Submission No 113

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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Att: Commission Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

I am a Community Mental Health clinician in a managerial position, Registered nurse and have worked the majority of my career in inpatient mental health settings but joined a community mental health team in the Sydney area in 2018. The team I manage is made up of around 14 clinicians including Social workers, Occupational therapists, Nurses, Psychologists and a Peer Worker. Together we care-coordinate around 300 people in a catchment area which has (rough estimate) around 50,000 people. Around 25% of clients are on a Community Treatment order, the people in this number change but the number itself does not change significantly (people come off CTOs but at the same time new people are put onto them largely by inpatient services and referred to us).

The first thing that comes to mind when explaining these numbers is that populations and demographics do not appear to be considered when allocating funding for community mental health. Instead, a very subjective funding model has been suggested (Activity based funding) or is "in the process of being implemented" for as long as I can remember. The amount of time it takes for a bone to heal may be calculable with some objectivity based on other health factors (age, smoking status, BMI, Diabetes etc), the recovery journey of someone with a severe mental illness is completely different. For this reason, allocating funding based on demographics such as housing density and demographic mixes (age, NESB, first nations, rural, employment opportunities/taxable incomes, DOH, boarding houses and others) would be much fairer. If 20 high rise housing complexes go up in an area, there is a good chance that the growing population will need more resources, this does not seem to occur. Instead the onus is put on the already overworked clinicians to "prove" that they are doing work by entering activity stats which say little about the actual work people are doing and is highly subjective. They appear to only give people in higher areas of the health system "objective" data about what is going on at the coal face without actually knowing what is going on.

The second point I would make is that it is problematic to look at Community based mental health care in isolation from the inpatient services with which they are attached. They are integrally linked both in the referrals that come from the overcrowded hospital inpatient services and the pathways into inpatient care when those treated in the community require hospitalisation for their illness. I refer the inquiry to the point 144 The Coroners Court of NSW Inquest into the death of Ziad Hamawy, Date of findings 21 July 2023

> "When making these findings it is important to acknowledge the effect of the very real pressures which exist in the public health system which were referred to by Professor Large46, Dr St George47, and Dr Snars. 48 The court was advised that there has been no real increase in funding for mental health facilities since the onset of the crystal methamphetamine epidemic. There are ongoing staff shortages and bed pressures given the volume of patients requiring hospital treatment. Professor Large explained that the necessity to move patients who have "recovered enough" out of mental health wards is a day-to-day struggle for psychiatrists in the public health system. The most pressing driver of this is the flow of newly presenting patients in emergency departments and the attendant

bed block and ambulance ramping which occurs. These factors can affect physical health care for community members in emergency departments across NSW. The pressure to discharge psychiatric inpatients in a timely way to keep things moving is constantly present."

Inpatient mental health services are in a position where they need to make beds for people and those discharged require community follow up to stay out of the busy hospital system.

The third point I would make is the lack of clarity and long term funding models for community based organisations in the NGO mental health space. Public community based mental health services are forever trying to keep up to date with what services are available in this area which could better suit our client's needs. Because we are, as mentioned, quite stretched, we need to look to the NGO sector for people who are in need but not in need enough to warrant our intervention. These NGOs come and go or vastly change their criteria due to funding issues often without enough time to make a meaningful impact the way they would like to.

The private sector is not meeting the needs of all the people who could benefit from psychological interventions (unaffordable for many and large waiting lists) at the less severe part of their experience and the public sector has no capacity to help anyone without the most severe of needs. Publically funded group models should be made available for people who currently have less severe difficulties before they become more severe. The enquiry will have better oversight into the waiting periods for DBT groups throughout the state but even for a major metropolitan city it is in excess of 12 months.

Some of the groups suggested above could be run online if an appropriate program exists however conducing more mental health activities with the majority of clients under care co-ordination by a public mental health team has a lot of barriers. Often technical ability and access to technologies such as a functioning mobile phone can be difficult. Education around targeted advertising may be of benefit to those with symptoms of paranoia (for those living with schizophrenia) as finding your phone is advertising products or services you have spoken of recently if you do not understand this technology can be anxiety and paranoia provoking.

In my regular dealings with police for safe provision of home visits or enacting of a mental health schedule it is apparent that many police officers are looking for ways they can improve their knowledge and provision of appropriate service to people in mental health crisis. The PACER program should be reviewed and expanded to as many commands as possible, if funding issues arise between health districts and police services this should be worked out with the help of elected officials to ensure it occurs as a matter of urgency.

Lastly, though a larger federal issue, NGOs have moved to relying on NDIS funding to individuals NDIS packages where previously group models would have had the ability to help larger amounts of people in a more meaningful way. The mental health care of the people with NDIS packages is awash with "individual plans" put together by planners who write reports then do not leave any funding in the persons package to train staff or implement the plan itself.