Submission No 26

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

Name: Name suppressed

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Submission: Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

I am from a CALD background.

I don't mind if my submission is published without my name because this makes me the most comfortable.

(a) equity of access to outpatient mental health services

I was unwell for a number of years before I came into hospital and was only then referred to public mental health services on a CTO. I did ask for help from the Access team and community mental health however a poor assessment by a social worker who contacted a private psychiatrist without my consent to get a stigmatised diagnosis for me prevented me from getting support at the right time. My own limited mental health literacy as a young person would have interfered with this process. I now have access to the public assertive team via a CTO and have had nearly 20 hospital admissions. I wouldn't need this level of intensive support now if I had the support I needed as a young person living with unknown mental illness. Public mental health services need to provide equitable support to young people when they ask for help.

(b) navigation of outpatient and community mental health services from the perspectives of patients and carers

(c) capacity of State and other community mental health services, including in rural, regional and remote New South Wales

There appears to be no capacity for community mental health services in Penrith, NSW to take on new patients unless they are on a CTO, this makes help seeking redundant further creating helplessness and depression from patient that seek support early but get no support, becoming more unwell and eventually reaching the severity needed to get support.

One of my CTO's was revoked and I was made a voluntary patient. In the middle of an hospital admission I was told I had no team, as the community mental health service had discharged me without any communication or collaboration with me. Collaboration and Openness are Core Values of NSW Health that were not met in this instance.

(d) integration between physical and mental health services, and between mental health services and providers

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

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

Given the state of the system with minimal places available for consumers to get support from public mental health services, CTO's are necessary providing a key in the door of public mental health support. My experience with CTO's has been that the service enforcing the CTO only turns up when it is time to administer the depot medication, they change medications without my knowledge leading to helplessness and suicidality. Penrith Mental health service required me to go to their clinic which I struggled with, the trauma of previous experiences, and leaving the house was difficult. Eventually I was referred to the assertive team, after 3 referrals I was accepted into the assertive team who were more available to see me moving from every 3-4 weeks with the Penrith Mental Health to weekly with the assertive team on a CTO. I have experience of experiencing unreality and being able to talk it out, not every instance had needed medication, rather connection to lead to a healthy state of mind and ongoing employment. Open Dialogue approaches talk about how psychosis occurs between people rather than to the affected person. Public mental health services need to offer quality time and connection as therapy not just jab and go visits, where all that occurs is an injection and the worker is off. When I was on placement, I struggled with visiting patients just to watch them take medications from a blister pack and then head off to the next patient after only 1-2 minutes of contact with the patient. Because I did my placement during covid I was excited and grateful to meet these patients even though it was for a few minutes, however I was left feeling that their support was extremely lacking in connection.

Plains Assertive Treatment Team: The assertive team does not breach me when I do not comply with the requirements of the CTO. The CTO requires me to see the service once a week in person, at my house, see the Doctor once every 3 months, take oral medication and receive a monthly depot injection. I have been accessing Open Dialogue externally and have experience with moving from unreality into reality just through connection with other people, particularly my old new grad social worker at the Plains team. I now have a worker who I really like but lets me down, as she is not able to see me weekly. I have received no communication as to why this does not happen. I do not get breached when the team doesn't see me weekly. But I do get breached when I refuse the depot. This is a neglectful and unfortunate process. With the reason being that weekly visits can provide much needed connection more vital for my recovery at this time than a depot injection. This week I have received 2 missed calls from my worker and a letter which I haven't opened. Last week she called me to find out if she could come for the depot, I said no. so she didn't come. Their office is a 5 min drive from my place. because I refused a depot I also miss out on them visiting me which when done for the right reason – connection and relationships has a better outcome on my recovery than a depot. CTOs are legal in nature however it has been up to the team to breach me on only what they want to. I get breached for not having the depot even when I am well and not at risk of becoming unwell. I do not get breached on my missed opportunities for connection. I believe the public mental health service needs to invest in Open Dialogue support for all consumers that are willing to engage in this form of therapeutic support.

(g) benefits and risks of online and telehealth services

Online and telehealth services are essential however not used widely in my area – Penrith, NSW. I have a lot of concerns with accessing the community and workers that can come to me, including telehealth make a big difference on being able to access services. At one point public mental health service denied patients from having the direct emails and phone numbers of workers. This goes against the equal partnership principal of Recovery Approach. I did point out this fact and some staff accidently call from their direct numbers and eventually got to the point of sharing emails. Despite this movement, staff continue to leave voicemails and send post when these are not my preferred contact methods. My preferred contact methods being sms and email. Openness to Telehealth has allowed me to continue my NDIS supported open dialogue sessions while I was in hospital. The doctors at Katoomba hospital did not want to engage in Open dialogue however my worker from the assertive team was able to come to an online session while I was inpatient at Katoomba and suicidal due to the restrictive nature of the hospital where staff have no time to engage with patients other than to administer midazolam for banging on the doors. Having access to the community through online, telephone and telehealth services are imperative in keeping patient's spirits alive during inpatient treatment.

I was told that the assertive team would Zoom with me, at one stage in 3.5 weeks I just received one voicemail from them only, when they are supposed to meet me every week as per the CTO. So telehealth support is not really being used to meet the connection needs of people.

(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

I am from a CALD background and my family were not receptive to my mental health needs for about 20 years. Which meant I was never referred to CYMHS services or any other early intervention as the right age of 15 years old. Since Open dialogue they have been more accepting of me.

(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)

The PACER program is vital to the Nepean Blue Mountain LHD. I had the PACER called for me on 2 occasions. Plus another visit via the Assertive Team. The PACER clinician was friendly and able to see me while the police waited outside. The PACER clinician organised for a direct admission into hospital and we rode in the PACER car instead of the back of a police vehicle which was a more dignified experience.

The PACER came with the Assertive Team and said we would go to TAC (Mental Health Triage and Assessment at Nepean Hospital) to see a Doctor to get some medication. But this is not what happened, when the PACER left I was sectioned for trying to leave TAC and had an

admission at Katoomba hospital. I am not sure whether this was a communication breakdown but this wasn't what was communicated to me.

During a police callout without PACER the police took me to a household where family violence was present, I told them that I couldn't go there for the reason of family violence but they took me anyway in the middle of the night. This wasn't a safe alternative for me and put me at further risk of trauma and abuse. What I learnt from this situation is that a person must say they are going to harm themselves or others (independent of whether this is true) to ensure they are not landed in a family violence situation, rather taken to a hospital emergency department. I am supposed to have access to NDIS respite services. So in instances where the community mental health team isn't available the police should be able to get in touch with the respite team instead of taking me to hospital emergency all the time and definitely not to a place of family violence.

(j) any other related matter.