Submission No 21

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

Name: Name suppressed

Date Received: 23 August 2023

Submission to inquiry relating to equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.

Dear committee members,

I am a senior social worker employed full-time in an adult community mental health team in Sydney. I have previously worked in a similar capacity in Wellington, New Zealand, and have also been a student in adult community mental health services in Melbourne, Victoria. All views expressed here are my own and do not necessarily reflect those of NSW Health.

Placing someone under the Mental Health Act (MHA) in New Zealand (NZ) differs to its equivalent legislation in New South Wales (NSW). Firstly, detention on certificate or 'scheduling' a person with a mental illness or a mentally disordered person requires a senior registered nurse or medical officer to confirm that a person requires an assessment (Section 8B of the MHA NZ). This request for an assessment is then reviewed by a Duly Authorised Officer (DAO) to ensure that the legal requirements of the Act are followed (Section 9 of the MHA NZ). The person must then be assessed by a different medical officer (Section 10 of the MHA NZ) (cannot be the same medical officer who completed Section 8B), who can then issue an order for inpatient treatment of no more than five days (Section 11 of the MHA NZ). The MHA NSW allows for a medical practitioner or accredited person to detain someone, and request police assistance to do so, and have them brought to a mental health facility (Section 19 of the MHA NSW). Whilst the MHA NSW allows for expediency in the process of treating someone who is deemed to be mentally ill or mentally disordered, it gives the clinician involved in the scheduling significant power and limited oversight. I believe the MHA NZ tempers this power by adding checks and balances in the form of a second clinician assessing the need for the MHA in treating the person, as well as the DAO ensuring compliance with legal statutes. I have personally seen the scheduling process cease at Section 10 of the MHA NZ when the medical officer's opinion differed to that of the clinician who completed Section 8B of the Act. With a single clinician, as in the NSW process of scheduling, additional checks do not take place, thus running the risk of clinical and legal errors and misjudgements. I therefore encourage the consideration of additional checks in the process of scheduling someone under the MHA NSW.

The second point I'd like to raise relates to treatment orders. Under the MHA NZ, all hearings relating to the making of an inpatient or community treatment order occurs in the Family Court of NZ. Whilst this put a significant burden on the court, a role that would better be suited to a tribunal, it does afford the legal process of representation. By this I mean the proposed subject of an order must: firstly, be present at the hearing for an order to be made; and secondly, they must have legal representation, unless they wish to represent themselves. Neither of these are requirements under proceedings relating to treatment orders in NSW. As a result, a person can be made the subject of a treatment order, typically a Community Treatment Order (CTO), in absentia in NSW. Additionally, whilst a person is entitled to be represented through Legal Aid, this is limited to one hearing. If an application is made to renew a CTO, the person is not entitled to legal representation through Legal Aid if they have previously been represented by Legal Aid. Lacking legal representation at a Mental Health Review Tribunal (MHRT) hearing for someone potentially being made the subject of a treatment order is a gross imbalance of power. By definition, the order is being sought due to the proposed subject lacking the capacity or insight to make decisions about their own healthcare; whilst they may have a support person with them, this support person may not have the same professional qualifications or experience as that of the mental health service or Tribunal members, thus further compounding the imbalance in power. I therefore implore the committee to consider extending access to legal representation for those who are being proposed as subjects of treatment orders, or who are already subject to treatment orders, where they are appealing their CTO or their CTO is being renewed. This would also have the effect of mitigating decisions made in absentia as the person's legal representative would be present at the hearing.

Further to the above point, a report is completed by the applicant of a CTO, which is submitted to the MHRT. There appears to be no requirement to provide this report to the proposed subject of the CTO or their legal representative. This appears to be out-of-step with most legal processes where reports and other evidence are typically provided to all parties involved in a hearing, prior to the hearing. I believe that requiring that this report be made available to the proposed subject and/or their legal representative would improve transparency and accessibility for those who utilise or come into contact with mental health services.

In terms of staffing and the delivery of community mental health services, the majority of presentations to adult community mental health services have concurrent alcohol and drug (AOD) concerns, or have a risk of AOD relapse. However, mental health and AOD services typically operate

separately in the community, thus resulting in service fragmentation. At Melbourne Health, I worked under an integrated model of community mental health services. Each community mental health team had a clinician trained in dual-diagnosis, thus they were able to provide specialist consultative services to the team or work directly with clients on mental health and AOD issues. I encourage the consideration of a similar model of care as it would dramatically improve the efficacy of both mental health and AOD treatment. Further to this, my anecdotal observations are that community mental health services in NSW appear to work strongly from a medical model of care. This manifests as a deficits approach to understanding and treating a person struggling with their mental health. Emphasis is placed on diagnosis and treatment with pharmacological agents in an attempt to rectify an illness or abnormality. This process is compound by CTOs whereby the clinician has a legal requirement to enforce administration of medications, thus limiting their capacity to provide other forms of care, as pharmacotherapy is prioritised. I was surprised when I started with NSW Health to find that psychologists, who have training in therapy and other psychological interventions, fulfil a similar role to nurses and other allied health staff, namely case management. I believe the skills of psychologists and other allied health staff trained in psychological interventions are more often than not wasted in a model of care and clinical culture where medications are seen as the primary, and sometimes only, treatment modality. As a result of this, and again from my own observations, the incorporation of a strengths-based, recovery-orientated approach to care appears to be very limited. Resultantly, clinicians spend a large portion of their time 'managing' a caseload of people, as opposed to providing effective treatment. I therefore encourage the consideration of promoting psychological and discipline-specific approaches to assessment, treatment and recovery. This will be particularly impactful for people whose recovery is not best support by medications. Diversifying approaches to treatment will also support the expertise of a multi-disciplinary approach to care.

In regards to equity of access, I believe model of care for community mental health services, described above, broadly focuses on people with diagnoses amendable to treatment with pharmacological agents. This includes the spectrum of psychotic conditions, for example, Schizophrenia and Schizoaffective Disorder, as well as Bipolar Affective Disorder. People experiencing personality disorders or vulnerabilities are often, although not exclusively, re-directed to private healthcare providers. I believe this is due to a lack of knowledge and expertise in how to work with people experiencing personality disorders or vulnerabilities. As a result, I encourage the consideration of further training for clinicians in community mental health services. Training in psychotherapies or case management practices suited to working with people experiencing personality disorders or vulnerabilities should facilitate better access and care for this cohort.

Thank you for taking the time to read my submission.