Submission No 121

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 for Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

6/9/2023

I have been a doctor for 20 years and a General Practitioner working with people who experience homelessness for over 10 years across WA and NSW. I have been employed as a GP by psychiatric hospital for 3 years seeing inpatients and outpatients.

Currently I am providing a GP service to people living in temporary accommodation in Sydney, who arrive homeless and in crisis from across the country. In my experience, people who are homeless often have multimorbidity and have often experienced complex trauma, grief and loss. Many people have undiagnosed disabilities and untreated mental health conditions, which have come from and lead to difficult social circumstances.

My patients rely on referrals to the public system run by NSW health to help provide mental health care as they cannot afford private psychiatry and counselling services.

NSW Health local district-based (“catchment based”) care does not help homeless people who are often transient between district boundaries- they “belong” to no catchment and are robbed of care continuity.

If I assess a patient as needing to see a psychiatrist, but not a hospital admission, there are few options.

For example, earlier this year I felt a prompt referral to a psychiatrist for medication recommendation and review of a new client was indicated.

The PHN cost-free telepsychiatry service gave a psychiatry appointment in 3 months’ time.

The 2 private psychiatrists I referred to are yet to respond.

The Mental Health line was called 3 times, offering no appropriate options, even during significant worsening of health the last time.

7 weeks after my initial referral, the client was admitted to the local psychiatric unit and was an inpatient for 2 months. They are still homeless and have a prolonged recovery ahead.

This person needed an outpatient psychiatry appointment early on, when they were engaged in care. There could have been an intervention. This is not an option at the LHD. We see more and more patients “risk assessed” but offered no therapy.

The story is harder for people with a dual diagnosis of mental illness and drug and alcohol dependence- this is a significant issue in my client group, and they rarely get appropriate

outpatient referrals when leaving hospital after acute admissions- there are no public options for follow up. Just back to me, the GP.

Telehealth psychiatry (PHN commissioned) is not suitable for homeless, marginalised patients who do not have a stable phone number, struggle to find a private place for a consult and can move out of the catchment. This is the only no-cost psychiatry service offered at present by the PHN. I do not know of any bulk billing psychiatrists accessible to my patients.

PHN commissioned psychology services are oversubscribed and poorly triaged- I've been informed they cannot offer face to face services for a patient who had no phone number and the PHN triage have threatened to cancel referrals with no justification- without seeing the patient.

Private counselling sessions can be over $150/ session even with a MHCP and are often virtual if available in language.

Free counselling services (like head to health) that are in a safe place and face to face are becoming appointment based and have very long waits. Apps and online supports are unsuitable for my patients who often can't access data as they are inapproapriate - pitched in the wrong language/require higher levels of cognitive capacity.

There are a cohort of patients that do need a face-to-face consultation, assessment and a plan, and patients should not have to try every alternative or become so unwell that they are formed before they get the care they need.

To meet the need, there should be more public psychiatrists employed with teams to support them, and trainees nurtured. Psychiatrists (like GPs) should be doing more patient care and less administrative work. Assessments and plans need to be shared across health districts, and with primary care.

My patients need psychiatrists to assist with diagnoses and management plans that can lead to improved quality of life. My patients need good discharge summaries and clinic letters so we can help them piece together a case for public housing, the disability pension, and the NDIS.

My patients need to see them and psychologists, face to face, timely fashion at no cost. There should be no wrong door.

Navigating current outpatient options is time consuming, wastes time and is exhausting. The patients deserve better, they deserve to have confidence in the system. GPs need a direct path to timely appropriate local services.