Submission
No 14

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

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Date Received:	8 August 2023

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https://www.parliament.nsw.gov.au/lcdocs/other/18316/Media%20release%20-%20Mental%20health%20care%20in%20New%20South%20Wales.pdf

https://www.parliament.nsw.gov.au/lcdocs/inquiries/2973/Terms%20of%20reference.pdf

NEW INQUIRY INTO THE EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE in NSW

Dear Committee Members

Just a brief history of my knowledge of mental health services. I trained as a Psychiatric Nurse in the 70's and worked in Drug and Alcohol and Community Mental Health. I left the public sector in the 90's and in 2015 returned. I am currently working in Community Mental Health. I would like to thank you in advance for finally getting an opportunity to vent my feelings about the collapse of our Community Mental Health Care as it is clear the current models of care are not consistent across the state, disintegrated and certainly not consumer focus or easily accessible.

(A) Equity of access to outpatient mental health services.

Community mental health services have always focused on the 'severely mentally ill', (eg) those with severe bi-polar disorder, schizophrenia and drug induced psychosis, yet people's mental health is a continuum. We have evidence of increased presentations of people attending ED severely distressed being labelled 'Personality Disorder' or when we are nice we call them 'Vulnerable Personalities'. These people are expected to access private service which are often not available or too expensive. We have failed to keep up with the ever-changing stress caused by addiction to devices, increase substance use, the bullying by social media and the increase in suicide and distress caused by a rapidly changing society. Failure to do this has seen maladaptive strategies such as suicide attempts, depression, increase use of drugs and alcohol and prescription medications and increase demand on hospital services. Our outpatient solution is ‘see your GP’ yet - we know that GP’s don’t have the capacity/expertise to deal with this influx.

(B) Navigation of outpatient and community mental health services from the perspectives of patients and carers.

Not answered.

(C) Capacity of State and other community mental health services, including in rural, regional and remote New South Wales.

Beginning with the Richmond Report the deinstitutionalization became the focus of mental health care – it was a great idea but taken by the government of the day and all those since as a cost effective way of dealing with mental illness. These reports are based on great principles, however, these report and others failed to deliver the ideal outcomes because the focus was financial - not care. Institutions were closed despite the fact most would agree there is a real need for long term rehab centres for mental health and drug and alcohol. There is no doubt that many consumers are worst off in group homes having to deal with untrained staff, yet out of sight out of mind allows governments to absolve themselves of responsible for our most vulnerable citizens.

State governments have the capacity to regrade how Community Mental Health Services are funded to ensure it is a specialist service. This would improve access to services outside Monday to Friday 9-5. We know staff recruitment and retention is difficult especially for nurses who find it impossible to survive on basic income while other nurses who work in institutions receive penalty rates, yet the risk and skill required to work in Community Mental Health is far superior (but not recognized) to their colleagues who are making sometimes twice the amount per annum Community Mental Health staff.

(D) Integration between physical and mental health services, and between mental health services and providers.

My comments are aimed at looking after people with a severe mental illness. It's time we get a hold on this whole belief that we have to 'normalise' people with mental illness and they should access the 'general services'. This concept for people with a severe mental illness is severely flawed and those who suggest it will work has unlikely worked in the system or has some academic/philosophical ideation that refuses to allow them to look outside the square and consider other options for the small per centage of consumers who will or cannot fit into their idealism. Surely we have a duty of care to be more diligent in caring for the MOST disadvantaged rather than letting them die early from preventable disease that goes undiagnosed. We are caring for a very specialised group who:

- Have severe mental illness and are often disorganized and do not visit GP's.
- GP's generally are untrained in dealing with mental illness as well as their reception staff.
- GP's do not follow-up clients who do not keep their appointments. There are many reasons clients do not attend such as they have forgotten or overslept or simply decided to do it another day.
- Most GP's charge and the client group we see cannot afford the fee.
- Despite the fact we know consumers with mental illness die 10-25 yrs younger according to WHO and I would imagine this is higher for First Nations people with a mental illness, we persist on spending millions of dollars on GP integration programs that has been a miserable failure for GP's and this client group. It's a myth that GP's can deal with every condition and unfair on many consumers to push this view.
- Fail to get the basic screenings for such things as breast cancer, prostate cancer and bowel cancers.

We can do better – just as many physical health conditions have pathways into the health care system so can community mental health. We could have senior medical registrars rotate through our Community Mental Health Centres who will provide screening and facilitate entry into hospitals for prevention screening such as colonoscopies. We often make people physically unwell with the use of our medications but we rarely do anything about this.

We have consumers who despite being forced to take medications, there is no improvement in their condition. The only real effect of these injections is to shorten their lifespan because they cause metabolic syndrome (weight gain, diabetes, heart disease), men suffer impotence/decrease libido, women have decreased libido and interference with their menstrual cycle and as told to me by consumers, ‘feeling dead inside, with the only way to feel good is to use drugs’ (often ICE).

We have multidisciplinary teams that take referrals and make recommendations that go no where because there is no GP to follow up these recommendations. It seems writing ‘GP Follow-Up” absolves them of any future involvement. In my view if a team identifies an issue it is their responsibility to see it these recommendations are completed.

We spend millions on recommending preventative and wellness programs but won’t pay for them because ‘consumers need to be normalised’ so should have to pay for the programs. People making these assertations are well paid health professionals – often without much life experience and certainly by this comment, never had to live on a pension. We give out free needle exchange and condoms ‘as harm minimisation’ but we won’t pay for free fitness programs which is a necessary tool to assist with the harm we cause with **our** treatments. Why doesn’t area health services work with local councils and other facilities to provide free access or provide free passes to those

who want to get fitter? Heaven forbid, the multinational pharmaceutical companies should contribute towards the cost of trying to reduce the effects caused by their medicine (which by the way cost the government for one injection hundreds of dollars and the newer ones over a thousand)?
From experience many consumers are disadvantaged with access to OPD services. Some consumers are unable to wait long periods to see a doctor especially if they are acutely unwell and agitated. This happens not only in OPD but in ED as well. They walk out but staff don't care, the attitude being they should conform, just another example how health workers are just as ignorant as the general population.

NDIS providers are not responsible to Community Mental Health facilities when clients are referred to them. These providers receive millions of dollars yet the service they provide is often having coffee for 2 hrs a couple of times a week. The staff are usually untrained and do not speak English. Services have little control over what these providers do and how they do it in terms of measuring their outcomes. To change providers is time consuming and difficult due to the client group.

(E) Appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, councillors, social workers, allied health professionals and peer workers.

This is one area that needs a lot of attention and has the potential to save millions. Who ever thought it was a good idea to separate services, for example to get to have access to have a drug and alcohol service the consumer has to call – as a case manager you can't do this, the consumer will often get a voice mail or have to call back and if they are lucky enough to get an appointment, they will have to wait a few weeks. There is no integration of services and at every point the consumer is judged. Long term accommodation for enforced drug rehab is extremely limited as is for chronic mentally ill who are a risk to society or themselves – these individuals often end up in the legal system. I was always taught that crisis was often an opportunity for change. Someone has decided to detox, the last thing they need is to be faced with a process that requires them to be logical and organized, yet again, we have set up services to meet the need of the staff/organization not the consumer.

We have assertive outreach teams servicing small numbers of people with many of the NDIS services taking off their role. Many of the clients who live in supervised accommodation are clients of Community Mental Health Services and make up for large numbers of the case load. One could say those clients may well be overserviced. These were important services several years ago but funding models have changed and those interventions need review.

All staff will tell you the outcome measures (statistics) required and considered a part of funding is useless. Most people do not do them and if they do they are likely to be inaccurate. The measurements do not seem to have any effect on consumer outcomes or funding for services. Some of the measurements do not attract funding yet people's time are wasted completing them. Its time to challenge those game playing techniques that are so flawed it is laughable.

Case loads are based on numbers not acuity – you can have a psychologist having a case load of 30 compliant consumers and seeing these clients every two – three or four weeks and then you can have a nurse with the same number but will need to do several home visits to give medications or chase up consumers for appointments some several times a week. This has been an ongoing issue for years which seemingly is put in the too hard basket.

Lack of Psychiatrist especially in some of the Western Sydney and Rural areas means a lack of access to treatments to prevent hospitalisations. Nurse Practioners need to be increased to managed this situation. Unlike physical health where a doctor may need to touch a patient, mental health lends itself well to virtual interventions. Why don’t we have a registrar from larger teaching hospitals attached to allocated regions as happens with other specialities such as paediatrics.

(F) The use of Community Treatment Orders under the Mental Health Act 2007

In my view this has been one of the most restrictive practices ever added to any ‘treatment’ approach. Prior to this change to the Mental Health Act 2007, patients were managed in the community and when they became significantly unwell would be Scheduled under the MHA – not controlled by the Act.

Once this Act became law we suddenly had doctors and Tribunal Members responsible for the ongoing control of peoples lives. Most people with chronic illness have continuous orders made – usually for 6 months. These orders put responsibility on staff to ensure consumers are forced to have medication and if they refuse, they are forcibly taken by police to an admission centre where they can be restrained and injected with medication (they may not even be psychotic, merely disobeying an order). Often times doctors are frightened of not having an order continued because consumers will say they won’t take their medications and they are worried about the consequences. Tribunal members are also there it seems ‘to keep people on treatment”, despite in many cases these treatments not working. We have set up a system that is now having health care being controlled by a legal framework. Doctors are not going to take the chance of being accused of negligence if a consumer harms themselves or someone else, therefore, most doctors will apply for a CTO. Reports highlights risk and The Tribunal will almost always concur with the doctor. I know consumers – indeed most – who won’t bother going to their hearing as they know the outcome, they are disenfranchised, they have no representation and even if they have on the rare occasion have legal aid these lawyers arrive on the day and have little understanding of the issues.

This is not only a health/legal issue it is also a human rights issue. We chemically restrain people against their will for years on end, yet we justify this as if we are some deity protecting society from these ‘mad individuals’. The abuse of CTO’s is supported by the research mentioned below.

We tell consumers they can appeal the Tribunal’s decision but unless they are well off and can afford a complicated process this does not happen. Indeed the whole process is there to take advantage of disadvantaged groups.

I have no doubt there are some exceptional circumstances where a CTO is effective but they are not only overused, in my view they are abused because of the fear and legalization of Mental Illness Services rather than being used as a last resort for treatment. Maybe its time that it does become a legal decision, made by a proper court, having proper legal representation with evidence based reasons to inflict such a restraint on individuals.

Research as shown CTO’s are ineffective, for example this study - https://www.ncbi.nlm.nih.gov/books/NBK554235/ concluded

The Conclusion from this study and others is “Community treatment order use varied between patients, provider trusts and local areas. ***Community treatment order use was not associated with shorter time to re-admission or reduced time in hospital to a statistically significant degree. We found no evidence that the effectiveness of community treatment orders varied to a significant degree between provider trusts, nor that community treatment orders were associated with reduced mental health treatment costs.*** Our findings support the view that community treatment orders in England are not effective in reducing future admissions or time spent in hospital. We provide preliminary evidence of an association between community treatment order use and reduced rate of death”.

Indeed even if reduced mortality we would have to ask ourselves if that outweighed the total removal of consumers rights to make choices.

One also has to ask why is being mentally ill a requirement for forced treatment. Other conditions such as gambling generally doesn’t incur forced medication or monitoring, this can have devastating effects on a persons mental health as well as those around them. Diabetics who end up in hospital in a coma due to not adhering to their medication isn’t subjected to forced monitoring yet the consequences are similar – hospitalisations, decline in physical health.

Out of interest it would be good to compare each Community Mental Health Centre to see the number of CTO’s – my guess it will be significantly different – WHY?

(G) Benefits and Risk of Online and Telehealth Services.

This has a potential for decreasing admissions and waiting times in ED. Having online contact with a psychiatrist or online Registrar on call would assist with assessment and treatment.

(H) Accessibility and Cultural Safety of Mental Health Services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability.

Not addressed.

(I) Alternatives to Police for Emergency Responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER).

This is a good imitative but comes with some restrictions. Many years ago when I worked overseas – if the police were needed to assist with a mental health issue they would arrive in unmarked cars and NOT in police uniforms. They would also have some training regarding mental illness. I feel not only does it cause stigma to the person to see a police car and uniformed police outside their home but it also has the potential to inflame the situation because as soon as authority is seen sometimes aggression is raised with people wanting to take the police on - also many the people listed in H would fall into this category, especially First Nations people, LGBTQUIA+ and some cultures where police brutality was a part of their life.

J – OTHER MATTERS.

This may be a sensitive issue but unfortunately it needs to be addressed. We have staff providing mental health services that cannot speak English or can't conceptualize consumers expression of needs. Indeed I have spoken with staff making referrals and had no idea what they were talking about. I know of consumers who have had Code Blacks called because they were frustrated with staff not understanding their request, they became more agitated and staff became more fearful – result – consumer is judged to be aggressive, medicated and may be put in isolation.

The other issue is the lack of education at a training level regarding even the basic understanding of the major mental illness. Most nursing courses and indeed allied health may only skim this topic and staff may never work in a mental health facility, yet they are employed to deal with situations most people could not handle – often because they don't understand what is going on. No one would be asked to work in ICU if they have not been trained but it seems people with a mental illness are not only treated as second class citizens in society but by our own health facilities.

We need to re-consider our treatment approach to Drug induced psychosis and Schizophrenia. While many are treated initially with the same medications it does seem that those with drug induced psychosis have different long term outcomes in particular with cognitive decline. There seems little training for staff to deal with those differences.

Many more Forensic Consumers are being released in the community. Training is virtually non existent for staff to deal with those consumers. Many of these consumers have committed serious brutal crimes and in the past they were in institutions with security guards, now staff often see them alone. There does not seem to be any strict protocols in place to manage this situation and reduce the risk to staff and the public.

There was a time when living skills, social groups and outings were a part of the service. Many would say NDIS will fill that role but ask any clinician and you will find this expensive service provides very little if any positive intervention, except take people to appointments or outings.

More support housing and in particular places such Supported Independent Living be more integrated with CMHC's.

Rotation of medical registers to community MH facilities to indoctrinate them into MH issues.

I spoke with several consumers regarding what they see that needs to change in the system. Several actually spoke about the refusal of access to smoking when they were admitted and the increase in agitation this created. They recognized that this also increased the anxiety in staff and often resulted in them being chemically restrained for the use of a legal substance that staff could have access to during their working hours but they could not.

Control seemed to come in many ways, for example a $20.00 Coles card was given to them for participating in a survey. The restrictions were that no alcohol or cigarettes could be purchased. They could however buy coke, chocolate or other unhealthy goods or indeed sell it for $15.00 so the cash could be used towards drugs or whatever they pleased. The mere thought of putting those restrictions on adults is not only insulting but indicative of our perceived ‘right’ to make decisions for them. It also reflects on a systemic attitude towards people with a mental illness. I recently participated in a research project that offered a supermarket gift card but it came without restrictions.

A colleague interestingly noted that not once during his request for CTO’s did the tribunal ask ‘Is this person a risk to society and if so what is your evidence”? Often we are good at words that infer risk then actually proving risk.

Financial Management.

Teams need training in financial management and given a budget based on their services and performance. There doesn’t seem to be any incentive for managers to do better or for staff to try new initiatives. There are virtually no rewards for individual teams to outperform other teams so its stifling ideas or competition. The system still manipulates the dollars which means high profile medicine gets priority over funds. Teams are told to complete their stats because we have activity based funding yet teams who seemingly do well in providing these stats (accuracy is questionable) still don’t get more funding.

ED Admissions:

It is completely unacceptable for psychotic patients to be taken to ED unless there is a life threatening medical condition. These patients are often very disruptive to other patients, they need security and specialling, they become more agitated and restrained or medicated unnecessarily, staff are not trained in dealing with their presentation and have a focus on medical emergencies. Why are these patients not admitted to an acute psychiatric ED with mental health staff caring for them? Should there be a medical issue then have one of the ED doctors allocated to treat them in the acute facility. Millions of dollars are spent annually on one-on-one patients who are not confined and indeed sometimes abscond.

Recommendations to be included in a new model of care:

- More training of GP's in Mental Health Issues.
- Revision of Mental Health Act to restrict use of CTO.
- More Nurse Practioners.
- Integrated mental health and drug and alcohol services. This would improve referrals, co-management and reduce the number of managers/admin staff. Smaller teams with clinician's can be absorbed into the larger teams giving greater cover and expertise. This would also increase the numbers of nurses for teams.
- Training in MH for all new staff including RN's and allied health.
- Rotation of Medical Registrars to Community Health Centres to monitor and refer people to hospital clinics who have no GP or the capacity to make and keep appointments.
- Implement programs to increase wellness without cost to consumers.
- Any system set up to monitor physical outcomes must also include mechanism to follow through with recommendations.
- Peer workers to actually have had a lived experience and has had a stated period of recovery. The lived experience should include having been in hospital with a mental illness.
- Review of outcome measures, any measurement not used to provide actual funding or improve consumer outcomes should be abolished.
- Review of caseloads to represent acuity.
- Review of how ED presentations are managed.
- Retention of staff especially nurses need extended hours as a part of integrating services. This will reduce costs by reducing management and senior nurses working

weekends and public holidays to supervise medication and other tasks that do not require their skill level.

I may submit further information as I speak with consumers regarding this topic.

Again thank you for allowing me to express my concerns. I came back to Mental Health as it has always been my passion especially those people with severe illness. You will not only have to address the many flaws in the system but more challenging will be having a government on side that will force some very powerful, influential people with their own vested interest in the system who speak the rhetoric but do their own thing. I am hopeful there will be a state wide model that gives all of our citizens some hope in getting care but more specifically and importantly is that you restore the rights we have taken away from our most vulnerable while still protecting those in need.