Submission No 82

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

Name: Name suppressed

Date Received: 6 September 2023

My name is and I am a 19yr old woman. I have accessed the NSW outpatient and CAYMHS services since I was 14 in 2018 and due to my mental health, I have also had a few interactions with police and ambulance. All my experiences with outpatient and community mental health care services were voluntary and based on my experiences, I would like to address the following points in the provided terms of reference:

- accountability and process of complaints for outpatient care (term b)
- the response and general preparation and training for GPs in the context of mental health (terms d and e)
- the process of deciding whether to admit or refer to community mental health teams when presenting to emergency (term e)
- Alternative responses to mental health crisis calls to Triple Zero (term i)

Term b) When navigating the mental health system, I believe that it is imperative to have explained to one about where to go and how to approach the situation if it is not providing the support a patient needs. Not only if there is a major issue, but also if perhaps a consistent attempt has been made for progress, however something just isn't working. For therapy to be most effective there needs to be trust, which is not something that can be forced. I know that in inpatient care, there is the official visitors box, however, I believe in outpatient care, more needs to be done to either explain how to navigate providing both positive and negative feedback, or, more extensive structures need to be implemented.

Furthermore, I believe existing systems of feedback need to be made more widely accessible in different formats. Just anecdotally, I have been attempting to file a complaint about a psychiatrist who is part of NSW Health, however, the only format the HCCC accepts is a written statement. I understand the need for record-keeping, documentation and being unbiased, but currently there is no support for people who are not able to file written reports. This provides a huge barrier of entry to many demographics who would be a large minority of affected persons, some of which include people who:

- Are neurodiverse,
- Are struggling with recovery after physical injury or complications from potential blunders
- Are of lower education or literacy levels (very often because of, or in correlation with, being of lower socioeconomic status)
- Those who just do not have the capacity, time or don't want to have to relive the trauma and agonise over the phrasing of individual words let alone an entire report
    - The internal turmoil and intimidation about reporting the misconduct, the second-guessing about "was it my fault", internalised victim blaming (for want of a better world) and "what did I do wrong", thoughts of "what good will it do" are agonising but regular thoughts through my brain

As stated before, this means that navigating the process of filing a complaint is inaccessible to a vast number of people who might otherwise fit the criteria and be entitled to at least a voice to raise their concerns.

- A simple fix to this issue of navigating the mental health system, in particular the process of raising a concern is to have different accessibility measures to ensure that the barrier of access is mitigated. Examples include dictation services, or optimistically speaking, a branch who can talk to a victim of alleged misconduct to help them document the often traumatic experience(s). I believe these services should have at least some experience or training in counselling, which would aid them in helping people to feel like their voice is being heard and listened to in a system which is at the moment very hard to navigate if the professional who is being paid to help you is potentially causing harm.

Term d) Another point I would like to address is term of reference d) being the integration of mental and physical healthcare which also bleeds into point c) and e). It is well known at this point that psychological services are highly sought after and needed in the present day, with the Australia Psychological Society reporting in February of 2022 that 1 in 3 psychologists were not able to take on new clients, an astronomical increase from the 1 in 100 prior to the pandemic. Combine this with the process for seeing a psychologist under Medicare requiring a referral from a GP, and that general practices are usually the first point of call for an issue, unless the situation has regressed significantly and an Emergency Department visit is needed.

GP's play a vital role in the medical system, as they are a jumping-off point for many people to reach specialists. According to the Black Dog Institute (no publishing date provided), "General Practitioners are not required to partake in any mental health specific training". However, as we see mental health becoming a more prevalent issue, it is important to cater towards the needs of society, and GP's not being trained in mental health is unfair to both patients and GP's. This article by the Royal Australian College of General Practitioners summates the issue well. This lack of training and resources is only exacerbated in rural, regional and remote areas.

Point e) Furthering my thoughts on point e) I think the current system that is set up predominantly in Emergency Departments is not a sufficient solution for providing support for people particularly with Suicidal Ideation (SI). At the moment, the framework is largely reactive so if someone has attempted to take their own life they will be admitted to an inpatient unit. I acknowledge there is a lengthy framework when assessing a patient with SI, however I have observed both anecdotally and more broadly through interactions with people online and face to face that essentially, if there is no intent communicated in the present moment, even if there is a plan in place, that is enough for clinicians to warrant discharge from the emergency department. There needs to be more extensive care taken in this framework for people who are suicidal and on the outer cusp of the threshold for admissions.

These people want help, they have presented to emergency with a serious concern for safety but there aren't enough resources and beds available to support them. They are deemed lower risk because they haven't yet taken active steps towards ending their own life. From personal experience and by talking to an extensive

number of adolescents who have issues with their mental health, I know that when this situation takes place, every single person I identifies feeling discarded and invalidated because “they just aren’t sick enough to deserve help”. This leads to people already at risk, taking drastic actions they may not have otherwise acted upon, because they so desperately need help but the only way to get said help in that moment is to attempt and fail to take their own life. In a worst-case scenario, this can unfortunately go too far in some scenarios and end up with the person passing away or being left with severe lifelong disabilities.

It is for this reason that I think the system of aftercare after discharge from ED needs to be vastly improved. Overall, in order to improve standards of care, I believe the mental health system needs to be more focused on being proactive as opposed to reactive. Follow up and check ins need to be more timely. The urgency and attention that is paid to these appointments need to show the person in crisis that people do care if they are alive or not and soothe and qualm the current feelings of isolation and rejection that are felt. Misconceptions that because you are currently asking for help, you can’t actually be suicidal because if you really wanted to kill yourself you would have done it by now. This has actually been said to me on a PECC ward by the consultant psychiatrist, which under the nursing unit manager, is the head of department. I do not say this to muddy any reputation but because I believe there is a huge disconnect between the attitudes of both inpatient and outpatient psychiatrists and the reality of their role when tending to patients. In my experience, some of the mental health professionals I have encountered have the attitude that patients are just on a “to see” list and don’t realise the impact they have on the lives of their patients.

> At the moment, on page 8 of “Planning and Transfer of Care for Consumers of NSW Health Mental Health Services” it states that follow ups needs to be within 7 days after discharge from a PECC (Psychiatric Emergency Care Centre) ward. To be clear, this is for people who have already been identified as a risk to their own or others safety and have been admitted because of concern. I was not able to find the policy regarding a discharge from an Emergency Department. I believe this is not given the amount of urgency it requires, which is supported by this study titled “Short-term suicide risk after Psychiatric Hospital Discharge”. The study states that “The period immediately after psychiatric hospital discharge poses an exceptionally high risk for suicide. Although only about 6% of mental health outpatients receive psychiatric inpatient care each year, approximately one-third of all suicides among patients with mental disorders occur within 3 months of discharge from an inpatient psychiatric unit” A separate study titled “Suicides in Users of Mental Health Care Services: Treatment Characteristics and Hindsight Reflections” states that “The results indicate that the quality of mental health care for suicidal patients could be improved by focusing on communication among clinicians, continuity of care, suicide risk assessment procedures, and the involvement of relatives”
>
> Additionally, and I acknowledge this is extremely idealistic, I don’t feel that a singular follow-up appt is sufficient, especially when wait times to see

outpatient support can be long – I don't know what the triaging would be like for patients who don't have outpatient or community support so I cannot speak to this, but even with another appt lined up it can feel very overwhelming and I do think there could be greater support on discharge. This support would not only benefit the patient but also help the families feel more comfortable in supporting their family member who is feeling unsafe.

In other terms of support, I believe the help lines already implemented are a good support for people who are feeling unsafe, however wait times mean that the amount of good they could do is limited at a certain point. Sometimes it also feels like the operator just takes your name and details and explanation of what led up to the moment and then tells you to go see your local doctor at your earliest convenience, with almost no input to the dialogue and no form of crisis counselling which isn't beneficial when the number and service is displayed as a helpline.

- To potentially improve this vital service, I believe more extensive training or ongoing development is needed so operators do not sound like they are reading off a script and are able to interact and empathise in a way that validates the caller and deescalates situations
- A higher number of operators or a way to even out the load between various helplines would also be useful to ensure the process of talking to a trained operator is as streamlined as possible

Term i) The final reference point (term i) that I would like to address is that I strongly believe that when dealing with crisis calls to Triple Zero, unless there is a patient who is violent, police should absolutely not be dispatched. Instead, I believe NSW and even more broadly Australia should implement something similar to various Crisis Response Teams that have been tested and implemented across many countries such as in America. I found this article which I believe explains some helpful structures that have been tested and implemented to great success. Police are gradually receiving more training in responding to mental health issues as seen in these notes from NSW Parliament, but I just haven't seen that put into practice from my personal experience. When someone is in crisis, their brain is often in "fight or flight", where thinking is focused on perceiving threats and prioritising identifying routes of escape. I believe that when police are involved in crisis response, in attempt to deescalate the scenario effectively their actions need to have a marked shift as opposed to if they were responding to a call where a crime is suspected. People in crisis are not criminals, and being able to effectively switch between those main two responses is challenging for police when given the little information on dispatch that I suspect officers are given. According to the Canberra Times, 1 in 10 calls to ACT Police are related to mental health.

- This indicates that if a scheme separate to, but in coalition with, emergency services were to be implemented, aside from the incalculable amount of good for Australia's mentally ill population, there would be more than sufficient return on investment. We already have the basic individual systems in place with the various help lines and the training that police are apparently being given, there

just needs to be the legislative structures and organisational framework to get people in these response roles who are not so confrontational or intimidating because of the uniform they wear or the connotations with the institution they are a part of.

Police have enough work to do where they are objectively helpful, with adding in dispatch responses where the value of their presence is more dubious. According to the ABC, as of May 2023, the officer shortage is at a crisis point. NSW did not provide numbers, but as the article states, Victorian police force are advertising 800 vacant positions, and Queensland is reportedly looking to increase their police presence by 1450 officers. Police should be allowed to focus on the tasks and situations that are directly related to their job description instead of having to also take up the slack where there is an arguable gap in the systemic handling of mental health crisis scenarios.

All in all, I know I didn't address every term of reference, and I have many other ideas that I didn't have time to put into this submission. The ones I did address include terms b, c, d and i. I would love to give evidence at a hearing as I have had a long experience in the mental health system and have many ideas for steps that could be taken to improve it. However, I have no options for how to express these ideas and this would be an amazing first opportunity.

Long form links and bibliography:
Article by RACGP long form link:
https://www1.racgp.org.au/newsgp/professional/a-huge-issue-call-for-more-gp-support-to-address-m

Short-term suicide risk after Psychiatric Hospital Discharge long form link:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8259698/#ref-list-a.l.ctitle

Police Response and crisis response teams long form link:
https://www.apa.org/monitor/2021/07/emergency-responses#

Police and mental health training long form link:
https://www.parliament.nsw.gov.au/la/papers/pages/qanda-tracking-details.aspx?pk=51177

Links and sources:
https://psychology.org.au/for-members/news-and-updates/news/2022/australians-need-psychological-help-more-than-ever#

https://amp.abc.net.au/article/102304538

https://www.psychologytools.com/resource/fight-or-flight-response/#:~:text=The%20fight%20or%20flight%20response,body%20to%20fight%20or%20flee.

https://www.blackdoginstitute.org.au/wp-content/uploads/2022/08/Finding-a-mental-health-friendly-doctor-fact-sheet.pdf

https://www.healthdirect.gov.au/psychiatrists-and-psychologists#:~:text=Visit%20your%20doctor%20(GP)%20if,your%20doctor%20about%20mental%20health.