

Submission
No 105

**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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Partially
Confidential

1. equity of access to outpatient mental health services

(b) navigation of outpatient and community mental health services from the perspectives of patients and carers

Referrals to Community based mental Health services [MHS] is challenging at best, the person seeking assistance has the option to self-present to a community mental health centre, but this can be daunting and frequently there are wait times and the outcome unfavourable, clinicians will minimise symptoms, are judgemental or time poor and not receptive to detailed descriptions by the person experience.

Frequently where presentations are dual diagnosis persons will be directed to drug health to get assistance “first” for their addiction problems.

Often the on referred person is re-directed back to MH services to address their MH symptoms.

Persons are encouraged to self-refer via the “1800 number “the clinician taking the call ‘triages’ the persons details and decides about the “acuity” this determines the response time by MH services.

The MH access line is a form of triage that for referrers: carers professionals, and persons experiencing a MH problem – is often experienced as a barrier to accessing services either acute or other.

I have spoken with numerous persons both carers & clients about their experience of accessing the 1800 line, the experiences are heavily themed with a sense of wasting the time of services, exaggerating symptoms, or observations, labelled “frequent fliers” – “not again” attitude, being left with a sense of being ineffective in managing what’s going on, having not done enough themselves to manage the problems, being shut down and unheard, distress minimised, not being listened to, interrupted, when feeling frustrated being told the call will be terminated because of the person becoming “aggressive, abusive or threatening”.

Being told the service is overwhelmed [frequently persons, families and stakeholders have told me of how they feel it necessary to “apologise” for calling services knowing how busy services are, I have heard this myself when working on acute care teams and community-based care coordination teams].

There are frequent delays in a response [not appropriate in acute matters] details required are often distressing for individual to articulate [assessment is not trauma informed] often lacks sensitivity and I have on making referrals found the process judgemental and a mechanism to deem those referred as ‘not eligible’.

The Triage process is variable in terms of detail required [in my experience making a referral & others with whom I have discussed this with both clients of MHS, families and other providers] often seek to attain evidence of historical suicide or present suicidal ideation/ activity for person to be deemed eligible for the service.

When a degree of risk is identified triage will advise the person to attend an ED or offer to call 000.

For persons who have attended ED they well know that they will wait hours to be seen and longer to access a bed [I am aware of one person who went to ED as they felt unsafe, were experiencing thoughts of wanting to kill themselves this person waited for 72 hours then left and returned to their home].

Often wait times can be days, as the person has attended “voluntarily” they are required to wait in the ED waiting area for assessment.

ED waiting areas are often full, loud and for persons mentally unwell is a traumatic, triggering, stressful & an unsafe environment.

They are treated differently than others, when a person leaves before, they are seen there is no follow up.

If the person is seen and deemed needing an admission, transfer to a mental health bed can take days during which time the person may be waiting in an ED bed or in a medical ward bed, both grossly inappropriate for someone with deteriorating mental health, hearing voices, paranoid, guarded, distressed, or elevated in mood.

Stigma and bias are present in ED's I have had staff tell me they are sick of the volume of MH clients who present daily.

Persons are told by MH teams and by GP and other MH Health services that if they require MH support to present to ED, currently there is not an option other than this, I feel that I am betraying my client and exposing them to trauma when as part of safety planning, I talk about accessing an ED and contacting 000.

My observation of responses by 000 services has been varied some Police and ambulance are warm, empathic, and helpful, however others are harsh, punitive and I have heard these services complain about needing to respond to “nutters” & that Police should not be required to respond, “it's not Police work”.

On one occasion I witnessed a Police officer ask a client why they had an aboriginal flag on the wall, the person answered because they were Aboriginal, the Police responded “well you don't look like an abbo” the person escalated started to shout and move about her unit, Police restrained & transported the person to ED in handcuffs.

(c) capacity of State and other community mental health services, including in rural, regional, and remote New South Wales

Services are currently [and have been for some time now] overwhelmed, & in my opinion do not have capacity to provide dignified, respectful, person centric, effective, sustainable care within community setting that aligns with best practice, is recovery informed, identifies the person as the expert in their care and knowledge of their illness, family inclusion and that is informed given diversity and individual preference of care, this is contributed to by the

culture within teams, toxicity of management, heavily driven medical models of care, risk aversion, high turnover of staff, challenges recruiting and retaining experienced clinicians who have skill set and knowledge to work effectively in a community setting, attracting suitable applicants to community based roles is further exacerbated by poor remuneration for what the role entails.

The system currently operates by a continuous application of band aids to a shot gun hole.

Management fails to address the systemic issues of poor, inadequate care provision. The same model of service is rolled out decade after decade despite it failing the most marginalised, vulnerable, and at-risk population. Emphasis is on discharging people & KPI's.

The breadth of referrals is now beyond severe and enduring and is inclusive of persons who have a myriad of other diagnosis where risk is pronounced, MH services are left with complex challenging clients who have been declined or discharged from all other services.

There is limited/ poor collaboration with physical health, referrals to medical services are protracted in wait times. Community case management teams now experience greater demand to respond to acute exacerbations, these incidents take away time and motivation to work with persons proactively as opposed to reactively.

Community MH services have moved to a heavily informed medical model of care, with a marked decline in the strength of the multi-disciplinary team, there is now lost autonomy, collective and shared decision making.

Drs are making decisions; this includes who is "suitable" to be seen by MHS psychiatrists or referred back to GP follow up based on demand exceeding supply of psychiatrists.

Clinical decision making is heavily driven by risk and mitigation of this. The current [and historically] intervention of 'care' is informed by a deficit approach, whilst the 'recovery model of care' is touted as implemented there is often little evidence particularly when the MHA/ CTO is in place.

Historically Acute Care Teams would visit persons to keep them at home with follow up supporting recovery within the home with family and other services engaged.

This could entail twice daily home visits, supervising medication, monitoring symptoms and use of PRN medication as required, support families and provide medication about the illness trajectory and use of medicines as well as liaising with other stakeholder services. This rarely occurs now.

During my recent time working with an Acute Care team. Home visits were predominantly "PDFU" or *post discharge follow up*.

Driven by a KPI all persons discharged from hospital are to be seen face to face with 7 days. My experience has been this is often lip service and a covering arse exercise.

The person seen is asked: how are you going” “have you got a supply of medication” “have you made a time to see your GP” & “when you see your GP get a Mental Health Treatment Plan so you can see a psychologist”.

On one occasion I was on a shift with an Acute Care team, I contacted the person scheduled for a PDFU & advised of our intention to visit and when was a good time, the person responded annoyed, :do not bother, it’s a waste of time & that’s how I always feel when you lot leave, like I have wasted your time”.

I encouraged the person to accept our visit promising this would not be the case.

On arriving at the persons home my colleague and I went to the persons unit, my colleague stated he would do the talking, he said hello, did not introduce me asked about pills and an appt with the GP and said good luck and left.

(d) integration between physical and mental health services, and between mental health services and providers

Greater inclusion & communication is required with GP and other health providers.

Metabolic screening

Use of services like ccCHIP

However, access to dieticians, psychology, physio, bulk billing GP, podiatry, and dentistry remains challenging/ impossible – in terms of timely accessibility.

Engagement with external providers is limited and often not pursued.

MH community services remain, essentially silo style in practice.

Marked decline in bulk billing GP has had a significant impact on accessing primary care.

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

Lack of Peer Workers [PW] in community teams, some teams do not have PW.

In areas of indigenous populations there is no indigenous PW support.

Nurses are near on impossible to recruit to MH community services.

Psychologists within community mental health teams are employed as case managers and are frequently not available for psychological therapies.

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

[reference to Mental Health Act for detainment included]

The use of the CTO has increased and frequently persons discharged from inpatient units are placed on a CTO, this is often after a first presentation, where there is.

- no evidence supporting a less restrictive means of care has been explored.
- No history of non-adherence to treatment or subsequent relapse in the absence of treatment.
- No evidence of risk posed to self or others due to non-adherence to treatment.

- No evidence of inclusion of family, significant others, or other stakeholders regarding use of CTO and feedback re same.
- Little to no evidence of planned discharge where time has been spent talking about the importance of medication adherence and other supports available to link to support the person, their family and other stakeholders.

Recently when speaking with a LHD I was advised the community MH team were declining referrals other than those where the person was on a CTO.

Inpatient units have applied to the tribunal for CTOs for persons prior to discharge who are usually itinerant, of NFA and historically are lost to care upon discharge, the CTO is un-implementable, therefore should not have been applied.

The Mental Health Act [MHA] is to be used only when there is NO opportunity for a least restrictive means of care in the case of assessment and containment of a person as an involuntary patient but also as an outpatient.

This is no longer the case.

When accessing assessment.

The MHA is now frequently used as a means of **ensuring** a person is reviewed /assessed when transported to a gazetted facility [hospital ED dept]

On contacting the 'bed manager' to advise of a person being transported for assessment [as is the procedure], the clinician will usually be asked if the person is under the MHA, the assumption being, if not why does the person require an assessment, what is the urgency or risk, the assumption is there is insufficient to warrant use of the MHA so the person can be "managed in the community".

On many occasions when a person is unwell, the person is agreeable to being supported to a place of assessment as a **voluntary** person, applying the act only to ensure assessment on these occasions is often detrimental to the persons experience, how they are received when arriving at ED, trust of the clinician supporting to ED, the MH community team and MH services generally.

e.g., A person was seen by the Acute Care team at their home.

The person was agreeable to coming to the ED for an assessment.

They stated they wanted to go voluntarily.

The clinician said he was going to make them an *involuntary* person so they would be seen and would be admitted to a mental health bed, also so the person would not be left in the waiting room for hours and highly likely sent home.

On arriving at the ED the person was shown into a 4 bed cubicle where both male and female patients were in beds.

The person was told to remove their clothing and put on a hospital gown.

The person declined; the ED staff member was visibly annoyed & insisted stating in a harsh authoritarian tone that this was "the rule".

On looking at the other persons in the ED cubicle no one was wearing a gown.

The person finally removed their clothing & shoes and put on a gown, their clothing was placed into a hospital bag and taken into the office.

The person got into the bed and was crying.

This person was female, first nations, had a history of sexual assault and trauma.

There was no trauma or cultural informed care, they were treated differently from others, they had their freedom removed to access a service.

I asked the nurse why there was a rule and why this person was made to put on a gown, remove her shoes and had her belongings shut in an office, the nurses responded, "it's because she is a mental health patient & may run away and suicide".

(g) benefits and risks of online and telehealth services

Greatest benefit – accessibility & frequently timely access

Risk – impersonal, reduced opportunity to build rapport, establish trust, connection issues can impact on assessment quality, use of interpreters adds additional layer of clunkiness.

When family and significant others in attendance online setting limits engagement. Clients sometimes decline online, frequently due to prior poor experiences.

Face to face gives a greater understanding of context, opportunity to assess body language, gauge responses, when you are asking a person to share details that are traumatic, personal, where the person is suspicious, guarded, or paranoid online is frequently ineffective.

Face to face allows opportunities to moderate your assessment, demonstrate empathy, compassion by body language, tone of voice, gestures. Respond kindly to suffering and distress.

Culturally virtual is not acceptable and inappropriate.

(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

Poor representation of first nations people in mental health teams both community & inpatient.

Until recently there was no access to Aboriginal supports in ED [Aboriginal Liaison officers] at RPA, referrals to Aboriginal MHS are frequently declined.

Limited engagement with Aboriginal MH services community based.

Limited understanding evidenced in practice by clinicians supporting indigenous clients.

Across all areas more work, support and representation are required within community-based MH teams.

Limited representation of LBGTQ service provision.

(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)

Historically MH Acute care teams would attend and assess someone who is experiencing an acute episode of unwellness.

With Police if indicated

Clinicians would lead the intervention.

ensure acute care services are knowledgeable in de-escalation, assessment, have a range of options about facilities/ resources to provide care, include family & stakeholders where available both initially and ongoing, have access to indigenous clinicians or support workers to lead interventions involving first nations people, increase understanding of cultural diversity and role this plays in acute presentations.

Provide interventions that are gender, language, culturally informed.

Always provide the least restrictive care.

Provide the person, *the expert of their experience* the time and opportunity to inform about what they need.

Support people to stay at home.

Do not assume that because someone is acutely unwell, they are unable to remain decision making and control in what happens to them.

Currently community members who identify a person who is unwell are required to contact the MH access line “1800”.

The information provided to the ‘intake’ worker [gate keeper] is used to inform the ‘category’, the category reflects the acuity, and the time frame whereby follow up will occur.

Increase accessibility, remove the gate keeper.

PACERS – great resource, expand across all areas including [**and especially**] rural and remote communities.

Use of Police to respond to acute matters – Police often lack the skill set to interact with a person who is acutely unwell.

This can exacerbate the presentation.

Police are law enforcers, not health professionals yet frequently attend situations where they are required to make decisions and interact with persons, families, and others.

Police have and continue to express concern about the amount of time spent with “MH” clients.

I have been present when on occasions persons who are mentally unwell have been searched by police, have had to remove shoes, have been handcuffed and transported in paddy wagons.

Make MH hubs visible and accessible via free GP consultations, use Nurse/ Nurse Practitioners in GP surgeries, in shopping centres – shop fronts, work aggressively to de-stigmatise, have services readily available to schools, increase GP awareness of prodromal symptoms, expand youth services especially first episode services for psychosis AND BIPOLAR symptoms & services tailored for the LBGTQ community.

Bring back proclaimed beds where those intoxicated can access a bed to “sleep it off” whilst promoted addiction services and making access on the spot seamless.

I recently applied for a role with a triage team.

On arriving at the interview, I was shown into a room and asked to listen to a recording of a person from the community contacting the '1800 line' I had fifteen minutes to complete the 'triage' document which included my impression and a plan.

I listened to the recorded phone call.

The caller was a female contacting about her husband.

He had a history of depression & alcohol misuse and when intoxicated expressed suicidal ideation.

Her husband had lost his job today & had returned home intoxicated.

He had x 2 previously attempted to kill himself, on both occasions had been admitted to ICU.

When intoxicated he has been verbally abusive and x1 physically assaultive.

Police have been involved, MH services had contacted after both admissions to ICU, once by phone and then x1 home visit. No onward referrals had been made other than the team confirming they had a GP.

There are 3 children in the house, 2, 6 and 11 yo

The family are migrants, the callers English is limited.

They have limited supports nearby & no family.

I completed my impression and partially completed my plan.

The task was not referred to during the interview.

Following the interview, I enquired about the task I had completed [as described above].

I was advised that the task was to evidence my **ability** to complete the triage assessment within 15 minutes, mainly as this is the "KPI".

I responded that the complexity and equally important the distress of the caller needed investigation and an empathic [not time restricted] response, also there were kids in the home, risk

I was asked what my approach would be, I advised my plan included: a Report of concern re kids to DCJ, assessment of risk and callers fear & response a referral to DV services for the wife either immediately or following day, contact Police re a welfare check tonight, provision of refuge information and support to make initial contact, information re local addiction services, assessment re safety of home for all occupants.

Also, that 15 min was insufficient to complete a thorough assessment and make subsequent findings as well as be supportive and empathic.

** I was told by the interview panel that this case [and any referral received outside of business hours] is referred to the Police only.

I with drew my application for the role.

(j) any other related matter. The terms of reference for the inquiry were

I have been a Psychiatric Nurse since 1994.

25 years was community-based employment, with LHD teams.

During that time, I have worked in Community, inpatient, forensic, correctional and Detention facilities, I have been employed as a manager both team & operational, have worked in education and not for profit NGO organisations.

I no longer work for the public health system and have no desire to work within that domain again.

The system is smashed.

I have observed my colleagues become burnt out and exit health all together.

The culture is medically centric, cold, restrictive, risk intolerant, traumatic, punitive, stigmatised, unfit for purpose.

Clients I speak with regarding contact with Acute Care teams tell stories of being let down, failure to follow up or respond to requests for support, stigmatised, voiceless, powerless.

I am loathed to refer any person to community based LHD MHS.

My former colleagues are burnt out, disrespected and unsupported.

I am sceptical change will be affected, I recently heard Brian Burdekin speak and reflected back to the early 1990's when after the Burdekin report there was great hope of change, that persons & families impacted by mental illness and addiction would finally have access to dignified contemporary care that was recovery focused, strengths based, personalised, free of judgement and stigma and was on a par with other health conditions.

Also, that the MHA would ensure no abuse of individual liberties and abuse and neglect would cease.

Unfortunately this has not been the case.

Thank you for the opportunity to provide this feedback.