Submission No 41

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

Organisation: ACON

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ACON SUBMISSION TO

Portfolio Committee No. 2 – Health

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

September 2023

HERE FOR HEALTH

About ACON

ACON is NSW's leading health organisation specialising in community health, inclusion, and HIV responses for people of diverse sexualities and genders. Established in 1985, ACON works to create opportunities for people in our communities to live their healthiest lives.

Our head office is in Sydney, and we also have offices in Lismore and Newcastle. We provide our services and programs locally, state-wide, and nationally. We are a fiercely proud community organisation, unique in our connection to our community and in our role as an authentic and respected voice.

Members of Australia's sexuality and gender diverse communities experience health disparities when compared to health and wellbeing outcomes experienced by the total population. They may also face significant barriers to accessing traditional healthcare pathways.

We recognise that members of our communities share their sexual and gender identity with other identities and experiences and work to ensure that these are reflected in our work. These can include people who are Aboriginal and Torres Strait Islander; people from culturally, linguistically, and ethnically diverse migrant and refugee backgrounds; people who use drugs; mature aged people; young adults; and people with disability.

Contact

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ACON acknowledges the Traditional Owners of the lands on which we work. We pay respect to Aboriginal Elders past and present.

Executive Summary

The stories we have heard in preparing this submission have told us that the mental health system in New South Wales is in dire need of reform. Chronic workforce and service shortages, lack of affordable services, long wait times, high rates of staff burnout, services that only see patients in crisis, services that won't see patients who are considered too complex, services that simply aren't safe for LGBTQ+ people, the difficulty of navigating a system that lets people fall through the cracks all too easily – all contribute to a system that is repeatedly failing those who need it, when they need it most.

LGBTQ+ people disproportionately experience poor mental health, and therefore disproportionately require access to mental health services. It is essential that these services are safe and inclusive for LGBTQ+ people, and it is also essential that these services are simply accessible to those who need them, and equipped to provide effective and empathetic care.

This submission reflects both the specific needs of LGBTQ+ people in accessing mental health care, and the broader experiences of inaccessibility of these services, as reflected by the experiences of our LGBTQ+ clients and community members.

The *NSW LGBTIQ+ Health Strategy 2022-2027* has the goal of improving access to safe and inclusive mental health and suicide prevention services for our communities. LGBTQ+ are a priority population in the *Strategic Framework for Suicide Prevention in NSW 2022-2027*, and the NSW Mental Health Commission's *Living Well: A strategic plan for mental health in NSW 2014-2024* recognises the need to address mental health disparities for LGBTQ+ communities.

If these strategies are to achieve their aims, mental health services in NSW must be equitable and accessible for LGBTQ+ populations.

Recommendations

ACON recommends that the NSW Government should:

1. Expand access to affordable, trauma-informed and LGBTQ+ inclusive mainstream mental health services in NSW by significantly improving workforce capacity and capability.
2. Expand access to therapeutic group programs within community mental health services to provide cost-effective and evidence-based support.
3. Alongside building the capacity of mainstream services to provide LGBTQ+ inclusive care, increase funding for LGBTQ+ specialist services, including crisis services.
4. Improve collaboration and communication between community and acute-care mental health services, non-government mental health services, and private providers to better understand and meet the needs of clients.
5. Expand capacity in rural, regional and remote community mental health services, including programs to address staff wellbeing and retention.
6. Advocate to the Commonwealth Government to:
    a. increase the number of Medicare-rebated mental health professional sessions available through the Better Access Initiative (to at least 20).
    b. provide MBS items for qualified and registered counsellors, psychotherapists and peer workers so that subsidised care can be offered to community members, especially in areas where there are capacity issues among psychologists and psychiatrists.
    c. ensure registered Medicare providers undergo LGBTQ+ inclusivity training with ongoing assessment and registration in order to provide safe and inclusive care.
7. Coordinate with the Commonwealth Government to provide shared care arrangements that respect a client's privacy while ensuring the continuity of their care as they seek different services.
8. Expand and promote the role and value of the peer workforce in NSW mental health services, including LGBTQ+ peers and peers with a range of lived experiences and identities.
9. Provide accessible and affordable pathways out of a Community Treatment Order to better empower community members to take control of their mental health.
10. Provide blended models of mental health care that allow for both face-to-face and telehealth services.
11. Work with key populations to build digital literacy to ensure telehealth is accessible.
12. Apply an intersectional framework to mainstream and specialist mental health services to ensure that they are all equitable and accessible for First Nations people, culturally, ethnically and linguistically diverse people, LGBTQIA+ people, young people, and people with disability.
13. Pilot and evaluate a trauma-informed emergency mental health response program that is not police-initiated and does not involve police in situations where there is low to moderate risk of harm to others.

Introduction

ACON thanks the Health Portfolio Committee for the opportunity to make a submission to this important inquiry. While many LGBTQ+ people in NSW lead happy, healthy and productive lives, there are a range of issues relating to poorer mental health outcomes, such as depression, self-harm, anxiety and suicidality, which disproportionately impact LGBTQ+ people when compared to the wider population. It is because of these impacts that we are a priority population in state and federal mental health and suicide prevention strategies.

In Australia's largest survey of LGBTIQ+ people, *Private Lives 3*, over 57% reported high or very psychological distress, compared with 13% of the general population. Trans people are especially experiencing distress; 75% of trans men, 66% of trans women and 75% of non-binary people reported high or very high levels of psychological distress.[1]

In the same study, in the last 12 months almost 40% had been diagnosed or treated for depression, 33% for anxiety, and 11% for post-traumatic stress disorder, and these figures are higher among trans participants. Almost 75% of the sample had ever been diagnosed with a mental health condition, compared to 45.5% of the general population.[2]

LGBTIQ+ people are attempting suicide, and experiencing suicide ideation at shocking rates – suicide ideation in the last 12 months is twenty times higher among LGBTIQ+ people than the general population, and suicide attempts in the last 12 months are ten times higher. 53% of trans men, 46% of trans women, and 40% of non-binary people have attempted suicide in their lifetime.[3]

Young LGBTQA+ report even higher levels of psychological distress and suicidality. 81% of LGBTQA+ people aged 14-21 reported high or very high levels of psychological distress. Almost 90% of trans young people have experienced suicide ideation, and 38% have attempted suicide.[4]

These distressing figures are especially concerning for LGBTQ+ with intersecting identities, including LGBTQ+ First Nations people,[5] LGBTQ+ people from culturally, ethnically and linguistically diverse backgrounds,[6] and LGBTQ+ people with disability or long-term health condition,[7] including HIV.[8]

ACON supports LGBTQ+ people and people living with HIV take control of their mental health by providing information, a range of counselling and peer services, ageing support and a care coordination program for people with complex needs. In 2022-23 across our services, we provided over 3,900 counselling sessions, over 6,600 care coordination occasions of service and almost 2,000 peer work occasions of service, spanning our suicide prevention, HIV support, trans mental health & wellbeing support, alcohol & other drugs, and sexual, domestic and family violence services.

It is through these services that we are in contact with many LGBTQ+ community members who have faced significant barriers to accessing community mental health care in New South Wales, and it is the anonymised stories of those clients and our Client and Clinical Services Teams that we share in this submission.

ACON has always advocated that improving mental health care is a critical component of the *NSW LGBTIQ+ Health Strategy 2022-2027.* It is critical that these stories and experiences are heard, and our mental health services are improved across the board for LGBTQ+ people in NSW to ensure they are truly equitable and accessible for communities who need them.

a) equity of access to outpatient mental health services

NSW's outpatient mental health services are plagued by long wait times due to high demand, a shortage of appropriate services, and a lack of preventative services meaning that presentations are often complex or in crisis, requiring significant assistance. This is especially pronounced in rural and regional areas (and further discussed under ToR C) where fewer services are available and affordable. This severely impacts the accessibility of these services for people who need them.

ACON's Client Services Team report that even if a client they are working with has the financial means, accessing psychiatry services on an ongoing basis is extremely difficult due to a chronic workforce shortage, which compromises the ability for community members to manage their psychiatric medications.

There is a lack of preventative and therapeutic group mental health services available. In community mental health settings, typically only patients experiencing acute or active suicidality are triaged for service. This means that those who are experiencing different levels of distress are not able to access these services, and are left to deteriorate to the point of crisis before action is taken.

When our gender and sexuality diverse clients are able to access appropriate outpatient mental health services, they are not trauma-informed or LGBTQ+ inclusive, resulting in actively worse outcomes for many community members who have sought out a service for help. LGBTQ+ people have long been pathologised in psychiatric and psychological settings,[9] which even in a context of growing depathologisation of our identities, often results in unsafe, and uninformed care.

Recommendations

The NSW Government should:

1. Expand access to affordable, trauma-informed and LGBTQ+ inclusive mainstream mental health services in NSW by significantly improving workforce capacity and capability.
2. Expand access to therapeutic group programs within community mental health services to provide cost-effective and evidence-based support.

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

It is common for clients in our services to approach community mental health services, only to be referred onward to a service specifically for sexuality and gender diverse communities. While these services are able to provide inclusive care, they are underfunded, under-resourced, experience long waitlists, and are often not available in times of crisis.

The disproportionate numbers of LGBTQ+ people experiencing mental distress, outlined in the introduction of this submission, means that all community mental health services need to be equipped to provide safe, inclusive and affirming care for LGBTQ+ people. Our communities need to be able to

access mainstream, as well as specialist services, in order to receive appropriate care, and for NSW to achieve the goals of the *NSW LGBTIQ+ Health Strategy 2022-2027*. Research indicates that 47% of LGBTIQ+ people want to receive care from mainstream services that are LGBTIQ+ inclusive, and 21% want to receive care from services that are specifically for LGBTIQ+ people.[10] Mainstream services must be able to provide inclusive care for all.

The pattern of referring onward also reinforces the notion that mainstream health services are not safe for our communities, further increasing experiences of stigma and trauma by telling our communities they are not worthy of care or can't be helped in mainstream settings.

When trans clients are seen by community mental health services, they repeatedly experience misgendering – whether it's services using incorrect pronouns, or 'deadnaming' – that is, referring to a client by their former name. This often occurs as a result of discordant identification, such as a Medicare card, client records, or other legal documentation with outdated information. There is a substantial administrative burden in updating identity documentation, and in many cases, it is not feasible.[11]

A lack of understanding of the specific needs of our communities also results in unsafe practices, such as discharging clients into unsafe home environments, where they are not safe to express their gender or sexuality, or may experience sexual, domestic or family violence. Clients also report a lack of understanding when re-engaging with services, especially those with chronic, long term and/or ongoing mental health needs. The expectation that clients will be 'fixed' after short term treatment can lead to a disengagement with services, rather than the effective provision of care.

The impact of misgendering, and unsafe practices at mental health services is significant, and results in increased distress, fewer presentations, and barriers to accessing future care.

ACON's TransHub and Pride Inclusion Programs offer services and resources for health providers to ensure they are providing gender affirming care, even when identity information may not match Medicare or other records.

To access community mental health services in regional NSW, clients must first present to Emergency Departments (and typically experience long wait times while in significant distress or crisis), or be referred by a GP. Our regional teams have worked with clients experiencing significant psychosis, suicidal ideation and disordered eating who have waited up to two weeks for an intake assessment call from community mental health.

In the interim period, clients have no information about what's happening, are still experiencing significant distress, and often turn to our care coordination teams to act as an intermediary or advocate to find out when they may anticipate support.

Clients also report cold and inconsistent care, attributed to a systems-wide issue of workers at capacity, experiencing burnout, stress, compassion fatigue and vicarious trauma, leading to high turnover of staff and a lack of empathy in service provision.[12]

Recommendations

The NSW Government should:

3. Alongside building the capacity of mainstream services to provide LGBTQ+ inclusive care, increase funding for LGBTQ+ specialist services, including crisis services.
4. Improve collaboration and communication between community and acute-care mental health services, non-government mental health services, and private providers to better understand and meet the needs of clients.

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

The capacity of services across NSW, but especially in regional, rural, and remote areas, is severely limited. There is a substantial number of people in regional areas falling through the gaps of our mental health system.

The limited resources in regional areas mean that clients are often turned away or discharged after being assessed by Community Mental Health if their level of risk is not extreme or life threatening to themselves or others. Experiencing suicidal thoughts or self-harm is not grounds enough to be triaged, managed or supported by Community Mental Health in a regional setting.

This means that adults who experience psychosis, significant suicidal ideation, significant self-harm and mood, personality, and/or eating disorders are often reliant on community providers of mental health support which have time limited sessions (10 sessions on a mental health care plan) and are not able to provide intensive support to those who cannot afford extra.

This results in situations where community members who have communicated suicidal ideation with a plan and means to complete are not provided support, and then present at in-patient facilities where they are unable to be admitted because the unit has no capacity. Our regional teams are aware of suicides that have occurred days after community members have not been admitted to inpatient facilities, or were assessed and discharged.

Psychiatry services are often only accessible in Community Mental Health services in rural and regional settings, which means that only clients in significant crisis can access psychiatry services, and routine care such as managing medications becomes virtually inaccessible.

Compassion fatigue and staff retention is a significant issue in regional areas.[13] We have heard of staff actively encouraging clients who are 'too complex' or 'too challenging' to discharge themselves, because there is little to no capacity to support these clients, and the support that is provided is tokenistic, and in many cases, actively exacerbates symptoms, adaptive behaviours, and suicidality.

Programs that encourage clinicians to take regional positions have their benefits, however, they often result in a revolving door of clinicians and little to no continuity of care for people in the community.[14]

This also mean it is likely that if clients are able to access a psychiatrist, it will be a different psychiatrist to the person who saw them last, often resulting in multiple or conflicting diagnoses.

Case study:

While safe and affirming mainstream care for LGBTQ+ people is an issue across NSW, it is especially pronounced in rural and regional areas.

An older gay cisgender man living rurally supported his lifelong partner to access emergency hospital care. Due to his past experiences of stigma and discrimination, he did not declare immediately to hospital staff that it was his 'partner' he was supporting. Hospital staff assumed it was his 'friend'. His partner shortly died after being admitted.

The man then sought community mental health support as he was considering suicide himself. He felt he needed to continue to refer to his now deceased partner as his 'friend' to the mental health services.

This compounded his grief and distress – as several significant people in his life, institutions and indeed, the state, did not recognise the significance of his connection to his partner, nor value this.

Recommendations

The NSW Government should:

5. Expand capacity in rural, regional and remote community mental health services, including programs to address staff wellbeing and retention.
6. Advocate to the Commonwealth Government to:
    a. increase the number of Medicare-rebated mental health professional sessions available through the Better Access Initiative (to at least 20).
    b. provide MBS items for qualified and registered counsellors, psychotherapists and peer workers so that subsidised care can be offered to community members, especially in areas where there are capacity issues among psychologists and psychiatrists.
    c. ensure registered Medicare providers undergo LGBTQ+ inclusivity training with ongoing assessment and registration in order to provide safe and inclusive care.

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

There appears to be a significant failure of services to integrate and provide continuity of care to clients who are continually moving between health providers, state, federal and private services, services with Medicare rebates, and NDIS services.

This results in a lack of continuity care, people lost to follow up, people falling through the cracks, people forced to wait, and people forced to advocate for themselves (or rely on care coordination teams at services like ACON to support them) to access a service when they are in crisis.

Where services are coordinated across state, federal and private systems, there are no shared care arrangements. ACON Clinicians report that it is near impossible to speak to the treating physicians of the clients they are also seeing, they are not notified when clients are discharged from services, and they are not provided treatment plans or discharge notes.

Our Substance Support teams report people with drug-induced psychosis are not offered psychiatry services after treatment and discharge from hospital. There is frequently no follow up after a psychosis admission, no treatment plan, and no discharge notes.

Our regional teams also report that young people (aged 18-25) are often referred as a first point of call to local headspace centres when they present to Community Mental Health with a level of risk not deemed significant enough. Headspace services are funded to provide support to low to moderate mental health acuity, so young people in significant distress are then referred onward again to private mental health services, which they often cannot afford, or they are deemed too 'high risk' for private care (but not high risk enough for Community Mental Health).

Case study:

A 21-year-old neurodiverse cisgender lesbian living regionally and with several physical disabilities, dissociative identity disorder (DID) and complex PTSD (Post Traumatic Stress Disorder) was discharged by community mental health to get counselling within the community.

She was experiencing significant suicidal ideation with a history of attempts, significant self-harm and periods of psychosis. Adult community mental health said they were unable to provide counselling and that she was not 'at risk' enough to be case managed by them.

This client then 'bounced' from counsellor to counsellor – counsellors were 'risk averse' and believed she needed to be seen by community mental health. She had used her 10 sessions under the mental health care plan within a few months, and maximised her sessions under healthy minds. She also was on a low income and could not afford counselling privately.

The client was also told she should be accessing NDIS support for counselling. However, her NDIS reviews seeking counselling continued to get rejected, with NDIS saying these needs were better suited to be supported by community mental health and community supports.

No one was taking responsibility for supporting this person's wellbeing and mental health.

Recommendations

The NSW Government should:

7. Coordinate with the Commonwealth Government to provide shared care arrangements that respect a client's privacy while ensuring the continuity of their care as they seek different services.

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

Our submission has already addressed our concerns surrounding staff shortages and service capacity, as well as patterns of continual referral and the difficulty of clients finding a service to take them on, and treat them safely. Our case studies highlight some of these issues in greater detail for individual clients.

The first port-of-call for mental health services in NSW is supposed to be your GP. However, as GP services are increasingly requiring out-of-pocket costs, they are becoming more inaccessible for LGBTQ+ communities.[15] We find that clients instead turn to hospital settings because they are unable to get support elsewhere, resulting in long waits in emergency rooms and inpatient facilities at capacity.

ACON has a long and proud history of peer work.[16] Our HIV health promotion services have always effectively leveraged the role of peers, and we understand the important role that LGBTQ+ peers play in supporting each other, both formally and informally. In recent years we have expanded our mental health peer work services to include dedicated suicide prevention and aftercare peer workers, peer navigators, trans mental health peer workers, and substance support peer workers.

Unfortunately, across the sector, the unique knowledge and expertise of peer workers is undervalued, the sector is underfunded, and support and learning and development opportunities to build resilience and training are limited. Our peer workers have had their letters of support or referrals undervalued when compared to clinician perspectives, despite having deep knowledge of the clients and systems they are working for.

Case study:

ACON's regional teams were supporting a 21-year-old trans man who was experiencing psychosis and was actively suicidal. He had several hospital admissions (6 in 6 weeks) due to suicidal planning and serious self-harm. He had been diagnosed with autism, severe borderline personality disorder, and an eating disorder.

The Community Mental Health team refused to accept a referral and allocate a worker, even after the treating hospital psychiatrist made the recommendation. Community organisations, including ACON, who were supporting this client made over 10 calls to the Community Mental Health teams to attempt to get information regarding his referral, with no response.

This cycle of no contact and refusing to accept the referral contributed to the deteriorating mental health of the client. It took a complaint from the psychiatrist, and ACON, to the mental health director before this client was allocated a mental health clinician.

As this is unfolding, the client is taking on the negative messaging from mental health services that he cannot be helped, and is not worthy of support, further compounding his distress and trauma.

Recommendations

The NSW Government should:

8. Expand and promote the role and value of the peer workforce in NSW mental health services, including LGBTQ+ peers and peers with a range of lived experiences and identities.

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

Clients we work with report a lack of clear, affordable and accessible pathways to overturn a Community Treatment Order. This process is time-consuming and a significant administrative burden, and typically requires a costly psychiatric review. CTOs therefore often remain ongoing, which means there is little opportunity to people subject to a CTO to feel empowered to manage their own mental health with supports that best suit them.

Recommendations

The NSW Government should:

9. Provide accessible and affordable pathways out of a Community Treatment Order to better empower community members to take control of their mental health.

g) benefits and risks of online and telehealth services

ACON advocates for blended mental health services, that is, the option to receive both telehealth or face-to-face care, depending on client need.[17] Our own telehealth services were significantly expanded during COVID-19, and continue to be popular with clients today.

Research both in Australia[18] and around the world[19] has indicated that telehealth is an important intervention for vulnerable populations, including LGBTQ people. Telehealth provides access to friendly and inclusive services, without the barrier of geographical distance.

As well as addressing access gaps, telehealth also allows for greater flexibility and choice, allowing consumers greater options of services, practitioners, and modes of delivery, encouraging greater engagement with health care.

Telehealth has also been useful to clients who have concerns around experiencing street-based harassment, discrimination, homophobia, and transphobia. Almost 70% of LGBTIQ+ people report that there are times when they don't feel accepted in public, and this is especially heightened for trans people.[20] Being able to seek mental health care without compromising safety is of huge benefit to our communities.

However, telehealth can present a challenge for people who do not have a private home environment, and this is especially difficult for LGBTIQ+ people who have not disclosed their sexuality or gender to those they live with.

Telehealth doesn't work for everyone, whether that be due to privacy concerns, access issues, digital literacy, or simply preference. Furthermore, Australia has both a significant digital divide and population health disparities that mean digital interventions cannot replace face-to-face health care, nor be the only solution to significant health inequity. Greater digital inclusion and digital literacy, especially among older people, linguistically diverse people, and people with low incomes, is needed to ensure that telehealth is an option for all to choose.[21]

Telehealth is an important and effective option in our mental health care landscape, but it must sit alongside continued investment in face-to-face services, continued evaluation of service delivery, targeted interventions for vulnerable populations including LGBTQ+ people, and ongoing research into effective models of health care.

Recommendations

The NSW Government should:

10. Provide blended models of mental health care that allow for both face-to-face and telehealth services.
11. Work with key populations to build digital literacy to ensure telehealth is accessible.

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

This submission has thus far centred on the experiences of LGBTQ+ people.

There is a tendency to silo different marginalised communities, without taking an intersectional approach that understands that people can have multiple, overlapping and intersecting identities and experiences, and may therefore have multiple, overlapping experiences of marginalisation or discrimination.

Services designed for LGBTQ+ people must also be culturally safe for First Nations people and culturally and linguistically diverse people, and accessible for young people and people with disability, including neurodiversity. Similarly, services with these populations in mind must also be safe for LGBTQ+ people. As mentioned in the introduction, it is these populations of LGBTQ+ people who experience disproportionate levels of mental distress, when compared to non-Indigenous, Anglo-Saxon, older and able-bodied LGBTQ+ people.

It is essential that these services do not require 'proof' in order to access.[22] The impacts of colonisation and forced displacement of Indigenous communities has resulted in a loss of connection to culture and mob for many First Nations people, which in itself is distressing,[23] and if this is a barrier to accessing support services, it can cause further harm.

Furthermore, services must not assume the cause of a person's distress is their marginalised identity. Our clients frequently report what is colloquially known as 'trans broken arm syndrome', where a trans person is seeking support for an issue not at all connected to their gender identity (such as a broken arm), and the consult instead focuses entirely on their gender, as though that is the source of the problem.[24] This occurs in mental health settings all too frequently.

Recommendations

The NSW Government should:

12. Apply an intersectional framework to mainstream and specialist mental health services to ensure that they are all equitable and accessible for First Nations people, culturally, ethnically and linguistically diverse people, LGBTQIA+ people, young people, and people with disability.

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)

LGBTQ+ people have a complex relationship with police due to significant historical miscarriages of justice and bias.[25] This is especially so for LGBTQ+ people experiencing distress, including those that have had police respond in times of crisis.

There is very little evidence to support police intervention in mental health crises, and novel approaches that do not involve police are required, and must be co-designed with communities, and rigorously evaluated. [26] Emerging evidence in the US demonstrates that models that use a police alternative are both efficient and effective.[27]

The PACER program is not a trauma-informed model of care because it is police initiated. This means that as a community-based organisation, we have to call Triple zero (000) to initiate an emergency response if we are concerned someone is suicidal and at risk of harm to themselves.

Police then have to identify that the individual would benefit from PACER (ie. a mental health clinician to attend alongside ambulance/police) and call them out to attend.

For individuals experiencing suicidal crisis, it is traumatising and potentially re-traumatising to have police turn up at your door. This model of care can and should be re-imagined, especially in instances where risk of harm to others is assessed as low to moderate. In these circumstances, a mental health

clinician and a trained peer worker should attend in place of police, to de-escalate and provide trauma-informed care and support to the person in crisis.

ACON staff were supporting a gender diverse client who was at immediate risk of suicide. One of our trained mental health clinicians called 000 and re-iterated their name, pronouns, their situation and requested that this person receive a mental health response, and not a police response, via the PACER program, and yet five police officers responded.

ACON staff have also supported a client who experienced rapid escalation of crisis by an ineffective response to their mental health needs, resulting in being held in police custody overnight and discharged without mental health assistance, and a client who was removed from their home by police who forced their door in with an axe, without the client hearing them knock or announce themselves in any way.

Recommendations

The NSW Government should:

13. Pilot and evaluate a trauma-informed emergency mental health response program that is not police-initiated and does not involve police in situations where there is low to moderate risk of harm to others.

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