Submission No 68

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

Organisation: HealthWISE

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Chair
Portfolio Committee No 2
Legislative Council
Parliament House
Sydney NSW 2000

05 September 2023

Dear Dr Cohn,

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

New England North West Health Ltd. (HealthWISE New England North West) is a 'for purpose' (not for profit), registered charity delivering primary care programs and clinical services across the New England and North West regions of New South Wales and the Darling Downs and West Moreton regions of Queensland.

HealthWISE is a major regional/rural provider of mental health, Aboriginal health, allied health and primary health care nursing services. Our current programs include Community Based Suicide Prevention Services (Aftercare Services), care navigation services to the Ezidi community in Armidale and support for Local Government Areas in New South Wales and Queensland in recovering from the Black Summer bushfires. The majority of HealthWISE services are provided free of cost to the client, made possible through funding from a range of government and non-government agencies, primarily, Primary Health Networks.

HealthWISE staff delivering mental health services in New South Wales have reviewed the terms of reference for the above inquiry and wish for the committee to consider the following:

(a) Equity of access to outpatient mental health services

- It is difficult for certain individuals to access mental health services because of a need for a mental health care plan. There are limited GPs and none taking on new patients in our town. Also, the cost of going to the GP for a MHTP now that bulk billing is rare is another barrier.
- Needs to be more accessible, in a timely manner and simplified referral processes for psychology, psychiatric and psychosocial networks.
- There is little or no access to outpatient services, waiting lists are high and the time for support is short - usually people are told to see their GP and get a MHTP to see someone else. There is not always service there for people especially young people in rural locations waiting lists are nearly 8 months for headspace.
- Psychiatrists and psychologists need incentives to come to rural and remote areas so that they can support those of us living in the country. Sessions need to be subsidised and on a sliding scale so people can afford to see a specialist.

- Lots of organisations do not like sharing information, tend to work in silo mentality, even though we receive referrals, it is difficult to obtain or share relevant or vital background information.
- Very difficult to access. People are often told they are not 'unwell' enough.
- Outpatient mental health services are often difficult to access. Patients who should be serviced by NSW Health outpatient services are discharged before they are well enough to access care from other mental health services in the community, and they often have significant wait times due to demand of such services, putting them at risk of relapse.
- Access is related to where you live. If you are in rural or remote locations this is complex. Outpatient mental health is usually limited to a phone call post discharge with instructions to follow up with a GP.

(b) Navigation of outpatient and community health services from the perspective of patients

- There is an inconsistency across different service providers and misinformation, stigma and limited understanding are ongoing issues that impact engagement and effectiveness of treatment and recovery.
- Referrals need to be timely and simplified.
- There is a lack of support for those that fall between being mildly-depressed/short-term depressed or needing hospitalisation. The 6-12 sessions for Mental Health Plans are inadequate and waiting lists are too long.
- Should be willing to share client information more easily.
- Lengthy wait times in emergency departments, frequent reports of no follow-up from Community Mental Health staff. Often people are discharged despite experiencing strong suicide ideation. Recent experience has demonstrated a distinct lack of care and effort to coordinate supports prior to discharge by community based Acute Mental Health Teams.
- Patients have commented to me that community mental health often don't follow up with them in a timely manner, there is difficulty with communication between patient and staff and they can be discharged from the service without their knowledge.
- Often very hard to access services in CMH because there are so many gaps and such a lack of continuity of care - CMH staff are over worked and cannot meet the needs of those who are accessing or trying to access the service.
- Difficult to understand what the role is for CMHT - limited resources in the community for recently discharged sub-acute people, access to Psychiatry is limited.

***(b)** Navigation of outpatient and community health services from the perspective of carers*

- It is frustrating when someone finally gets up the courage to ask for help, especially when you have been encouraging them that support is there for them and it is helpful, for them to then have a GP tell them, "Talking about it won't do you any good". Or for a therapist to minimise and invalidate an experience by meeting valid concerns with, "Lots of people do that."
- More simplified and timely referrals. Plus sharing of client information needs improving with efficacy instead of using confidentiality as a barrier.
- It is really difficult for people to navigate services within community mental health - often people don't know who the person is who is providing the service to them, and ringing doesn't always work I think that families often feel they are left to sort it out themselves and that the client is often blamed for being unwell. Attitudes especially in

ED are shocking and often result in people leaving then the staff say that people chose not to stay which I understand but often it feels like that is the aim of the interaction to get people to leave and see the GP - often there is no GP so families are left to work it out for themselves and this will often include the ambulance or police

- It's frustrating to see your loved one fall through the cracks due to the problems mentioned above. Not to mention stressful if they start to succumb to their mental illness, as the help they need is not easily available.
- Carers feel that they have limited input into the services the person they care for receive.
- It can be hard, sometimes feels like you are going in circles and that no one wants to help.
- It is not clear what to expect or what the plan is for support post discharge.

(d) The integration between physical and mental health services

- GPs are often the first port of call and do not have to have any mandatory training in mental health. How is this even allowed? The brain is part of the body and mental health affects physical health.
- More simplified and timely referrals.
- This is pivotal to recovery and wellbeing. General health is often over looked and "somaticized" - no investigations, no treatment and often patients are labelled pests looking for pain relief.
- Doctors focus too much on a patient's physical health compared to psychological health. They don't understand that quality of life means having a sound mind which is more important to patients than physical health concerns.
- Better communication between each other, easier and simplified referral pathways
- There is research based evidence that indicates there is strong links between good physical and mental health. Physical health services (where clinically indicated) should always be considered in a care plan, but is frequently overlooked.
- Often there is a barrier because co-morbidity and collaboration of care is not something that aligns well in services. Very few collaborate and work together to achieve the best for the client.
- Very little integration including side effects of medication - chemists don't seem to have a dedicated role.

(d) The integration between mental health services and providers

- There needs to be a well advertised, up to date hub to access all services via questions that point you towards the right resources and service providers. There may be something like this already that is known to providers but the community and individuals who need it have no awareness of it because it hasn't been nationally advertised.
- More simplified and timely referrals, more accurate client history
- Some good some not so good when a client becomes increasingly unwell and needs acute care this can be a real problem lack of voluntary beds and increased home care services for mental health could have a positive impact.
- Community Mental Health services are often out of touch regarding what is available within the local community. They also often have misguided ideas about what services in the community can provide.
- The demand for mental health services outstrips provider's capacity in the community. Also, underfunded models of service, there can be a lack of continuity of services,

leaving patients untreated or with only minimal care, when funding is ceased or moved to another provider.
- Usually, negative interactions related to lack of resources and the client not answering the phone then discharged - little follow up.

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

- Rural areas have a lack of services. There has been improvement with telehealth services but not face to face. It's actually gotten worse. Peer workers and Lived Experience workers often don't have clear guidelines around their role and others also rarely have any idea what their role involves either.
- We tend to work in a Silo workspace, afraid of sharing information or not sharing, limited health professionals available, common responses are its not in our budget or our responsibility! Lots of our clients are very unwell and require case management by a MDT which I believe needs to be actioned or improved immediately.
- Co-employment is difficult but a good model if it were a bit easier to manage.
- Obviously under-staffed in rural areas, and they can all play a part in assisting a person with their mental health although psychologists and psychiatrists are sorely needed.
- Timeframes, costs, referral processes are too complex, this need to be simplified with regular updates, especially with outstanding court offences.
- Psychiatry is very difficult to access, especially for low income earners. I believe in our area we only have psychiatrists that visit the area from elsewhere, typically very few (if any) live locally and often cannot be seen with any kind of regularity. GPs are also incredibly difficult and costly to access as well. Often, people will go without GP appointments simply because they cannot afford them.
- The GP is often the first point of call for mental health treatment. Unfortunately, due to a lack of bulk billing, patients cannot afford services. Even when they can afford to pay to see their GP (if they have one, many rural areas have long waiting lists to even see a GP), seeing a psychiatrist is completely unaffordable. Subsidised services are seeing increased demand due to this situation. Peer workers form a critical part of treatment for many patients but are often unavailable due to lack of funding.
  All of which are in short supply - month or even year long waitlists are not sufficient when individuals are unwell.
- Limited primary health care funding and this is reducing every year GP access is difficult long term waits for appointments and no bulk billing.

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

- I think this is a step in the right direction toward more person centred empowering mental health practices. There is still a lot to learn from those with a lived experience.
- This requires total support for the entire MDT, not just one person such as an NGO has limitations.
- This should remain with the public health sector.
- CTOs empower those who need support to live in the community, but mental health support agencies/NDIS services are woefully inadequate. Staff are not well-trained nor supported enough by their employers. The administrators of these services are more interested in how much they can pocket from the NDIS than caring about the people they support.

- While CTOs are an important part of treatment in the community, they can be very difficult to get off, even when the patients mental health has improved. This is particularly true in rural, regional, and remote areas, where there is a lack of support services to form a care coordination model of care.
- Sometimes it is effective and sometimes it is not. It is oppressive and suppressive often adding shame to someone who may be facing issues and dealing with large amounts of shame already.
- This needs to remain with NSW Health

(g) Benefits and risks of online and telehealth services

Most mental health professionals at HealthWISE believe there are benefits to telehealth, especially around access:

- In remote areas, people who are limited physically, or who have severe anxiety about leaving the house. It also allows us the option to still deliver a planned session/appointment when people are sick with cold/flu/COVID etc.

- Definitely, some people have no transport, work, have children, or may be unwell; therefore, this works, even just for a brief check-in, though 'face to face' is preferred.

Our team identified the following risks with telehealth:

- Trauma informed care is difficult in a telehealth setting where co-regulation is important.
- More difficult to observe the issue, communication can be blurred.
- Breakdown of internet connection during consultation can cause important information to be lost/not heard/mistaken for something else.
- More difficult to provide certain techniques or strategies, more difficult to understand if unable to see the client's presentation or body language.
- Yes - but I wouldn't say it's any riskier than in-person services.
- Telehealth is an efficient medium to access mental health support however if this is taken away from a local provider then we lose the local service knowledge and the options for face to face.
- There are no benefits if those who are on welfare cannot afford to have a computer + internet/internet connection that is strong enough to support telehealth. Telehealth can also feel a bit impersonal as it doesn't have the same human connection as being in the same room together.

(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

- Neurodivergent clients are widely misunderstood and stigmatised. Misdiagnosis is common amongst those who are neurodivergent and their neurodivergence is rarely taken into account when presenting with symptoms of anxiety, depression and emotional dysregulation which is often linked to the neurodevelopmental disorder.

- Everyone should be treated equally, fairly and with no discrimination regardless of background, cultural or gender preference.
- Inadequate services for young people - headspace is only one service and we need more services that cater to the young. The new acute mental health unit Banksia doesn't have enough beds for young people needing MH support.
- Can take time to for trust and therapeutic relationship, at times lack or recourses or suitable clinicians.
- Accessibility for young people in our regional/rural area is severely lacking. Often, CAMHS do not have the staff to see young people and their guardians and are unable to deliver the appropriate care that a level 5 service (in the stepped care model) should be able to deliver. I have been informed on a number of occasions that clients - 'aren't severe/unwell enough' despite significant evidence being provided to indicate otherwise - they do not have enough staff to take a young person - they do not have the appropriately trained staff to deliver the kind of therapy a young person and their family need. In addition, for some young people who are acutely unwell, they are only given brief interventions such as a one-off psychiatry review and one or two meetings with a staffer before being discharged.
- There is difficulty accessing appropriate services that are culturally safe in rural areas. There is also a lack of appropriately trained staff for gender diversity, young people, and people with a disability.
- Access expectations are not realistic long wait times for youth services.

(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)

- Harm minimisation practices and lived experience workers trained in mental health first aid to work alongside but at the forefront of these situations. It would be amazing if lived experience coupled with safety training was valued and seen as a strength and not as a threat amongst police and other emergency services.
- No different to any health professional, they have a difficult job and are trained to deal with the situation, possibly have the police force provide some psychoeducation to health professionals on what they learn and situations they are faced with.
- Limited resources in the community, CMHT / DACS are limited and tend to refer chronic or complex clients way too early.
- Alternative services should absolutely be an option for responding to emergency situations with people experiencing acute mental distress, however given we are placed in a regional/rural area, we see very little of these options. Thorough training should also be rolled out to what services we do have to ensure a more informed response from emergency services, especially police.
- CMHT mobile after hours teams linked to rural and remote locations via Telehealth Standing orders for non-attended ED for Nurses to administer medication and admit overnight for safety

(j) Any other related matter

- MH services need to work more closely with each other, simplify the processes and make the service more accessible to everyone.

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- Funding to support services such as HealthWISE should not just be dependent on meeting quotas but also consider the needs of the community and fund accordingly. Funds should be set aside so that new projects can be developed on an as-needed basis.
- Regional areas continue to struggle with a lack of services, including early intervention.
- Emergency departments continue to be a source of stress and humiliation to clients who often will not attend due to being dismissed or penalised for non-visible illness leading to delayed intervention.

HealthWISE value opportunities to participate in developing mental health services to meet the needs of our communities.

Yours faithfully

Sally Urquhart
Acting CEO