**Submission No 42**

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

I am a mental health consumer peer worker based at a Community Mental Health Service. My role is 100% community based. I have worked in this role for 25.5yrs and am very proud to work as a peer worker in the public sector.

I would like to submit statements to the following parts of the terms of reference: a, b, d, e, f, i and j. I am writing as a peer worker who supports people in the local community and participates on various quality and executive committees. I would therefore like my submission to be anonymous.

**Terms of Reference:**
**(a) equity of access to outpatient mental health services:**

The demand on **acute services** is high. The Acute team can have in excess of 100 new people (referrals and walk-ins) each month. The pressure on the staff to support and discharge people is high. People requiring this support are generally not ready for discharge in the short timeframes that occur, yet our service sees discharge within 48hrs as a positive. The clinical load on each staff person is also high, reducing the time dedicated to supporting people in their recovery processes. The acute team do not see it as appropriate to complete Wellness Plans or Care Plans with people they are supporting. I believe this to be false as these assist people living with mental health issues to gain insight and greater efficacy in maintaining their mental health.

The **older persons mental health** (OPMH) teams are grossly under-staffed. As people living with mental health issues move into residential care there seems to be a disconnect with mental health care.

**CONSUMER STORY:**

A woman was transferred into residential care following a fall and rehabilitation. She was there a few months when she reported being physically unwell. The staff told her that it was her mental health issues not physical health. Even with this belief it took them 4 weeks to call in the mental health clinician. She attended on a Friday and when she saw this woman, she told them to call an ambulance as she was physically unwell. The woman died the following Tuesday. This woman was a friend, and I was very angry at the way she was treated by the residential care service. I had visited her every Saturday to play scrabble and I felt very hopeless to help her.

Following her death, I contacted the MHDA Director for OPMH to report this as a death that was avoidable if care had been provided sooner. I was made aware that mental health clinicians do not routinely visit these settings unless a referral is made by the service provider. I suggested a peer workforce ought to be sourced for the OPMH services. It took over a year, but resources were dedicated to a peer workforce. They are grossly under-staffed and do not currently visit residential care services.

Clinical and peer worker teams require further resourcing to meet the needs of people living with mental health issues in the community.

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

People report to me as a peer worker that they are/were not satisfied with their experiences with the acute team. They use language such as "I did not feel listened too", "They just wanted to pass me off to someone else." People have come to me as an advocate saying that they went to the reception to ask to see their care coordinator and were told that they are no longer registered with the mental health service.

**CONSUMER STORY:**

I had a call from a woman recently who had been rung on a Sunday night by her care coordinator and told that she was being discharged tomorrow (Monday). She was in tears when she called me and said "I didn't feel like I had any say in the decision. I feel lost. I will never go to them again." I discussed with her the re-entry process and that if she felt a need for the service, she could make a call or walk-in. I also reassured her that I was available to assist her at any time with this process and that she is welcome to attend our groups and activities.

I ask people if the clinicians discuss with them the re-entry process. I have never had a 'yes' response to this question. People's rights are being violated. They are not being prepared for discharge. They view this as a rejection. These practices destroy people's trust in the services they need.

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

The mental health service I work with is very good at the integration between physical and mental health services. There is an exercise physiologist and dietician within the service. They have established relationships with a gym in the community and at the local hospital to support groups.

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

All mental health teams are under-resourced. Clinicians can be supporting high numbers of people resulting in more phone calls and less physical contact, low completion of Wellness Plans and Care Plans.

Peer workers are very valued by our mental health services. We are under-resourced and do not have peer leadership in place. There are inconsistent practices across NSW and the Framework is not implemented well. In the District where I work, monthly external peer group supervision is provided and funded. This is well attended and appreciated. This is not a standard practice across NSW.

Dedicated funding is required to support peer workforces across NSW Mental Health services. We need peer workers that have the skills and time to support people in all settings, (ED, hospital wards, mental health inpatient and all community settings). We need to be involved in training of undergraduate students, GPs, ambulance, police, residential aged care, and community groups.

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

The service I work for has initiated training for staff on supporting people on CTO's. The peer workers provide 1:1 support for people to prepare for their hearings and to complete their self-report form. We are available to attend hearings with people and to discuss recovery and options for their care going forward.

**CONSUMER STORY:**

In December 2022, a woman called me in distress. She was wanting to visit her parents and son (5hrs train journey) between Christmas and New Year. she was told repeatedly that she could not go as she needed to be at the mental health centre for her monthly injection on the 29th. She was at a low point in her relationship with the acute team as she felt "let down" and "not cared about." We discussed some potential options. I asked her to call her parents and get their GP service number and make contact to see if they could give her the injection. They were happy to assist. I emailed the acute team leader to open dialogue on this option. The phone number and email were given to the acute team leader who contacted the GP service and provided details of what was required. The woman was able to have her time with her family, have her injection on the day it was due and maintained her relationship with the team. This evidenced that flexibility is possible. People's lives can be supported in the community and options are possible.

**(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)**

In the sector that I work for we have constable training 2-3 times a year. I present in these sessions from a peer worker perspective and from my personal experiences as a person who has had police intervention in the instigation of a transfer to hospital. We discuss language, values of empathy and maintaining the person's dignity and self-efficacy. I can share with them the trauma that resulted from my police intervention and the problems with neighbours who witnessed the event on my return home. The behaviours of neighbours (spitting and yelling at me, leaving rude/cruel notes at my door) was intolerable and I had to move as a result. The trauma of that event remains with me today.

The service where I work, we have a PEER STOC worker who supports people from inpatient to community (6 weeks post discharge). He is a wonderful caring and supportive peer worker. At times, the clinicians knowing there will be police and ambulance at the persons home will ask this peer worker to attend and support the person. When this has occurred the transfer to hospital has gone without a negative consequence. He can connect with the person as a peer and engage them to participate in their care.

I have heard in the past of a police service where they had plans in place for people whom they are repeatedly called to when they are unwell. These plans included notes about needing to wear plain clothes for people who are triggered by the uniform. Some people will respond well, but many can become triggered and aggressive when an officer in uniform approaches.

**(j) any other related matter.**

NDIS has been positive for many people. However, for people who have not received a package are left in the community with no access to psychosocial services. The Community Managed Organisations who previously were open to anyone from the mental health community, now only accept people who have an NDIS package. This has created a gap that is not filled anywhere else in our community. To attempt to provide options, I have established groups within my work as a peer worker. I am fortunate that my manager enables me to work two Saturdays a month to provide groups in the community. These are well attended as weekends are difficult for people who are feeling lonely and isolated. I provide a supported access to a local club's Bingo game. A woman who attends has made a connection with a woman from Bingo and has gone to the movies and other activities with her. It is nice when people see us in at the shops and they say "hello, how are you. Are you coming to Bingo …". I feel connected to my local community as do others who attend.