Submission No 102

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

Name: Name suppressed

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I am a mental health professional currently working with NSW Health in a Community Mental Health team. I have been working with NSW Health for almost 2 years and have noticed a few areas in community mental health that I strongly believe could be improved to better support our community.

a)

There is a clear divide between accessibility to mental health services of private vs. public patients. Many private hospitals and clinics offer regular therapeutic groups for people struggling with mental ill health, including groups based on Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, etc. There is a strong research base for therapeutic groups and anecdotally, I have heard of many positive outcomes for people. Unfortunately, in my experience, NSW Health community mental health teams often do not have the staffing or resources available to run regular therapeutic groups. Some local health districts have a Dialectical Behavioural Therapy clinical team that regularly runs groups for patients at risk of suicide and self-harm, however, not all local health districts have this available. As such, public patients often miss out on this group therapy, missing an opportunity for effective, and often preventative, mental health care.

Further, staffing issues also cause inequity for individuals seeking community mental health care. I am aware of many vacant positions within community mental health teams, resulting in clinicians carrying large caseloads. This at times results in clinicians focusing on more acute patients. However, this is not a preventative or recovery-focused approach as patients with moderate mental health concerns may not have as much support from clinicians as patients with more severe mental health concerns, risking those with moderate mental health concerns further deteriorating.

There are also access issues for many people with mental health care needs. In my experience, it is difficult to arrange patient transportation for outpatient mental health patients to support accessing appointments. As such, community mental health clinicians are often required to drive long distances to see patients at home. On some days, clinicians can spend 1 - 2 hours of their time driving. This time could be better spent on clinical care. This means that some patients do not see their clinicians face-to-face as regularly as their counterparts who can drive to appointments.

e)

There appears to be a standardisation of clinicians within the NSW Health community mental health teams, where all clinicians (regardless of their discipline) are performing case management duties as a large part of their role. At times this results in less availability of specialised services as clinicians (whether it be psychologists or occupational therapists or another discipline) are providing a case management service, meaning they have less capacity to provide psychological therapy or another specialised service. This standardisation of clinicians also means that at times there may be an inequitable difference between the quality of care provided to patients. For example, a patient who is being case managed by a nurse

(who can monitor medications and physical health) and is seeing a psychologist for psychological therapy will likely receive higher quality care than someone who is being both case managed and receiving psychological therapy from one psychologist who is not as highly trained in monitoring medications and physical health as a nurse is. This issue is also exacerbated when teams are short-staffed, as team members want to support each other to have reasonable caseloads, meaning that case management is prioritised over specialised services.

I do not wish to give evidence at a hearing.