Submission No 48

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

Organisation: PsychOrium Forensic and Clinical Psychology Services

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Portfolio Committee No. 2 – Health
Legislative Council (Upper House)
Parliament of New South Wales

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

To whom it may concern;

PsychOrium Forensic and Clinical Psychology Service is a unique practice located in South West Sydney. At PsychOrium, we specialise in working with individuals that have been subject to the criminal justice system, as well as working with individuals who present with complex trauma presentations. We strive to take a humanistic trauma informed approach, and we are committed to providing equitable and respectful care to all clients, regardless of their histories. PsychOrium is a practice dedicated to advocacy, compassion, and authenticity. Our team is led by Dr Carollyne Youssef (Principal Forensic Psychologist), and includes Ms Sarah Van De Velde (Forensic Registrar Psychologist), Ms Tuyet Ngan-Doan (Forensic Registrar Psychologist) and Ms Annalise de Groot (Forensic Registrar Psychologist).

This submission is intended to provide the committee with insight into the problems we have faced, both individually and as a service, with the capacity of outpatient and community mental health (CMH) services in NSW to appropriately provide treatment and care to clients that exhibit complex presentations and comorbid conditions. It is our opinion that these problems stem from systemic issues in the design and implementation of government funded mental health services, and that these issues are apparent on a statewide level.

There are significant problems in the delivery and accessibility of outpatient and community mental health services. We note that there are also significant issues relevant to

the inpatient mental health system, and that these also affect the outpatient/community system. Specifically, there is a burden on the outpatient system resulting from the paucity of inpatient beds, the lack of appropriate discharge planning and the difficulty in accessing inpatient care for members of the community. Notwithstanding those problems, we assert that there are fundamental flaws within the design and delivery of the community system in NSW.

This submission is intended to address all terms of reference outlined by the committee. Many of the issues we will highlight fall under the broad term of reference *equitable access*. In providing this submission, we have summarised our perceived issues and collated our experiences within the current CMH service provision.

The current model of access to CMH services hinges on the acceptance of a referral to a person's local community team via the mental health line (MH line) triage. The NSW Health Policy Directive PD2012_053 defines triage as "*a clinical process to assess and identify the needs of the person and the appropriate response required*". This policy directive comprehensively lists the various risks and presentations that may be referred to the mental health line, and provides prescriptive directions about the assessment of risk and associated actions/timeframes for response.

The triage policy directive (PD2012_053) specifically notes that one of the purposes of triage is to "*determine whether there is a need, or potential need, for further intervention by the Mental Health Service, particularly face to face follow up, or whether referral to another service should be considered*". The guidelines for call triage (GL2012_008) indicate that when an emergency services response is not warranted there is an onus on the triage clinician to develop a safety plan and remain involved until care is assumed by the relevant LHD service. The guidelines indicate that the responsibility for the client lies with the triage team until appropriate handover is made. Further, the guideline states that the triage team ought to "*ensure all callers are offered healthcare assistance where indicated irrespective of the need for public mental health care*". The guideline specifies that the triage clinician is to utilise the Urgency of Response (UoR) framework to determine the appropriate actions for a caller. Within this framework there are degrees of intervention and timeframes specified. There is also a category that indicates that the caller does not warrant public health intervention; a response in this category specifies referral to an alternative service.

Contrary to the guidelines and policies referred to above, we have observed problems related to the appropriate assessment and treatment of clients by the MH line triage system. These problems are apparent from the initial point of risk assessment, to the appropriate categorisation of response urgency, to the follow up and management of referrals as a whole. An outline of these problems is as follows:

- Suicidality:
    - Focus on suicide as the only potential risk, to the exclusion of other presenting problems, and dismissal of any degree of suicidality that is not deemed imminent.
    - Narrow understanding of suicide risk, whereby the apparent criteria used by triage clinicians is whether or not a client has a plan to act, and anything less than that level of risk is dismissed as non-urgent.
    - There also appears to be a tendency to presume that if a client is help-seeking that they do not require an urgent response. While insight can be a protective factor, this position dismisses those that are actively reaching out for help as a preventative measure for more imminent thoughts of suicide or harm.
- Risk of harm to others:
    - Limited understanding of the nuances of risk to harm and the reasons a professional may refer to the MH line rather than Police.
    - Apparent panic and fear-based responding when risk of harm or history of violence is included in referral information.
    - Limited understanding of the intersection between forensic systems and MH systems. Poor understanding of community treatment orders and legislation related to forensic patients.
- Psychosis symptoms, drug use and other MH presentations:
    - Dismissal of presentations complicated by substance use as being derived only from intoxication rather than representing or exacerbating underlying illness.
    - Limited understanding of complications in various nuanced MH presentations, resulting in dismissal of concerns as indicative of "*attention seeking*" or "*medication seeking*".
    - Lack of holistic care protocols and siloing of services; tendency to refer comorbid presentations to other agencies that can only manage one part of the

presentation (e.g. NDIS, Drug and Alcohol services). This creates a loop of shifted responsibility where clients are referred through multiple agencies that then refer back to one another, ultimately resulting in the client not receiving any assistance.

- Limited alternative referral options:
    - Lack of alternative referrals being made at all, or information about referral pathways being provided only to the client and not the referrer, despite the client's poor mental health making it difficult for them to retain or organise information.
    - Reliance on GPs to provide trauma-informed appropriate mental health intervention as a referral pathway. Many clients may not even have a regular GP relationship, and many GPs appear unaware of options for referral outside of private paying services that clients are not able to afford (e.g. seeing a private psychiatrist).
    - Tendency to refer clients back to our practice despite us referring them to the MH line due to the limited crisis intervention that we are able to provide.
    - Commentary from MH line clinicians about what we ought to provide as a private practice, that is beyond the scope of our ability to provide.

Collectively, we have observed a lack of knowledge and awareness in the community of the process of referral to and working with CMH services. Generally, clients and their carers appear unaware of the options available to them in regard to CMH services, and are not familiar with the MH line at all. We have observed that clients from underprivileged backgrounds, culturally and linguistically diverse communities and First Nations peoples have expressed distrust of government systems based on their prior experiences, and have indicated that they are not amenable to referral to CMH services for fear that their rights as individuals will not be respected. We have also noted that these beliefs can be reinforced and/or confirmed by the treatment of clients by CMH staff that is not trauma-informed. There have been experiences where we have observed clients to be treated abrasively and prejudicially based on their presentations and limited confidence in advocating for themselves.

In addition to these barriers of initial access, we have observed that there are a percentage of clients that have become institutionalised and overly familiar with the workings of the mental health system. We have observed this to manifest in the phenomenon of 'knowing what to say', wherein clients have informed us that they have either expressed or withheld information from CMH services due to an understanding of what statements will or will not result in being seen by a treatment team. Efforts that we have made to remediate this problem by communicating with triage and treating teams have been largely unsuccessful.

While we understand that not all clients can be serviced by the NSW public MH system, due to resourcing constraints, we note that there appears to be a gap in service provision for clients presenting with chronic conditions. Our experience has been that clients presenting with ongoing chronic risk are typically not triaged into CMH services, thus perpetuating their ongoing risk and sending the message that they will only be seen if they present with acute risk. This limits the likelihood that clients will be accepting of CMH services later, due to their experience of being dismissed when they originally attempted to seek help. There is a distinct absence of early intervention opportunities for these clients within the CMH system.

The points outlined above are intended to provide the committee with insight into the challenges faced by consumers of this system, in addition to the challenges faced by us as treatment providers working adjacent to this system.

We propose that the following changes are implemented in the effort to improve the outpatient and community mental health system in NSW:

- Improved accessibility to services through triage clinics with staff trained in building rapport and developing a sense of safety.
- All referred clients to be seen by a psychologist and/or psychiatrist for comprehensive assessment.
- Supported referral pathways if the client is not deemed to need government services (i.e., social workers to make and follow up referrals to alternative low or no cost services).

- Removal of the funding separation between drug and alcohol services and mental health services, and provision of treatment under the public system regardless of other presenting problems.
- Development of a complex needs branch of community mental health teams, where clients that have comorbid presentations and/or additional prejudicial factors can be seen.
- Training for community mental health clinicians specific to assessing and understanding risk of harm to others.
- Improved communication between service providers/referrers (GPs, private psychologists, disability services) and community MH services. Including, involvement in discharge planning, provision of follow up support post-discharge, and development of prevention plans.

We hope that the committee finds this submission to be of use, and we are able to be contacted to clarify any points as needed.

Sincerely,

Dr Carollyne Youssef

Ms Sarah Van de Velde

Ms Annalise de Groot (Correspondent)

Ms Tuyet Ngan-Doan