

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

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This submission is from a registered nurse and registered psychologist who has worked in mental health for over thirty years. Most of this was with an inner west community mental health service and ten of those years were as the nursing unit manager of acute care services (aka Crisis Team).

[This account is personal and does not reflect the position(s) of NSW Health or any area health service.]

I am also someone who has experienced mental illness and was, for over twenty years, the carer for a family member with a serious mental illness. I am now recently retired, primarily due to burnout, having struggled through the impact of Covid on health services. Covid is not the cause of problems in the NSW mental health system, but it did bring into sharp relief many of its short falls and limitations.

[Note: “patient” and “client” are used interchangeably, and “clinician” refers to all types of mental health professionals and to general practitioners, depending on context.]

[a] Equity of Access >>> The Richmond Report (Richmond, 1981) and its restructuring of services was a watershed point in NSW mental health. It set out a model of mental health care that recognised mental illness is in itself an obstacle to access.

However, ten years later, this “Assertive Community Treatment Model” (ACT) was already approaching a high-water mark. By the 2000’s clinicians would still talk about “assertive intervention” but over the last 10 to 15 years the word “assertive” has disappeared.

Over my many years working in this field, one thing, in my view, has remained consistently true - “a few clients get more than they need, many get less than they need, and some get nothing at all”. In this observation, Stein and Santo (1998) were commenting on services in America and, like Richmond, saw ACT as the pathway to a redemptive mental health system.

My experience has become that “many get little at all”. If the ACT model has the capacity to bring people with serious mental illness into safety, it has been consistently eroded from the 1990’s onward to the point where many clinicians do not know about the ACT model, and what was a coherent structured model of

mental health care has vanished to be replaced by a service system that is fragmented and overburdened.

Richmond's (1983) report is well worth revisiting. It isn't a definitive answer, but its compassion is unmistakable, and its coherence is incontestable.

[For an explanation of "Assertive Follow-up" and further commentary please see last page of this submission. It is crucial to any service seeking to address clients mental health issues and underpins the ACT model.]

[b] Navigation of Services by Patients and Carers >>>

It takes a tremendous amount of courage for a person with mental health issues to first approach a GP or a community mental health service, and the chances of stumbling at the very start are quite high. Consequently, patients are much more likely to not present until they have an acute mental health crisis where it is, in turn, much more likely that patient experience is one of losing control over their life and having solutions imposed. A crisis though does not always have to be resolved in this way, but working through a crisis takes a significant skill level and patience (time) for clinicians to protect and maintain a patient's belief in their own autonomy.

Perhaps the most significant factor in navigating services is the clinician that the client and carer encounter when being triaged and receiving treatment. In the public community health system this is highly variable because the training base and clinician's level of experience is so variable. During most of my time in community, new clinicians learnt assessment skills from another clinician in their workplace. It is only in the last couple of years that my area health service has recognised new clinicians need structured training.

Patients are often exquisitely sensitive to a clinician's non-verbal cues that indicate their underlying attitudes and values. For some patients, this is symptomatic of their disorder. But neither they nor the clinician really quite grasp this fact. It is very easy for a patient to go away feeling that the clinician has not heard them. Add to this the time constrained clinical environment, and the most successful patients will be those who have recognised they need to work the health system to get what they want.

Mostly, this comes down to "interpersonal skills". Patients with the most significant mental health needs generally have the least developed interpersonal skills. And a clinician who also has underdeveloped interpersonal skills will tend to have poor outcomes. The most experienced clinicians talk about building a therapeutic alliance with the patient. But this skill is not something taught to new clinicians. It is also a skill that takes a long time to develop.

The next most significant factor is money. Those patients with resources can move to access outside the public system. They also tend to have a level of social support that helps this process. In my own case I was lucky enough to find a psychiatrist who firstly listened and secondly only charged a gap of \$50. My access to a psychiatrist over a number of years far exceeded that of anyone in the public community setting. Sometimes for months a time I was able to talk weekly for 50 minutes. Even a patient with a psychotic illness that does respond to medication well needs to talk very regularly for good outcomes. For very many patients, psychiatrists are too expensive and psychologist access is too infrequent.

[c] Capacity >>>

When I started community mental health in the early 1990s, the local crisis team carried a client load of about 30 to 40 patients. The number of people with mental health problems in the community was probably much the same then as it is now. However, the patient load (even before Covid) almost routinely exceeds 100 patients. The community's mental health literacy and understanding of mental health issues has increased dramatically thus influencing referral numbers.

There is no recognised staffing ratios for community mental health teams and there has not been a concomitant increase in community staffing numbers. This has amplified the clinician's role in gatekeeping access to community mental health resources. Clinicians of necessity decide the patient's level of service access and therefore its quality. There are many ad hoc clinical rationales for these decisions and while many individual clinicians are personally troubled by this, there is not a thorough and ongoing service recognition and discussion of these problems. This can and does result in individual clinician conflicts about how to assist patients and how much responsibility should be quarantined as belonging to the patient and their family.

Increasingly community mental health teams have become focused on where else they can refer patients. Cost and availability are always an obstacle to patients/clients but the community service on the whole does not seek feedback on whether the redirection of the client has been successful.

[d] Integration between Physical and MH Services and other Providers >>>

While the interdependence of physical health issues and mental health issues is well recognised in community mental health (not so in the 1990's) it is not something that has been successfully addressed. Firstly, much the same obstacles to good physical care exist as for mental health. This is reflected in the life expectancy of people with serious mental illness – twenty years or more less than the general population.

Secondly, GP's and MH services have not routinely resolved to share the care and management of mental health patients. Each, when making a referral to the other, is hoping the other will take over responsibility. Add to this that GP services are also not assertive about follow-up and we see patients easily falling between services.

One possible remedy would be to create an *assertive* component within group GP practices and medical centres. This is possibly a hard sell (GP's say they are not funded for this), but a practice nurse, experienced in community mental health and situated within a GP practice could have a role co-ordinating between services (including with psychologists) and promoting regular treatment and medication supply and compliance to mental health patients. This would also benefit patients by increasing points of access to mental health service and normalising MH treatment in the community for both patients and GPs.

[e] Appropriate and efficient allocation of mental health workers >>>

Where the need for mental health services far exceeds the available resources, the management of clinicians is unlikely to be efficient. The allocation of clinicians requires a much more nuanced discussion conversation about who should be prioritised for services. When I started, for example, people with borderline personality were not regarded as the focus of community mental health treatment – they didn't have a real mental illness and as a group were often discriminated against. But this has changed as a result of research, advocacy and training (particularly through Wollongong University) and for a long time community mental health struggled with providing appropriate treatment. Now the question is how sick must a person be before they receive treatment. Inevitably there are those who receive and those who do not. (Refer back to the last paragraph of section [d].)

[f] Community Treatment Orders >>>

CTOs are not an "assertive" mental health intervention, they are "coercive" interventions. And while it is not hard to find examples of patients who have improved significantly while on a treatment order, they have improved because they took medication. The question of whether or not it is possible to achieve medication compliance using assertive interventions remains unanswered.

CTOs are used for the convenience of mental health services. Primarily by inpatient services to facilitate the movement of patients out of hospital into the community and reduce the frequency of re-admissions.

They are a clinical intervention but surprisingly there are no clinical best practice guidelines for CTOs and little if any discussion about the detrimental effects on the patient. In the initial stages they can become significantly resource intensive for

community teams as they resort to breach orders and police interventions to maintain medication compliance. From the outset the order obstructs the treatment options for the client and nullifies the development of a therapeutic support between patient and clinician.

People with chronic serious mental illness are more likely to attract a CTO but they are also most likely to have an already damaged sense of autonomy. They lack “. . . a continuing sense of competence and mastery over their own lives, [such] that they may not believe that their [own] actions can lead to any improvement in their lives.” (Richmond; Part 3 p 26; 1983)

My observation is that it has become standard practice for hospital staff to make decisions about a CTO and there to be no meaningful input on the part of community clinicians other than to rubber stamp the decision. Usually, the community clinician charged with implementing a CTO has never spoken with the client (let alone discussed the CTO) before the client is discharged from hospital.

It is possible to negotiate a CTO arrangement that tries to preserve the patient's autonomy, but it needs to be between the patient and the community clinician and done face-to-face. Best practice guidelines are desperately needed, as is a focus on minimising and reducing the use of CTOs (similar to inpatient programs focused on reducing the use of seclusion).

[g] Benefits and risks of online services >>>

Online services can do many things and are of great use when patient and clinician cannot meet face-to-face, but they have different results from actual face-to-face contact. This is particularly true of crisis situations. Understanding someone's non-verbal cues and their attachment style is very foggy online. The difference might be comparable to a community MH clinician seeing someone at a community health centre versus seeing the patient in their home environment. All people engage in impression management, intentionally and unintentionally. If a clinician is invited into a patient's home, impression management is harder, and things become clearer at a whole new level.

[h] Accessibility and Cultural safety . . . >>>

These groups are undoubtedly best placed to comment on their own experiences. There are many bad experiences for each of these groups and they are not necessarily identical experiences for each group.

But the groups listed at this point, in my community experience, have always been welcomed by clinicians. Where difficulties arise are when the member/patient of a

minority group is struggling with their minority status. In this situation, services struggle to find appropriate clinicians with the minority-group understanding and skills that are needed.

One group not listed in this point are refugees and illegal migrants. This group faces a double jeopardy. Firstly the trauma of persecution and fleeing this, but also the trauma that all mental illness carries with it.

[i] Alternatives to police . . . >>>

Police are usually called upon by community mental health in specific situations where there is a duty of care that cannot be fulfilled by clinical staff without legally authorised assistance. This includes situations where mental health assessment is needed but clinician are unable to gain access to the patient, enacting a schedule (S19) under the mental health act, and enacting a breach of a community treatment order. Police are needed to gain legal access and where physical restraint might be required. The main difficulty in these situations lies with creating a dialogue between patient, clinician and police that seeks to minimise the patient's sense of violation and loss of autonomy. This is time consuming and when clinician and police don't know each other (often the case), negotiating this approach is difficult to do without any of the parties escalating the situation. Given the power relationships, it is generally the patient who loses out.

[j] Other related Matters - Training >>>

The Richmond Report and its implementation included a training component using the Institute of Psychiatry. The need to up-skill clinicians for community mental health was acknowledged. But by the early 1990's this training was no longer available. Since then training has remained ad hoc at best and a dedicated training for community MH clinicians has only re-emerged in the last couple of years in one area health service. There should be a general acknowledgement as to the specialised knowledge required for community mental health work, and training should be a branch in its own right.

References and Reading

Burns, T. and Firn, M. (2002); *Assertive Outreach in Mental Health, a Manual for Practitioners*; Oxford University Press, Oxford UK

Richmond, D.T. (1983); *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled*; NSW State Health Publication No. (DP) 83 - 020

Stein, L.S. and Santos A.B. (1998); *Assertive Community Treatment of Persons with Severe Mental Illness*; W.W. Norton and Company, New York

"Assertive follow-up" as used in the ACT model for community mental health refers to a proactive and persistent approach taken by MH services and clinicians to promote to the client the continuation of appropriate care and support.

In community mental health it describes the efforts made by clinicians to maintain contact with and monitor the well-being of their clients or patients, particularly those who may be at risk of relapse, non-compliance with treatment, or disengagement from services.

The features of assertive follow-up include:

- **Regular Contact:** Clinicians make consistent and regular efforts to reach out to clients, by phone calls, centre based appointments and home visits.
- **Monitoring:** The client's mental health condition, medication adherence, symptom progression or regression, and overall well-being are regularly assessed during follow-up. (Ongoing monitoring becomes problematic when client load increases beyond capacity.)
- **Support:** clinicians provide ongoing emotional support, psycho-education, and guidance to help clients manage their mental health conditions.
- **Crisis Intervention:** Where necessary, assertive follow-up includes swift responses to crises or deteriorating mental health conditions (role of crisis teams).
- **Collaborative Care:** Community mental health clinicians work with other healthcare providers, social services, and support networks (family and carers) to ensure clients receive a holistic approach to their care. (This is an underdeveloped aspect of care because outside of community mental health clinicians often don't entertain sharing care and responsibility on an ongoing basis, and there is a weak understanding of the concept of assertive follow-up. In the case of General practitioner services, they are also not funded to provide assertive follow-up.)

- **Goal-Oriented:** Follow-up efforts are often directed toward achieving specific treatment goals, such as improved symptom management, increased functioning, or reduced hospitalisation rates. Efforts also focus on needs identified by the client. This is crucial to therapeutic engagement.
- **Client-Centred:** The approach is tailored to the individual needs and preferences of each client, recognising that different people may require different levels and types of follow-up.
- **Documentation:** Detailed records are maintained to track the progress of clients, including changes in their mental health status and responses to interventions.

Assertive follow-up is particularly important for individuals with severe and persistent mental illnesses, those at risk of self-harm or harm to others, and those who have a history of non-compliance with treatment.

It aims to enhance engagement in treatment, reduce the risk of relapse, and improve the long-term outcomes and quality of life for individuals living with mental health conditions in the community.
