Submission No 112

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

My name is and I am an endorsed Psychologist with 11 years of experience in various community mental health services in NSW. I currently work in the Community Mental Health Service, however, I am making this submission as an individual clinician and not speaking on behalf of any organisation. I would be prepared to give evidence at a hearing if the committee would like clarification on any of the issues raised. I would prefer my name to not to be published.

I wish to address terms of reference points a, c and e. I will focus my submission on the discipline psychology, however, some of the issues may also be relevant to other allied health disciplines.

a) equity of access to outpatient mental health services:

In my experience each service differs regarding whom they provide services to (diagnoses, risks etc) and what services they provide (case management, psychiatry, psychology, social work, occupational therapy, neuropsychology assessments, specialist programs such as Keeping Body in Mind. This means that people in one geographical area have access to treatments and supports that people living in another area do not. For example, one Sydney based service I worked in accepted consumers who had primary diagnoses of personality disorder and provided evidence based psychological services to treat these conditions. The most common personality disorder diagnosis was borderline personality disorder and consumers were able to access a full length comprehensive Dialectical Behavior Therapy(DBT) program, a modified short DBT program and/or individual psychological therapy in a variety of modalities.

In another service I have worked in, psychological therapy was not available until recently, and is quite limited in scope as the focus is on short term "management" of clients. Therefore, people with personality disorder related difficulties (including suicidality, self-harm, addictions, interpersonal difficulties which detrimentally effect their family, work and social lives) are often turned away without receiving evidence based treatment. As this is also a socioeconomically disadvantaged area, these people are usually unable to afford treatment by psychiatrists and psychologists in private practice. Additionally, due to the risks and complexity of such presentations, practitioners in private practice are often unable to treat these people adequately as they require acute and multidisciplinary services. When people with acute mental health needs (such as suicidality and/or self harm) are accepted by a community mental health service which does not provide evidence based psychological treatments they are usually "case managed": what this entails varies from service to service. Typically, in my experience case management provide access to a psychiatrist and some

helpful supports such as linking a person with NGO supports, assisting with social needs such as housing or Centrelink . However, this is not evidence based treatment; for these conditions psychological therapy is indicated and should be the main treatment. They may of course benefit from case management but it should be in addition to psychological therapy, not instead of.

In summary, access to evidence based psychological therapies for people with some of the most serious mental health conditions currently varies from service to service. Therefore, people across the state do not have equity of access to outpatient mental health services.

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

I do not have data regarding the differences in clinical capacity between geographical locations and I sincerely hope that submissions are made by organisations that do have such data. However, I would like to share some clinical observations. In all the areas I have worked in, many people are turned away from community mental health services towards private services. Private psychologists and psychiatrists are usually unaffordable for financially disadvantaged people, have closed books, long wait periods, or cannot manage people with highly complex or acute mental health conditions. As a result, many people end up presenting to community mental health services multiple times before they are accepted for service. This results in their condition becoming more acute and/or chronic before treatment is offered, which in turn leads to poorer outcomes.

Obviously increasing the overall clinical capacity of community mental health services with additional staff is one solution. I would respectfully suggest that some mental health funding currently going to piecemeal programs offered by NGOs, charities, PHNs etc would provide better value if channelled to community mental health services which already have relevant clinical structures and expertise.

However, there may also be more effective ways of utilising existing staff. For example, in all the services I have worked in, highly qualified psychologists with specialist endorsements (eg: clinical) are utilised for primary clinician/case management work which limits their capacity to provide the evidence based psychological therapies and specialised assessments they are trained to provide. I would suggest that psychologists with endorsement (who usually have a minimum of 6 years of university study plus a 2 year post graduate registrar program) would be more effectively utilised by limiting their roles to discipline specific work. This would increase the capacity of services to provide psychological assessments and therapies. For example, while consumers experiencing psychotic disorders such as schizophrenia, schizoaffective disorder and bipolar disorder make up the majority of community mental health consumers, none of the services I have worked in provide evidence based psychological treatment for psychosis. Many consumers with personality disorders do not get access to evidence based therapies due to limited capacity. Many consumers would benefit from neuropsychological assessments (eg:

cognitive, ASD, ADHD) or specialised risk assessments (eg: violence risk assessment) but psychologists with the relevant training and skills cannot deliver these when their capacity is limited by primary clinician/case manager duties.

In summary, capacity needs to be addressed both by services being expanded to meet the need in the community as well as utilising the skills of existing clinicians more effectively.

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

In my submission relating to point c) above I have highlighted one issue that relates to the appropriate and efficient allocation of clinical tasks to endorsed psychologists. That is, in all the services I have worked in, highly qualified psychologists with specialist endorsements (eg: clinical) are utilised for primary clinician/case management work which limits their capacity to provide the evidence based psychological therapies and specialised assessments they are specifically trained in. I would suggest that psychologists with endorsement (who usually have a minimum of 6 years of university study plus a 2 year post graduate registrar program) would be more effectively utilised by limiting their roles to discipline specific work. This would increase the capacity of services to provide psychological assessments and therapies. Primary clinician/case management roles could be provided by clinicians with lower level qualifications.

One of the most useful aspects of community mental health treatment is that it is provided by multidisciplinary teams who are able to collaborate and tailor treatment for individuals and assertively manage high risk situations. However, this benefit can only be utilised when each profession works within their professional scope. The current practice of having "generic" positions that can be filled by nurses, social workers, occupational therapists or psychologists is problematic as it can result in clinicians working outside their professional scope of practice. For example, I have witnessed managers directing nurses to provide psychological therapy and directing allied health professionals to assess physical health. These practices are potentially harmful to consumers and divert clinical expertise away from where it could potentially be most useful.