR PETTERSSON: So consideration of the Canberra Hospital master plan is still a factor. Does that mean the Canberra Hospital site is still an option?

Ms Lopa: I have been working on the Canberra Hospital master plan. Yes, the location of a Safe Haven Cafe on the hospital site is being considered and will be advanced in the Canberra Hospital expansion project. We are currently working with Canberra Health Services and Major Projects Canberra to bed down exactly where that will be. We are looking at somewhere that is close to the emergency department, not too far away from the emergency department. I am just looking at my CHS colleagues, but I think a decision on where that will go is imminent and will be

progressed.

Mr Mooney: I acknowledge the privilege statement. The point that Liz makes is that, with Major Projects, we are going through the detailed design development of the Canberra Hospital expansion. It is part of that consideration. The exact location has not been confirmed, but, as Liz has advised, there is active consideration of that particular requirement in the critical services building or the Canberra Hospital expansion.

MR BRADDOCK: What is the justice health position on a needle exchange program in the AMC?

Ms Davidson: I might hand over to officials to talk about where that is up to.

Mr Peffer: I would ask Ms Rea if she has any advice to provide on that one.

Ms Rea: I am afraid I am going to have to take that question on notice.

MR BRADDOCK: Thank you.

MRS JONES: Minister, during the lockdown, has there been a death at the secure mental health unit, Dhulwa?

Ms Davidson: Yes. I think you know that there has been.

MRS JONES: When that occurs, what is the general process for investigation into causes, and reasons, and what is the policy practice? How do we handle that situation?

Ms Davidson: I will hand over to officials to talk through the policy process, but, yes, it is always a difficult situation when something like that occurs. It has a big impact on staff who have worked with the person involved. I want to acknowledge that it is a difficult situation, but we have been doing some really good work out there.

MRS JONES: Of course.

Mr Peffer: The investigation of any death like that is led by the police and the coroner. Our team notifies the police, and then there is full cooperation to support that investigation.

MRS JONES: What is the normal time frame on these types of investigations? Do you usually get an outcome within a year and then you can look back on your processes? Or do you analyse the processes within the facility at the same time as the police?

Mr Peffer: We will always review what has happened in parallel when we have a death like this. But we will await the coroner's findings and any determination that is there. It really is on a case-by-case basis. There are no defined time frames or a process that it has to follow. It will depend on the individual and the circumstances. Some of the coroner's investigations can take some years for findings to be handed down.

MRS JONES: Do you ask the coroner for updated suggestions for improvement? My concern is that if it takes two or three years for the coroner's findings to be released, there might be processes inside the facility that need improvement and we do not have that information.

Mr Peffer: I might ask Ms Rea to expand on this, but for this particular matter we have had some early communication from the police and the coroner around the matter and there have been no specific recommendations or suggestions for things that need to change at this point in time. But I do have to add the caveat that this is a matter that is outside our control and entirely subject to the normal justice process.

MRS JONES: Of course.

Ms Rea: This has been a really challenging situation for everyone involved in the care and treatment of this individual. Like any incident that has this level of harm score, in this scenario the team attend the site and conduct an immediate incident review. We also do risk notifications so that all our clinical governance processes are enacted to ensure that we can have internal reviews. We do not necessarily wait for a coroner's report to do an internal investigation and ensure that our processes and our actions were appropriate at the time. And we can amend anything if appropriate.

What then occurs from that situation, based on that risk notification, is that our hospital clinical review committee also review that as a peak committee. Locally we also have a mortality and morbidity committee review that is tabled with our local team. They go through case reviews and often find internal recommendations as well. We put time frames on any of those recommendations that are then approved by the relevant governance committee, and then there is a time for us to deliver on those as well.

MRS JONES: Can I ask, on notice, where we are up to in those internal governmental processes? What has been achieved and what is yet to be achieved? Could that be given to us, on notice, in this case? I am not asking for details of the case—just the process. Secondly, is this the first death in the secure mental health unit or have there been others?

Ms Rea: I might refer to Denise Riordan, Acting Director of Clinical Services, to answer that one.

Dr Riordan: I acknowledge and understand the privilege statement. In response to your question, this was the first death of a consumer in the Dhulwa mental health service. To reiterate what Katrina said in terms of referral through to the CRC and to the morbidity and mortality committee, that happens as a matter of course.

One thing to note in this situation is that the person was detained under the Mental Health Act, so there would be a process review that would involve the office of the Chief Psychiatrist. We would look to work very collaboratively with them. The other thing I want to mention, in order to bring completeness to the discussion, is that a significant part of our work was to ensure that support was offered to the family of the deceased person and to the staff involved, both staff who worked on the unit at the

time and knew the client there, and staff who had worked with this particular consumer—

MRS JONES: Has that support been taken up? Have any staff taken up that support?

Dr Riordan: We facilitated some group debriefings with staff, both on the day and subsequent to that. Obviously, staff were made aware of the opportunities they had to seek individual support. I am not able to comment on whether any individual staff sought individual support. We certainly made sure that we addressed with them issues of their own wellbeing and response to what was obviously a distressing situation.

MRS JONES: Can I go back to the question that I asked to be taken on notice? Is that able to be taken on notice—where each of the standardised processes is up to in this case?

Dr Riordan: Yes, we can take that question on notice.

THE CHAIR: During lockdown I had a meeting with Heidi Prowse, the CEO of Mental Illness Education ACT, who put to me a particularly unique lockdown challenge with the mental health of Canberrans. To paraphrase, we have Canberrans who struggle with their mental health, who have a range of coping mechanisms, strategies and relationships with healthcare professionals, which they tapped into when things got a bit tricky under lockdown. But we have this growing cohort of Canberrans who may not have had a mental health ailment diagnosed or may not have thought to access mental health services, who are starting to experience acute mental health illness.

I want to explore that in more detail to see what the government's short-term response to that has been in terms of the lockdown, as well as how much that is framing our thinking in terms of a long-term response for people in Canberra who have not had a relationship with mental health professionals before, but who, over the course of the coming months and years, may need to for the first time.

Ms Davidson: Yes. It is really important to acknowledge that there will be people who are finding for the first time that they are experiencing issues with their mental health and wellbeing. That is why we have invested in things like more support for organisations like MIEACT, as well as other organisations that provide mental illness education, awareness and prevention, and mental health first aid—organisations like OzHelp—and providing mental health first-aid training for small business owners as well, through the recent additional mental health package funding.

There will be people who find that they need access to those resources that have not experienced that before. This connects with Canberra's need to look at mental health as part of our social recovery from COVID, for which I also have responsibilities—but not in this committee—and these things are interconnected.

Having the wellbeing indicators framework will be really helpful for us as we go forward in terms of assessing planned budget expenditure and looking at how that might impact on people's mental wellbeing, particularly as we are coming out of a really difficult time which will have a long tail. Social determinants, as the

Productivity Commission report shows, have a really big impact on people's mental health and wellbeing. Can you remind me of the question, and what it is you are looking for there?

THE CHAIR: The question specifically is: does the government have a strategy for how it will promote services that the government is running and that the government is funding in the community sector for Canberrans who may not think, in the first instance, that they are suffering from a mental health ailment and may need to connect with services for the first time?

Ms Davidson: I might pass over to Dr Elizabeth Moore to talk about the work of the Office for Mental Health and Wellbeing's focus on early intervention and prevention, and our strategies for managing that.

Dr Moore: As you can see from the mental health support package, we rely on good information not only from our clinical services but also our non-government partners. Of course, MIEACT is one of our valued non-government partners. The strategy has been to listen to community and to identify those particular priority groups that have had more of a struggle.

It is really important to acknowledge that anxiety is actually a normal reaction, especially in these abnormal times. Part of the work of the office is to look at services across the continuum. That includes mental health promotion at a population level, at a targeted level, and then early intervention, going into our valued clinical services and into rehabilitation and recovery.

We have been working with the Community Services Directorate on social recovery because we know that the social determinants of health are really important in terms of building that resilience. Some of the work that we have been doing has been in schools—again, with MIEACT—with the Youth Aware of Mental Health program, which, fortunately, has not been greatly impacted by COVID. It is a face-to-face program that builds resilience in year 9s. It has five modules and it looks at what you need to look after yourself, what you need to look after your friends and how you can build that into a safety package for yourself. That is part of the work in the children and young person space. We are also looking at earlier interventions in eight to 12-year-olds.

In terms of a broader mental health focus for people that may not identify that they do require some help, part of that is around mental health promotion per se and joining with the commonwealth in "It's okay not to be okay" type promotions. We have also been looking at different ways of accessing people. Not everybody will access social media. Not everybody will look at television advertisements. What we have done with MIEACT—and we did this during the first lockdown—is to produce a pack around anxiety and around depression and self-care. We used part of our communications allocation in the last mental health support package.

We will also be looking at what we have seen works with, particularly, younger people in terms of TikTok, to reach as many people as we can. We also rely on not duplicating, so with respect to non-government partners that have in-reach into areas that we do not particularly have good in-reach into, it is about using their networks to

spread the word about what the symptoms are, what you can do about it and where you can access further help.

We will continue that strategy over the next year because, as the minister said, the modelling has shown that there will probably be an increase in mental health concerns, but it is about that stepped level of concerns. Not everything needs a specialist mental health response. Many people just need to understand what is going on, what they can do to help themselves and help others, but then we need to have that stepped care approach.

THE CHAIR: If you need help with a TikTok promotion, you may find some experts in the Assembly.

MR MILLIGAN: I am interested to know how much funding the justice health service received for this financial year, 2021-22. Has that differed between last year's budget and the projected funding for this financial year?

Ms Davidson: Before I hand over to the officials to give specifics about last year's funding compared to this year's funding, I want to note that justice health also received some additional funding in the recent mental health package, specifically because we expected that, with the impact of lockdowns and reduced contact for people who are in AMC, there might be a need for additional mental wellbeing checks and support for people. Additional funding was provided both to justice health and to Winnunga, who provide really good quality services to people in the AMC as well. That is something that is unique that we do in Canberra, to provide a bit of additional help. I will hand over to CHS to talk a bit more about the difference in funding.

Mr Peffer: In terms of an aggregate number, I do not have that in front of me, but I will ask Mr Ogden, our Chief Financial Officer, whether he has that information.

Mr Ogden: I do not have that detail at the moment. I can take it on notice and get back to you.

MR MILLIGAN: I am happy with that.

MR PETTERSSON: Could someone update the committee on what work is underway to increase the mental health workforce in the ACT?

Ms Davidson: Before I hand over to ACT Health to talk about that, that is something that we are in a really good position to be able to work on in the ACT, having access to universities here, as well as the teaching hospital. There is work going on there at the moment to do that.

I also note that we are not just looking at the mental health workforce in terms of mental health nurses, for whom we have recently had an increased ratio, psychologists and things like that, but also the peer mental health workforce is growing in Canberra. Things like the Safe Haven Cafe that is coming on board and the step up, step down services are part of that bigger picture. I will hand over to ACT Health to talk a bit more about workforce.

Ms Rea: By way of general context, when we are looking at the mental health workforce, we do that in the context of the territory-wide service planning that we are doing. There is a piece of work to look forward to what all of the health needs will be in the territory. As part of that we can then plan our clinical services and our workforce. Within that we will look at what is needed for mental health. It is important to put it in the context of this fitting within a much broader exercise that is underway to plan for the territory. I might see whether Elizabeth or Michael want to talk specifically about the mental health workforce.

Dr Moore: The mental health workforce will be a focus of the office over the next year. As the minister said, we need to look at it in the context across non-government, community clinical and clinical inpatient services; again, within the context of the territory-wide services plan—those processes and those services that we expect to come forward.

We have had one meeting where we have scoped where we would like to go with this piece of work. Of course, it also sits within the national mental health workforce strategy that is currently underway. It is a complex piece of work, because there has to be the scope of different areas of practice. Peer workforce is something that particularly the office and Mental Health, Justice Health and Alcohol and Drug Services is looking at. I will hand over to colleagues to give the CHS perspective.

Ms Lopa: We have done a lot of work in the workforce development space. The way that we work through it is attraction, retention and development. We look at all of those different facets when we are looking at our workforce planning.

By way of attraction, particularly in line with the opening of the 12B inpatient unit, but also to address other workforce attraction strategies, earlier this year we conducted a workforce campaign. You might have seen some videos on either the CHS Facebook site or LinkedIn page that were promoting that. That was attributed to a LinkedIn campaign that saw a huge amount of traffic headed to our recruitment adverts. We have been quite successful in attracting a number of new members to the team through that process. We continue to support recruitment activities.

With respect to some of the things that we are really proud of in terms of the local development of our team, about a year ago we implemented a future clinical leaders program, which was a program to support junior mental health nurses to become more senior mental health nurses. It was a program that we conducted in pilot, in conjunction with the chief nurse's office. We identified a number of candidates. They received supernumerary days with more senior staff, and regular training days as well. Those individuals are starting to graduate out of that pilot program now, and have been successfully appointed to more senior roles. That is something that we are looking to expand in future years.

Another really exciting thing around the 12B expansion was certainly the capacity to start to recruit not just peer workers but also carer workers, which are part of the model of care for 12B, which is really important in terms of meeting the holistic needs of our consumers. I might give Denise the opportunity to talk to any psychiatry-specific campaigns that we have been involved in recently.

Dr Riordan: In relation to the medical workforce within CHS for psychiatry, we held a successful recruitment stand at the royal college congress in Tasmania, where we had a number of staff and we were able to speak with representatives and people attending that conference. That has certainly generated some interest. Just within the last week, we have had a registrar from Tasmania approach us, wanting to move to our training scheme.

We have had recent advertisements for psychiatry, and from each of those interviews we have appointed people to our service, including homegrown, if you like, or locally trained psychiatrists, as well as psychiatrists coming from interstate.

We have also diversified the career pathway for our psychiatrists. We do have some psychiatrists in training who, for a variety of reasons, might not complete the whole of the college training program but who are very good clinicians and who need to take a kind of alternative pathway for a while.

We have increased the number of clinical medical officers within our workforce, which allows us to have that more consistent, stable workforce. Offering people a variety of different career paths is also very important in terms of both attracting and retaining our staff.

We have been keen—following on from what Kat was saying—to develop future leaders. We have also been looking within the psychiatry workforce at how we help staff develop to the next stage of leadership and management across the medical workforce. We have appointed two assistant directors, and we have an ad out for a third—people moving from that staff specialist, senior staff specialist, to a clinical director role. That is obviously very important for the ongoing development of our workforce. That is quite a big leap for a lot of people, so we have implemented a stepping stone towards that, where we are offering people much more support.

One of the other things we are very committed to is our psychiatry training scheme. For a lot of the registrars on our program, as has been the case nationally, people have been to some extent hindered in their training because exams were cancelled last year. It is something we have contributed to very significantly here in Canberra. In the first instance, when the national providers pulled out of hosting one of the critical exams, we worked very collaboratively within Canberra Health Services to make sure that all of those people locally were able to sit that exam; we hosted it, according to the college guidelines, in-house.

Other things that have been delayed for a number of people are some of the clinical OSCE-type exams. Again we have certainly contributed to that by encouraging and being very pleased by the number of our own psychiatrists who stepped forward to work as examiners so that we can continue to progress the training of our registrars. That is very important because we have a number of registrars who were towards the end of their training, really getting ready to make that next step, but were held up because of some of those delays.

Very specifically, for people who know me, I wear a child and adolescent psychiatry hat as well, so I always have to mention child and adolescent mental health at some point. Child and adolescent mental health services within mental health services are

particularly difficult to recruit to. We have had unfilled consultant places, but at the same time we have a number of registrars who have been interested in doing advanced training in that specialty. We are looking to create more advanced training positions for child and adolescent mental health so that we can contribute to our workforce in that way.

MRS JONES: I have a quick question on exactly the same line. Are conversations going on about the number of places being offered in Canberra at universities with the universities themselves? I know that with some of our mental health workforce we rely on graduates here. Do those conversations include discussion of whether there are sufficient clinical placements for people, and how we can assist with that?

Ms Davidson: Conversations go on with the universities in Canberra about workforce planning and where they fit into it. They have been really engaged with us and really keen to work with us on how we can progress this work. I will hand over to ACT Health to talk a little bit more about what has been happening.

Ms Rea: At a high level there is an ACT Health and Wellbeing Partnership Board, which has the ANU and UC on it, as well as CHS, Calvary, Capital Health Network, the Health Directorate and Health Care Consumers. They are looking at how we can work in partnership to improve the ACT health system.

One of its working groups is specifically looking at workforce education and training and what the workforce needs are across the ACT, taking into account our territory-wide service planning and those other things that I mentioned. ANU and UC are actively engaged with that at a very high level. We also work very closely with them at a more operational level. I do not know whether CHS wants to go to the specifics.

MRS JONES: Can I give one small example—I am sure there is lots of work going on—where we might not be getting quite the right outcome? For example, I found out this year that, with occupational therapists, we are only putting out 15 or so a year from UC, and they are a critical workforce shortage for NDIS. They assist greatly in lots of mental health situations because they help people to work out how to live with their conditions. The information that I had from UC was that the maximisation of numbers in that course was around the fact that they could not get enough clinical placements for people. Whatever discussions are going on, the outcomes on the ground are not quite as good as they could be. Is there some work that can be done to touch base with the people lecturing, about what is wrong?

Mr Peffer: There is a lot of collaborative partnership work that occurs between the health service and the universities. But when you make these decisions you have to ensure that you are providing a really rich learning environment for any of the placements. If you start to spread those placements very thin, the opportunities that people have to learn, go on their learning journey through university and set themselves up for a great career start to be impacted.

MRS JONES: Do you think that we are already at our maximum capacity for placements like OT in Canberra?

Mr Peffer: I cannot comment for the broader system. I can comment for one of the health service providers within the system. There is a considerable resource that you devote to being a learning health system and training people—

MRS JONES: Absolutely.

Mr Peffer: to complement what they are doing through university. I am not sure that you could run an uncapped course, or even scale it dramatically, without impacting the numbers that you have now and their experience—

MRS JONES: But what about scaling a little bit? What about an extra—

THE CHAIR: Mrs Jones, you have the next substantive question, so let us try not to take too many liberties on the supplementaries. I will let Mr Peffer finish.

Mr Peffer: These are discussions that we have each and every year with the universities that are placed here in the territory. We were very grateful for the partnerships. But there is a limit, a constraint, that we have to place on how much we can invest while creating the right and safe learning environment for—

MRS JONES: So you would say we have done enough?

Mr Peffer: I would say that each year we revisit the issue and we do everything we can to provide the right learning environment for as many people as we can.

MRS JONES: Minister, we have a couple of key roles in mental health. One is the mental health coordinator and the other is the Chief Psychiatrist. Can you please explain the difference between those roles and who has overarching responsibility for feeding back improvements that are needed to the system?

Ms Davidson: Both people who are in those respective roles have been giving some really excellent, valuable advice to my office about both what we are seeing in the system at the moment and where we might want to be headed in the future. I might hand over to Dr Elizabeth Moore to start with a bit more detail about the coordinator-general role.

Dr Moore: The Coordinator-General for the Office for Mental Health and Wellbeing has a lead role in looking at system architecture, improvements in the system, and looking at the whole of system. That means actually ensuring that there is a mental health wellbeing lens across government. This has been helped enormously by the ACT government adopting a wellbeing framework.

Particularly, our first work plan looked at mentally healthy community and workplaces, and suicide prevention as a multi-strategy process; then supporting people through their mental health journey, and that is supporting people and their carers. That may be family and carers separately.

The other thing was around system capacity and workforce. All of it was underpinned by research, quality improvement and evaluation. We have a collaborative set of committees with the Chief Psychiatrist, with the non-government sector and, of course,

with our clinical colleagues.

MRS JONES: Can you take on notice exactly what those committees are that both the Chief Psychiatrist and the mental health coordinators sit on—either/or—so that I can get my head around how this system works inside the bureaucracy?

Dr Moore: Yes.

MRS JONES: Minister, the Chief Psychiatrist, in answer to a question on notice, has not provided you with any official reports or recommendations, according to that question on notice. That is one of the reasons that I started to home in on it. You said that they have been quite helpful to your office; what is the nature of that assistance? Is that just conversations? Is it not the job of these two senior mental health advisers to try and help with problems in the system?

Ms Davidson: They have two quite different roles. The kinds of conversations that I might have with the Chief Psychiatrist might go to clinical care situations or how we are ensuring that a particular facility is meeting its needs. The conversations that I might have with the Office for Mental Health and Wellbeing might be more about how social determinants are impacting on mental health and wellbeing outcomes, and where we might need to plan for systemic change.

MRS JONES: Is it the Chief Psychiatrist who basically feeds back to you about those acute mental health settings and whether they are fulfilling the requirements there?

Ms Davidson: If I wanted some advice, for example, about whether a mental health facility was suitable for a particular purpose, I might ask the Chief Psychiatrist for his views on that.

MRS JONES: If they are fulfilling their required roles, is that him or is that the coordinator?

Ms Davidson: Are you talking about a mental health facility that already exists?

MRS JONES: Yes.

Ms Davidson: Yes, I would probably talk first to the Chief Psychiatrist about that.

MRS JONES: In the answer to that question on notice, where it says that the Chief Psychiatrist has not proactively provided recommendations or reports to you in two years, is that because that is being done verbally? It seemed quite stark to me that there had not been any in two years.

Ms Davidson: I have had a number of conversations with the Chief Psychiatrist where I have asked for some advice about specific issues. That is not necessarily the same thing as asking the Chief Psychiatrist to provide, say, an overarching report on a system. On that kind of thing I would go to the Office for Mental Health and Wellbeing to seek advice.

MRS JONES: The roles cross over; is that what you are saying?

Ms Davidson: Yes. It is really important, though, that they are two separate roles because the Office for Mental Health and Wellbeing are able to work proactively across different directorates. If we are going to address mental health and wellbeing across our system, we need to be thinking about the social determinants that come into play and how different things interact. I refer, for example, to education—

MRS JONES: Yes, I see; so it is broader. If there are carers, consumers or family of people who have either suffered and passed away or are currently suffering, and there is a belief that the system is not working, who do they go to? Is there an official complaints process? The feedback I am getting is that people do not see change in the system when they need to. What occurs to me is that, if I was running a shop and the product was not satisfying the customers, I would want that feedback. What is the official mechanism to get those changes made when people realise there are flaws in the system?

Ms Davidson: I am pretty sure we have been through the official processes with your office previously, but we can send you another list of how people can go through the official process, depending on which service they are being—

MRS JONES: Does that process sit under the Chief Psychiatrist or under the mental health coordinator, or is it something that works directly with your office only?

Ms Davidson: If you are talking about someone who has had an experience with a service that has been less than satisfactory, each service will have a complaints management process.

MRS JONES: But what about the service as a whole?

THE CHAIR: Mrs Jones, that is the final supplementary.

MRS JONES: It is a very important question.

THE CHAIR: It is, but there are a few very important questions in a row. We will ask the minister to finish answering this question; then we will move on to another substantive.

Ms Davidson: In the first instance, you would want to identify the service that they had the experience with.

MRS JONES: Numerous services, often, across the board, so who is responsible for getting the problems resolved when there are issues across various systems within mental health in the ACT?

Ms Davidson: You are very welcome to forward those individual constituent—

MRS JONES: So there is no complaints process for the system as a whole; is that what you are saying?

Ms Davidson: There are processes—

MRS JONES: Individualised, per service.

Ms Davidson: We would be going through each of those complaints to make sure that each of them is addressed individually, so that—

MRS JONES: They are not being addressed. That is the reason people are coming to me. I am giving you the opportunity to paint us a picture of how they—

Ms Davidson: I suggest that you forward them on to my office so that we can follow them up.

MRS JONES: Some of these people have been well and truly through your office, Minister Davidson.

THE CHAIR: I will draw the line, Mrs Jones, because there were a fair few supplementaries there. I have a substantive. I want to ask particularly about the Winnunga Nimmityjah Aboriginal Health and Community Services at the AMC. I noticed in the budget a funding allocation of $2,314,000 for the 2021-22 year, but I have noticed nothing budgeted for the forward years. I wanted some clarification of whether that is additional COVID-related funding in this particular budget. What is going on there?

Ms Davidson: Thanks for the question. There are two things for which you may have seen line items recently. One is in the budget and the other one is additional funding that was provided to Winnunga during the COVID lockdown for mental health and wellbeing support for people in the AMC. In the budget we have provided additional funding for nurses and a psychologist for Winnunga, in delivering services in the AMC. I will pass over to ACT Health to talk a bit more about what that funding will do.

Ms Rea: My recollection from the budget process is that we had put in a year of funding and we were going to do some further work with AMC on the particular model of care then come back for additional funding once the model of care had been sorted out. I think it was largely run by Meg Brighton, who finished up on Friday. I am not sure if there is anyone who can give more detail on that at the moment. Could we take that on notice and get back to you?

THE CHAIR: Yes, that would be absolutely fine.

MR MILLIGAN: You mentioned additional funding going to Winnunga. Part of that additional funding is enabling Winnunga to see more detainees that come through, or that are referred to them. How long does it take for a detainee, after completing the paperwork, to begin the service?

Ms Davidson: When someone comes into the AMC, they have the choice of whether they want to receive their health care from justice health or Winnunga. They can change their mind about that at any time. They might start receiving care from one service and then decide to change to the other. That is something that they can do.

With respect to the additional funding that is being provided to Winnunga, for example, the additional funding that was provided in the mental health package was to enable more mental wellbeing checks to happen with people who are in the AMC during lockdown—understanding that tensions might increase and people might be struggling a little bit more than they would otherwise. I will hand over to CHS to talk about the process for how someone transfers their care to Winnunga.

Ms Rea: From January 2019 to 27 September 2021, 90 clients have had their health transferred to Winnunga. As the minister has advised, that is a continuum as well. People often change their mind in terms of where they want to receive their service. Our primary health service team will re-ask the question later in someone's journey, if they would like to be transferred at a later date.

Currently, 21 clients are being received by Winnunga. That is either a combination of Winnunga owning the care or sometimes there is a shared care model between Winnunga and justice health, depending on the type of health services Winnunga are able to provide, and the acute services that are available at AMC as well.

That is basically a referral process between our services. There are an additional 20 clients, or a bit over that, waiting to receive the acceptance of their referral to Winnunga at the moment. I do not have a specific time frame for Winnunga's methods and their triage times. We work really collaboratively with the team on the ground, and the teams have a great relationship in terms of transferring care between services.

Ms Davidson: One of the things that is really great about the way Winnunga provides services is that the staff who provide services in the AMC also work in Winnunga's clinic in Narrabundah. That means that when someone has come out of AMC and they are back in the community, they can still access the same services from the same healthcare providers, and have that continuity. That is really important for a lot of people, particularly if they have complex healthcare needs. We know that there are a lot of people in the AMC who have underlying health conditions or disability.

THE CHAIR: Mr Pettersson, there are two minutes left. Do you happen to have a quick yes or no question for the minister and her team?

MR PETTERSSON: I am happy to defer to Mrs Jones; I can sense her enthusiasm.

MRS JONES: Thank you, Mr Pettersson. The restrictions on visits in the mental health facilities after the last lockdown took months to be made the same as the rest of the community, regarding access to their loved ones. What is the plan with the easing of restrictions this time and returning to allowing visitors to the mental health facilities that we have?

Ms Davidson: Is there a particular mental health facility that you are asking about? Are you asking about AMHU?

MRS JONES: I would not mind information about each of the secure facilities—AMHU, SMHU, the facility out at Calvary, the one at UC, and the inpatient hospital units. If you have to take it on notice, that is fine. I have been asked by patients when

their loved ones will be able to visit them again. They are afraid that, as happened after the lockdown last year, it could lag by months behind the rest of the community.

Ms Davidson: We are going to have to be very flexible in how we manage the situation, going forward. We are dealing with a virus that is still new, and working out what is the best way to manage that will change from time to time, based on what we see happen clinically.

MRS JONES: Of course.

Ms Davidson: I will hand over to CHS to talk about the process.

Mr Peffer: In terms of the process, we go through the clinical health emergency coordination centre. We have ongoing discussions about visitor restrictions and the settings we should have in place. We recognise the impact that has on individuals, on our patients, their loved ones and their families. These are never simple decisions to take; they have to be risk assessed.

We have expert infectious disease and infection prevention control advice coming into that committee to guide the decision-making. What we have dealt with over the last couple of months is a series of exposures. On a number of occasions it has involved visitors coming into a hospital and bringing in that virus. When we are dealing with that situation in some of these sensitive areas within the hospital, where transmission cannot be as easily controlled as you would have in a designated COVID ward, say, or in parts of the emergency department, it does make it challenging.

MRS JONES: To put it very simply then, when we have visitor restrictions lifted for the rest of the hospital, is that the same time when it is expected that visitor restrictions will be lifted, for example, for our locked facilities, where people cannot just wander in and out but they would like to see their loved ones? Are they expected to be in line with each other?

Mr Peffer: The short answer is yes. However, the caveat is that, as the minister has said, it will be an ongoing review situation. That could change very quickly if we were to have an exposure event and we needed to lock down a facility.

MRS JONES: Of course.

THE CHAIR: I will draw a line under it there. Thank you, Mrs Jones. On behalf of the committee, I would like to thank the minister and all officials who have appeared at today's hearing. If witnesses have taken any questions on notice—and there have been a few—could you please get those answers to the committee secretary within five working days of receipt of the proof transcript. If members wish to lodge any questions on notice, please get those to the committee secretary within five working days of today's hearing. The committee hearing is now adjourned.

The committee adjourned at 1.31 pm.