Submission
No 119

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

Name: Name suppressed

Date Received: 6 September 2023

Partially
Confidential

Please ensure name and email are redacted due to privacy of my family member relating to my personal carer experiences.

I am making a personal submission, with a 20 year history of employment within Mental Health services (Local Health Districts), and personal experiences relating to carer responsibilities of a person with serious, persistent mental illness and complex trauma history.

References to Community Mental Health Services in this submission are referring to "NSW Health Local Health District" based community mental health services, unless otherwise stipulated.

(a) equity of access to outpatient mental health services.

Local Health District Community Mental Health (CMH) accessibility is not standardised across the state, or even within Districts. Access to NSW Health-funded services is highly dependent on: The region the referral is made to, resourcing factors affecting/limiting service delivery, and the ability of the referrer to articulate their needs in a way which adequately reflects the severity of the mental health needs. Where CMH services are experiencing high demand and limited resourcing, inequity of access to MH services is increased. Refusal of services/declining of referrals is often conducted with a lack of transparency to referrers. Referrers who are not familiar with aspects of 'least restrictive care' considerations can be misled around reasons for declining of referrals. Recent personal example: An LHD Older Persons CMH Team provided feedback to myself as carer that they would be discharging the consumer, with the reason that they provide a voluntary service and the person was not under the MH Act. I as carer advised them that the consumer was *voluntarily wanting* to be engaged with their service, and that the consumer was not requesting/seeking discharge. I further explained that the person had severe unmet needs, and not only that, but the person's private psychologist had discharged the consumer due to the severity of their symptoms – discharge from this Older Person's team would mean they would be discharged to zero services while experiencing severe symptoms. The response to me was to again reiterate that the Older Person's team was a 'voluntary service' and that the consumer was 'not under a MH order, therefore they are not forced to receive a service from their team'. When I again reiterated the consumer wanted their service, was satisfied with their service, and their clinical severity indicated they definitely needed this service, the response was that there was nothing further they could do, and the consumer was being discharged. This shows a clear lack of equity of access for voluntary consumers who are wanting/needing a service, using the MH Act through false clinical reasoning, to convince carers that consumers *have* to be discharged, which is not correct. Carers without knowledge of the MH Act or who are not strong advocates do not have any system in place to protect them from this incorrect clinical reasoning.

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

Ongoing feedback is very strong from consumers, carers, and other key stakeholders such as MH Non-Government Organisations (NGOs) around the difficulty of navigating services, the difficulty of knowing what services may or may not be available/exist to meet a consumer's needs, and how to advocate and tailor communication at point of referral to ensure the correct team is identified for the consumer.

This matter is worsened due to the use of the Medibank contract to manage the Statewide Mental Health Telephone Access Line (MHTAL), as they are not an LHD-based company and do not adequately engage with Districts to comprehensively understand local District information to help MHTAL callers/referrers to navigate this process. Consumers and carers report experiencing relief

when they are finally ‘funnelled’ through to a clinical service, due to the major level of difficulty jumping through ‘hoops’. Recent personal example: At one point recently I was unable to make an MHTAL referral for the person I have carer responsibilities for (severe, acute exacerbation), therefore another family member did so. While the family member making the call advised me they were treated with dignity, respect, and were listened to, unfortunately their concerns were not taken seriously until I was able to quickly message them the key terminology to use while speaking to MHTAL and the Acute District MH Team, to ensure the referral was rated correctly as per the Crisis Triage Rating Scale, etc. It should not require having a family member with 19 years of MH experience to tell you the key words you have to use in order to elicit the correct response to gain service provision.

Services additionally use terms such as ‘tertiary referral’ requirements, further causing distress to carers and consumers where there are many unrealistic ‘hoops’ to jump through in order to prove the consumer’s mental illness severity is as severe as the consumer/carer is trying to advocate. This is a significant issue in the area of Child and Youth community MH Service provision, as there are many families experiencing major intergenerational mental illness issues, where parents may have severe mental illness and may not have the capacity to understand (and services will not guide them) to ‘jump’ through the hoops to get their children into ‘tertiary referral’ Child and Youth services. In many instances, parents such as these end up giving up on attempts to get their child MH services, and generally the child finally receives the originally-required services once they deteriorate to the point they are admitted involuntarily and severely mentally ill to inpatient MH units.

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

Current caseload sizes experienced by CMH teams are very varied, with some teams being over-resourced (more often speciality teams), but many are extremely under-resourced (particularly District CMH teams). When I was a new graduate, 3 months after commencement of employment, I had a caseload of 55 consumers, all with severe and persistent mental illness, a broad range of complex psychosocial issues, and presenting with very significant risk of harm to themselves or others. Expecting a new graduate clinician to manage a caseload of 55 community mental health consumers is unrealistic. Some teams who operate based on evidence-based clinical models allow for caseload size to be determined according to evidence around models (eg: some Assertive Community Treatment Teams operate with a small caseload such as 10 -15 consumers), yet the reasons their models allow for small caseload size could also be applied to the service delivery of non-model-based CMH services as well. Unfortunately standard District CMH teams are not able to ‘cap’ caseload sizes or scale up easily with staffing during times of extremely high demand. Even if ‘scaling up’ with increased staffing at times of high clinical demand were possible, staffing shortages would impact such an option.

By contrast, inpatient mental health units are dominated by patient bed flow and bed numbers, with a capped immovable number of inpatient consumers at any time. The Unions heavily monitor and scruitinse any deviation of inpatient numbers (eg: discrepancies when a patient is put on extended leave as part of good discharge planning, yet their bed may be utilised by another), yet there is no attention or monitoring of excessive CMH caseload numbers. Standard responses of ‘increase the number of consumers discharged’ is not clinically appropriate if teams are ensuring their caseloads are only targeting consumers with significant MH needs. For example, if a team can demonstrate all consumers have active care plan goals, and are reaching HONOS scores of two or above consistently, discharge is likely not indicated, regardless of increased caseload size.

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

Within Community MH services run by Local Health Districts, there is a noticeable lack of counsellor positions (usually zero or close to zero funded counselling positions). Additionally, there are few psychology-specific positions which have position descriptions solely focussed on dedicated Psychology duties only (ie: they are often employed in multidisciplinary positions where they are not allocated time to perform psychological interventions. This issue seems at odds with the need to offer psychology-specific interventions to consumers of community MH services, and consumers and carers often express confusion at this arrangement. Consumers are predominantly required to access a GP to have a MH Care Plan completed, and then have the task to try to find a private psychologist who (a) doesn't have a wait list, (b) is located near them, (c) only charges within the rebate amount of the GP MH Care Plan, ie don't charge the consumer an excess.

Multidisciplinary positions within Community MH (LHD) services remain vital to ensuring a robust staffing profile, broad clinical input into clinical case reviews, opportunity for the benefits of various disciplines to provide their expertise in CMH teams. However, more discipline-specific positions are required across all CMH Teams – their individually discipline-specific input is vital to proper comprehensive service provision to consumers, and they are ALL valuable. Within CMH (District) context, I am referring to Social Workers, Occupational Therapists, Registered Nurses, Psychologists, Peer Workers and Psychiatrists.

The funding associated with the allocation of workers is a major issue – the main multidisciplinary positions used in CMH teams (Social Work, Occupational Therapist, Registered Nurse and Psychologists) operate under 3 different Awards – these awards do not align in their pricing of base grade nor senior roles. As such, there are times that a multi-disciplinary position may have to leave out certain professions solely due to the grading the position is at, ie: not being able to afford the Award costs of certain professions. For example, the Psychology award costs more than the equivalent level of 'senior' positions of Social Worker, Occupational Therapist, or Nursing, so there are many examples of where a Psychology position is left out of the position's grading due to exceeding the financial limit of the position. Additionally, a major contentious issue among clinicians is the fact that a staff member applying for a distinct position will be paid *very* differently depending on their profession. It is unacceptable to expect staff members to perform the exact same job, but be paid higher or lower based on which of the 3 primary awards they are paid under. All of the 3 primary awards covering Nursing, Psychologists, and OT/SW should have equivalent grading and pricing to ensure equity for same job, same pay within District LHD services.

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

The care and treatment of severely mentally disordered people over a long period of time remains a significant issue. Our society is failing consumers with complex trauma histories who have personality disorders (predominantly I am referring to Borderline Personality Disorder (BPD) in this instance). Some consumers with extreme trauma history and major mental distress require longer periods of involuntary treatment than is supported in the MH Act. When a person with BPD is not engaging with mental health services /refusing services, but their impact of BPD is causing severe trauma to their loved ones, this is not able to be addressed. The cumulative effect of trauma on family members of people with severe BPD who refuse services cannot be overstated, and it is an area of impact which is ignored, is not adequately addressed in the MH Act, and is creating new generations of traumatised carers. Relatively new services such as "Whole Family Teams" or

equivalent does address gaps in this area of addressing intergenerational trauma, however the threshold a family is required to meet by way of risk level is very high, so only a small population of families are eligible/suitable for this. The risk of harm to children and Child Protection information is the key legislation used to guide suitability for this type of team, however, not the MH Act.

Separate to the MH Act, but still relevant to this matter: the lack of availability of District CMHT services providing evidence-based therapies for BPD consumers further exacerbates the issue of not adequately addressing the needs of this population. Most District LHDs do not provide a formalised Dialectical Behavioural Therapy program or equivalent, and as such, with no tangible intervention available for consumers, this is a population who is normally not engaged in therapeutic CMH services. Detaining the person while determined to be 'mentally disordered' under the MH Act appears to be the only method of therapeutic interventions to this population, yet it is not an actual therapeutic intervention at all.

(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)

There are anecdotal reports of excellent trauma informed practices occurring more with the involvement of PACER teams, with positive responses from consumers. Police responses to the people described under (i) continue to be a source of consumer and carer concern where PACER is not involved. Opportunity for increased coverage of PACER shifts, and geographically covering broader regions would be a positive way to continue to reduce the trauma associated with Police engagement with people while they are presenting with these extremely difficult issues.