Submission No 52

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

Organisation: Official Visitors Program

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Official Visitors Program

Submission

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

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1. Orientation to the Official Visitors Program

This submission is limited to declared Community Mental Health Services and mental health consumers on Community Treatment Orders. As per the NSW Mental Health Act (2007), the Official Visitors Program are restricted in their jurisdiction to community mental health consumers who are under a Community Treatment Order.

1.1 Establishment and Functions

Official Visitors were established in 1843 under NSW Governor Gipps, as part of the *Dangerous Lunatics Act 1843.* Following changes in social thinking and common British Law, the Act separated people who commit crimes from people who were mentally ill. The Act provided safe custody for people seen as 'insane' in dedicated asylums. Official Visitors were established to oversee these hospitals and ensure treatment was humane.

Today Official Visitors remain embedded in the NSW Mental Health Act 2007 as an independent entity under section 129. It states

(1) The Minister must, by instrument in writing, appoint Official Visitors.

(2) A person may be appointed as an Official Visitor if the person has any of the following qualifications—

(a) the person is a medical practitioner,

(b) the person is a registered psychologist,

(c) the person has any other qualifications prescribed by the regulations,

(d) the person is otherwise a suitably qualified or interested person.

(3) An Official Visitor has the following functions—

(a) to refer matters raising any significant public mental health issues or patient safety or care or treatment issues to the Principal Official Visitor or any other appropriate person or body,

(b) to act as an advocate for patients to promote the proper resolution of issues arising in the mental health system, including issues raised by a designated carer or principal care provider of a patient or person detained under this Act,

(c) to inspect mental health facilities as directed by the Principal Official Visitor and in accordance with this Part,

(d) any other function conferred on Official Visitors by or under this or any other Act.

The Official Visitors Program undertook radical reform from 2015 and is now a fully professionalized service. This occurred in consultation with, and encouragement from, senior leaders in the Ministry of Health, the Ministers for Mental Health and other stakeholders. The work of Official Visitors locally and the centralised reporting from the Program now makes a significant contribution to the Mental Health sector.

1.2 Visits

Official Visitors regularly attend all declared mental health units (including Emergency Departments) and private licensed mental health units in NSW. A hospital may have several mental health units, and each is visited and reported on individually. A total of 261 units.

The frequency of visits are:

- Monthly: 148 Inpatient units (mental health intensive care, high dependency, acute, sub-acute, children & young people, substance use, rehabilitation and older persons units).

- Monthly: 39 Emergency Departments (with a mental health facility on site), Psychiatric Emergency Care Centres and other admission/assessment centres

- 3 Monthly: 16 Small, rural Emergency Departments

- 6 monthly: 62 Community mental health centres to review people treated involuntarily on a Community Treatment Order (CTO). The scope of Official Visitors is restricted to consumers attending Community Mental Health Services involuntarily, i.e., people treated under a Community Treatment Order (CTO). Official Visitors attend these services six monthly in accordance with the *Mental Health Act 2007*.

Recommendation

The OVP recommends that, with appropriate funding, visits to Community mental health services occur monthly. This would require an amendment to the NSW Mental Health Act (2007). As outlined in this submission, regular visits to community mental health services would ensure an adequate percent of CTO files are reviewed, consumers have the chance to meet with Official Visitors and discuss any concerns and Official Visitors will be able to follow up issues at regular reoccurring visits.

2. OVP Response to the Terms of Reference

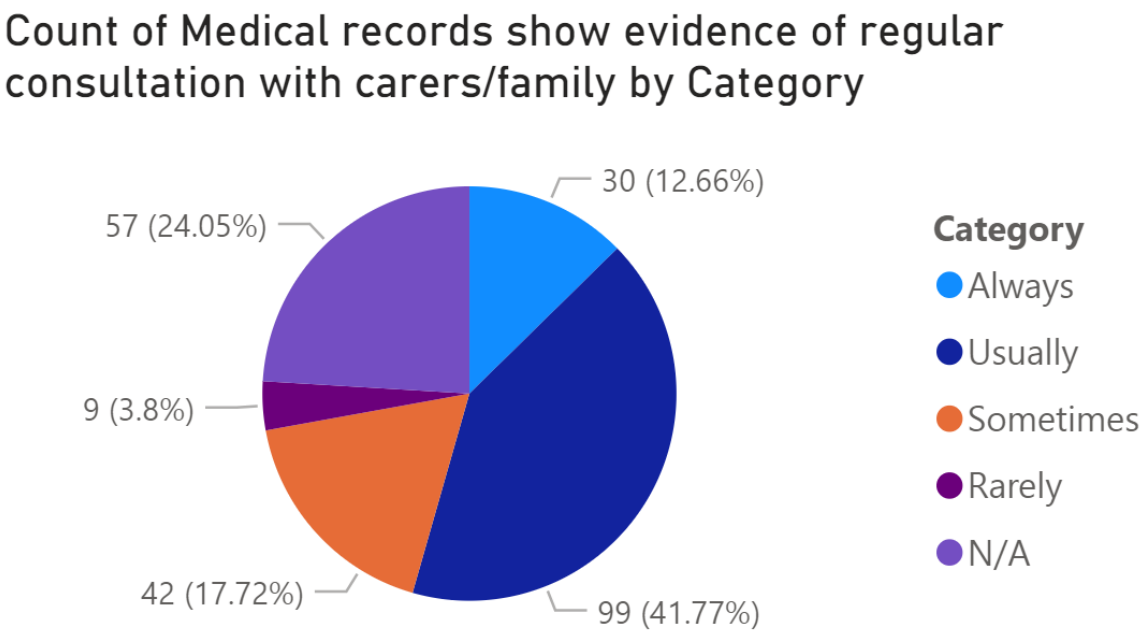
2.1 (b) Navigation of community mental health services from the perspectives of patients and carers.

On each visit, Official Visitors check consumer files to see if there is evidence of regular consultation with the consumers carers or families. In the period of July 2022 until July 2023, only 12.66% of files checked (237 files) had significant evidence of regular consultation with carers and families (figure 1). This is disheartening as over 21% of files identified that consumers and families were not regularly, or in some cases never consulted.

The Official Visitors phone line regularly receives phones calls from consumers families and carers asking for advice and assistance regarding their loved ones. Carers are regularly left out of the Mental Health Review Tribunal process, are not contacted by the treating teams, and are often left out of the conversations regarding discharge.

Figure 1 shows that less than 13% of files reviewed by Official Visitors always record regular consultation with carers and families. Over 20% of files reviewed in the 12 month period between July 2022 and July 2023 show that carers and families are only consulted sometimes are rarely.

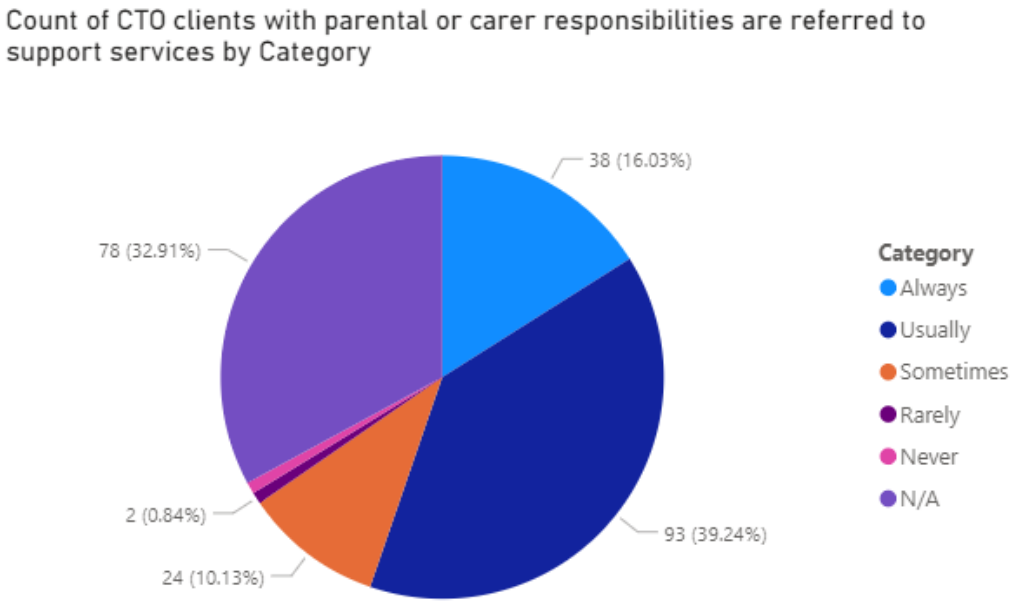
Figure 1- Evidence of files showing regular consultation with carers and families.



It is also important to identify that over half of consumers who were identified as being on a CTO had parental or carer responsibilities of their own (figure 2). This cohort of consumers needs greater support to ensure they are able to fully participate and thrive in their caring responsibilities. As

identified in response f, the large number of consumers assigned to cased managers prevents this level of support from happening.

Figure2- Count of CTO clients with parental or carer responsibilities.



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

People may be on a CTO to ensure *they get a service*. The community workload is excessive, and priority is given to people on a CTO, subsequently in-patient clinicians recommend a CTO purely to ensure the person gets a service. This contributes to the variation in numbers of consumers on a CTO from service to service. The number of cases assigned to a community mental health worker can vary from 3 to 32, of these up to 65% may be on a CTO.

Official Visitors have reported on a number of visits to inpatient mental health units that the staff feel the transient nature of locum consultant psychiatrists leads to them applying a more conservative approach on discharge, and often results in a recommendation for a CTO in circumstances where a full-time consultant may not have.

Official Visitors review the systems used to monitor the provision of the CTO. Predominately this concerns giving depot medication (long acting drugs given intramuscularly, absorbed over days/weeks). There is significant evidence from the data collected by Official Visitors that services do not have an effective record keeping system to ensure either the process is undertaken effectively or "breaching" (the process of following an escalation plan when a person is non-compliant with requirements) is according to policy.

If a consumer does not attend the mental health service to receive their medication as per their CTO, they are breached. However, a CTO care plan outlines the responsibility of the mental health service towards the consumer, such as regular reviews with a psychiatrist. There are not formal pathways for consumers to initiate a breach of the service when they have failed to provide an adequate service as

Recommendation

Currently Community mental health services are declared based on their address, rather than declared as a service. Many community mental health facilities host multiple teams, ranging from child and adolescent to older persons mental health. It is inappropriate and ineffective to conduct one visit by Official Visitors to all services. We recommend that declarations are determined by teams not by address, allowing Official Visitors to conduct a separate visit to each team who care for consumers on a Community Treatment Order. This would result in greater insight into the practices of each team, more directed comments and feedback on their adherence to relevant legislation, policies and guidelines and ultimately a more constructive and useful visit for the team.

It is also a concern that mental health services are declared on their address, however teams are regularly split over multiple sites, with the declaration being at only the main location. Official Visitors have identified that many community mental health services, who care for consumers on Community Treatment Orders are not visited at all as they are not the declared site. Consumers who are accessing these services do not have the opportunity to meet with Official Visitors at their local service.

It is also recommended that there is a statewide system for the provision of care for consumers on a Community Treatment Order. Official Visitors regularly attend services who are unable identify the Medical Superintendent or the Director of Community Treatment Orders.

outlined in the CTO treatment plan. Official Visitors regularly find evidence of consumers on a CTO not being reviewed by a psychiatrist for up to 12 months, or they are reviewed coincidently when the consumers CTO is needing be renewed.

2.5 (j) Any other related matters.

At each visit Official Visitors identify the top issues from that service. The top issues from Community mental health services over the 12 month period July 2022 to July 2023 are identified in table 1. The top issues are care plans, recruitment and retention of staff and communication with other units or services.

Table 1. Top 20 raised issues recorded by the Official Visitors
July 2022 to July 2022

Issues	Number of Visits	% of Visits *
Care Plans	87	37%
Recruitment and/or retention of staff	57	24%
Communication with other unit or services	50	21%
Legal papers	35	15%
Consumer access to Peer Support Worker	34	14%
Discharge / transfer of care	32	14%
Communication with consumers / carers	31	13%
Nominated Carer forms	27	11%
Metabolic monitoring	26	11%
Incident documentation (IIMS)	24	10%
Physical health care	24	10%
Staff training	24	10%
Consumer access to Psychiatrist / Doctor	21	9%
Death / Critical incident	21	9%
Individualised approach to care	19	8%
Nursing staff	19	8%
Building design / layout	18	8%
Psychiatrists / Doctors	18	8%
Consumer Wellness Plans	17	7%
Service understanding of recovery orientation	17	7%

Total number of visits n=237 across 62 units

2.5.1 Care Plans

Care planning is an opportunity to work with a consumer to identify their goals and ensure all aspects of health care are delivered. On 37% of visits, it was identified that this standard was not met.

This is compounded by CTO Management Plan being clinically focused and handwritten (often illegibly in part).

The service may not include direct consumer contact. Frequently contact may be a series of phone calls and voice mail messages. There is an underlying assumption that the phone is connected, has credit and the message will be heard. The medical records will indicate 4 or 5 contacts when these are really 4 or 5 phone messages.

Official Visitors comments:

- On review of the medical records, we noted care plans were very clinical, with little or no personal consumer goals evident. Care goals were not documented in the progress notes and used as a guide for care. They tend to be very generic, and not specific to individual consumers.

- We noted in documentation that care plans are very clinical, essentially copied from the CTO plan. The manager confirmed this and said staff know care plans are a requirement but do not have time to implement in detail due to current caseloads (up to 32 patients per clinician).

- We were told that there should be care plans for all CTO clients. We looked at twelve medical records and there were only three care plans. The quality-of-care plans was quite good, detailed and the information was not just a rehash of the treatment order from the Tribunal hearing.

2.5.2 Recruitment and Retention of Staff

Official Visitors have identified the significance of staff shortages and the high turn over of staff has on consumers of community mental health services. The lack of continuity and the inconsistency in consumers care is a significant risk in their recovery, as rather than forming a therapeutic relationship with their treating team, the community mental health service staff are used as crisis management and implement short term strategies. Mental health consumers required longer term, stable connections rather than seeing a different case manager at every appointment.

It is also difficult for Official Visitors to develop relationships with staff on visits to Community Mental Health Services, due to the high turn over and only visiting facilities every 6 months.