Submission No 130

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

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Submission to NSW Upper House Mental Health Inquiry

Thank you for the opportunity to make a submission to the NSW Upper House Inquiry into Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.

I am Dr Tim Senior, a General Practitioner working in an Aboriginal Community Controlled Medical Service in one of the poorest urban locations in NSW.

I also have national roles with the Royal Australian College of General Practitioners, including co-chair of the Poverty and Health Specific Interest Group, and I am the author of the mental health chapters of the NACCHO/RACGP National Guide to a Preventive Health Assessment in Aboriginal and Torres Strait Islander people. I was invited to present on the issues in this submission at the Australian Society for Psychological Medicine conference in May 2023. However, this submission is my own and does not represent the view of any of my employers or any organisations I have been contracted to do work for.

I will address all of the terms of reference at some level in this submission. I am unable to give specific examples due to my obligation to patient confidentiality, but the examples given are seen frequently among my patients, and the patients of my colleagues working in similar circumstances.

Background

I wish to start my submission by highlighting some of the data regarding mental health in Australia (with no evidence that NSW data would be different) which I will draw on in this submission.

There will be many submissions that highlight the prevalence and incidence of mental health and mental illness across New South Wales. Of particular importance in consideration of health equity, is of course, the increased need for mental health services in rural and remote regions of NSW, and the importance of services for Aboriginal and Torres Strait Islander people that are culturally safe, as judged by Aboriginal and Torres Strait Islander users of the service. Mentioned less frequently, but just as important is the influence of poverty and low income on mental health.

Data from The National Health Survey shows that there is a clear income gradient with psychological distress – that is, the less money you have the worse your distress. The difference is stark. 1 in 4 of the poorest fifth of Australians psychological distress at a high or very-high level; this compares to about 1 in 20 people in the richest fifth of Australians. People's levels of distress are very similar in urban and rural locations.[1] Levels of psychological distress are closely correlated with having mental health disorders.

In thinking about the mental health system, it is important that GP's are included.

In 2020-21, 12.9% of people saw a GP for their mental health, and of those with a mental health condition lasting 12 months or more, more than a quarter of all men and nearly half of all women saw a GP for their care[2]. This is more than for any other health professionals being seen for mental health.

The RACGP Health of the Nation report[3] shows that psychological issues have consistently been the most common reason people present to their GPs. It should be noted that Medicare mental health item numbers are not a good measure of the amount of mental health care taking place in general practice, or the degree of complexity of mental health care in general practice. There are limits on the number of times a Mental Health Care plan can be billed, and very often mental health will be

discussed along with other health problems, or the consultation doesn't fit the mental health item descriptors in some way, so a normal attendance item will be billed.

Health systems are more effective, make more efficient use of resources and are more fair when they are based around primary care.[4] This is as true for mental health as it is true for all other health problems – indeed, there is a lot of overlap of symptoms and co-morbidity of physical and mental illness. The principle features of primary care that make it effective are important to keep in mind: first contact for each need; long term, patient-centred (not disease-centred) care; comprehensive care for most health needs; and co-ordinated care when it is required elsewhere.

Regarding each of the terms of reference:

(a) equity of access to outpatient mental health services

The National Mental Health Survey shows that for most people wishing to discuss their mental health, they see their GP. Any system view of outpatient mental health services must include general practice as a crucial part of the system, as so much mental health care takes place in this sector. Indeed, when access to other outpatient mental health system is limited by long wait times, affordability, or long distances, or lack of transport or any other reason, very often the GP continues to provide care unsupported by the rest of the health system. It is entirely appropriate that general practices operate as part of the health system, as health systems based around primary care are more effective, more efficient in their use of resources and are more equitable for patients, and this is just as true for mental health conditions as for any other health condition. The effectiveness stems from being patients-centred, not diagnosis centred – so people can come to discuss any concern they have, and won't be turned away as the patient is not eligible. Care in general practice is based on relationships between doctors and patients, and this is crucial in all health care, but even more so in mental health care, where the condition itself can limit the desire to seek help, and there can be a lot of stigma attached to mental health problems. Most problems can and will be managed in general practice without onward referral.

The effectiveness of primary care in mental health is much enhanced by having appropriate referral pathways. Currently, my experience working in one of the poorer suburbs of metropolitan Sydney is that the mental health workforce is very much distributed towards the areas where people can pay. Private psychology is mostly unaffordable, and private psychiatry is even more out of people's reach. The public system is so overstretched that the only way of accessing it is through emergency department attendance in a crisis, which is almost always worse for the patient. Routinely, my patients seen by the Community Mental Health Emergency Team are discharged back to the GP without any other mental health follow-up arranged.

There are outpatient services run through the Primary Health Network, and these on the whole are accessible to patients and designed for those who can't afford care. They are limited by workforce pressures – the PHN contract out to local pre-existing mental health workforce, I believe – and so their service availability is limited by this. There is access to a psychiatry service via Telehealth (but there is a specific exclusion for ADHD, and any certificates or reports for agencies such as Centrelink or NDIS). I have also had reports from patients that they have been banned from the service for being reportedly abusive or angry. Of course staff have to be kept safe, but also many patients with a history of trauma have problem with emotional regulation, so mental health services do need to be able to deal safely with this. This is something that the staff at an AMS, for example, are very able at managing safely.

It should be noted that accessing referrals for mental health care is very bureaucratic and requires a lot of paperwork. The requirements for a Mental Health Care Plan to be done and billed under Medicare are fairly onerous, the additional paperwork required to access care by the PHN makes sure that a large component of the consultation is taken up with paperwork that does not contribute anything to clinical care.

I myself, as well as other colleagues, have had patients with health insurance (a very small minority in my practice!) who have been refused by the private system for being too complex.

There is no affordable access to neuropsychiatric assessment, social work can be crucial but hard to access, and longer forms of therapy for those with more complex illnesses such as Dialectical Behaviour Therapy (DBT) or Eye Movement Desensitization and Reprocessing (EMDR). The system is deigned for people with more simple conditions amenable to a short course of psychology. The difficulty accessing treatment for more complex conditions means that inappropriate services may be used, as something is better than nothing, or that patients symptoms are made worse as they are passed between providers – this is especially a problem when the cause of their condition has been unreliability in relationships throughout their lives.

In addition, access to care for drug and alcohol detoxification or rehabilitation can be very difficult due to very long waiting lists in the public system. Again, this is unhelpful and tends to keep people unwell, as when someone with an addiction decides they are in the right position to take action, then they need to be supported quickly to maximise success. Community detox may be an option for many people, with the right support provided to GPs, but often the complexity of people's circumstances means this cannot be done safely, and detox is therefore inaccessible.

Having said how crucial the GP workforce is in managing mental health, this is a time of crisis for general practice. Medicare rebates do not support the cost of providing general practice care. This is exacerbated in practices managing a lot of mental health, where consultations can be long, and the co-ordination of care generates no rebates, but the care (which is predominantly provided by female GPs, one cause of a significant gender pay gap in the profession) is cognitively and emotionally taxing, leading to burnout. Where patients can't afford a co-payment – the same areas which will have the highest mental health workload for the reasons described above – general practices will become unviable with urgent action. Given that most of the mental health care is provided by GPs, and access to psychology and psychiatry is entirely through GPs, there is a real risk that the mental health system disappears in areas where it is needed most.

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

Navigating between different services can be really complex. At its best, services through the PHN are able to contact the patient and arrange appointments directly with the patient. Trying to arrange services for people with more complex or long-term requirements can be extraordinarily difficult. I've really only seen this work well when a patient had an advocate or support worker who knows the system who can do a lot of the leg-work of calling round different providers, making appointments and co-ordinating the required paperwork.

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

I note that the findings of a NSW Upper House Inquiry into health outcomes in rural regional and remote NSW hear evidence that per-patient funding in South West Sydney was less than that of the

Blue Mountains (by $250 per person), Central Coast (by $600 per person) or Central Sydney and the Inner West (by $780 per person). Given what we know about the social gradient in mental health, this will clearly have an impact on the capacity of State mental health services in areas of greatest need.

The well-recognised difficulties of recruiting health professions to rural and remote areas will exacerbate this, and it should be acknowledged that services are stretched beyond capacity already as well in the outer metropolitan areas of Sydney.

The limited access caused by factors mentioned above, combined with high need for mental health services and the difficulties recruiting mental health workforce to rural, remote and regional areas as well as areas where patients can't pay a co-payment exacerbates the capacity problems in the State system, when there is no other viable alternative.

GPs will often find themselves picking up the slack in this system and trying to cover gaps elsewhere, but GPs are also at capacity, and many, especially those who do mental health well, will have waiting lists of several weeks to be seen.

It should be acknowledged that the Safe Haven program for people who have significant thoughts of self-harm or suicide is a useful initiative that adds to the capacity of the health system at moments of potential crisis.

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

People with chronic disease often have co-existing mental health problems, and people with mental health problems often have physical symptoms, and these can frequently mimic more serious conditions. GPs are specialists in managing these co-existing conditions and symptoms, investigating when required, and not over-investigating when not required, and referring when warranted (and if available) to other health professionals and providers.

Without GPs being seen as a central part of the mental health system, symptoms, such as fatigue or palpitations might be ascribed to anxiety, when in fact they are due to thyroid or heart problems, as an example. The metabolic effects of medication for mental health problems are best managed in general practice, and GPs are best placed to do most preventive health care, such as smoking cessation, immunisation and discussing cancer screening. GPs intentionally develop therapeutic relationships with people that allow them to discuss problems they may be too embarrassed to discuss elsewhere, or be afraid of not being taken seriously. This trusted relationship enhances the care provided by other health professionals too.

In my experience, the integration between physical and mental; health services has been very poor. One of my patients has complex mental health problems including a The medical team were able to treat her malnutrition but had little ability to treat her mental health, whereas the mental health team were unable to treat the physical aspects of her and, indeed, might stop seeing her if the became too severe. This patient is fortunate in having private health insurance and NDIS support, and has a good team of health professionals around her.

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

Most of the mental health workforce is centred around access to psychology. There is a need for more mental health nurses, especially mental health nurse practitioners. (I've worked with a mental health nurse practitioner, and it working together in a clinical team really enhanced the range and quality of care we were both able to provide for the patient.

Similarly, specifically including social workers on the mental health team, really enhances the care that can be provided, especially in help accessing supports such as Housing, Centrelink and NDIS. The lack of access to this support worsens people's mental health.

There is also room for Aboriginal and Torres Strait Islander mental health workers, that are able to provide practical support to patients through difficult times. Patient support organisations also have lay workers with lived experience who provide important support for many patients.

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

I know of examples where patient is on a CTO has stopped getting treatment, and there's no follow-up. As patient's regular GP I wasn't informed!

I know of other examples where mental health treatment under a CTO is with a mental health team, but the GP is advised to make changes to mental health treatment to alleviate side effects without input or support from the team implementing the CTO.

(g) benefits and risks of online and telehealth services

Only 4.4% of people accessed mental health care via phone or digital technologies. This was highest in those aged 16-34, but even then was only 8% of people[2]. The vast majority of people initially talk to friends or family, and face-to-face care will always be the mainstay of care. Telehealth and digital technologies may enhance the role of face-to-face care, and will enable access for people where distance or transport can be a barrier, as well as for those whose mental health problems can make it very difficult to get out to services in-person. However, telehealth and digital technologies are very unlikely to successfully replace in-person care, or to run alongside it without integration. The fundamental factor of success in mental health care is that it is based on trusting, respectful relationships, and cannot successfully be done through impersonal transactions. Digital health and telehealth models will only be successful if they are integrated into face-to-face models of care. Without this, they run the risk of fragmenting care, and removing the benefit of primary care in being truly patient-centred (not diagnosis-centred) as well as being overly transactional, and therefore ineffective.

In the context of the social gradient previously discussed there is good evidence that current e-mental health tools require a level of literacy and digital knowledge that is beyond many who might be directed towards using the tools[4]. Without addressing this, recommending the use of e-health tools run a real risk of *worsening* health inequalities.

It's worth noting that while there are influential advocates for remodelling the mental health system using widespread adoption of e-health and technology, the uptake that this would require from the current level would be an unprecedented systemic change. None of the evidence has demonstrated that this widespread uptake happens even in a trial setting, or that it is prolonged enough to make a difference for the majority of people. The modelling on which these recommendations are made does not produce results that stand up to scrutiny of the modelling, despite its widespread use by advocates.

(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

I write this as a non-Indigenous person working in Community Control for the last 18 years. My observations are as an outsider, and importantly the cultural safety, and appropriateness of any approach will need to be judged by the local Aboriginal and Torres Strait Islander community.

Working in an urban Aboriginal Community Controlled Health Service, we are fortunate to have a Social and Emotional Wellbeing team, in our service. At its best we had a mental health nurse practitioner, several psychologists, a child psychologist, a social worker an Aboriginal mental health worker, and a youth worker, along with visiting support from a visiting psychiatry registrar (specialists in training) and a drug and alcohol nurse CNC. However, this team is now much smaller and stretched to capacity but the same workforce issues experienced elsewhere, and amplified in regional, rural and remote areas. Currently the wait for a psychologist in this service is up to 8 months.

The importance of this service, though, is not just the range of team members, it is very much the philosophical approach. The team is run by an Aboriginal Community Controlled Health Service, so it is accountable to the community, and has deep roots in the community. This means that the service is trusted, and so can reach people that the rest of the health system says is "hard to reach."

Any mental health system or service needs to at the very least have meaningful input from the community it is serving, and ideally should be genuinely co-designed or run by the community it serves.

Our service operates on a model of social and emotional wellbeing, rather than just mental health. People's wellbeing depends on their connection to Country, to community and to family, and so the management of mental illness might include individual therapies such as medication or psychology, but will also include community connection, connections to Country and culture and support for the whole family. Activities like art groups, community gardens and community kitchens, even line dancing are a crucial part of recovery and keeping well. While this model is crucial for Aboriginal and Torres Strait Islander people, I suspect that it is actually crucial for many communities, probably all communities, and links such as these should be expressly made within the mental health system.

Throughout the mental health system, all health providers and all services need to be culturally safe, as judged by the community they serve. Currently there is no easy way for a potential patient to identify whether a service would be culturally safe or LGBTIQ+ friendly. Without this, people run the risk of being harmed in merely seeking appropriate care.

As a general principle, it is crucial that mental health services and systems have systems that allow control and input from the communities that will be using them.

With regard to suicide prevention in Aboriginal and Torres Strait Islander communities, it is absolutely essential that suicide prevention strategies are designed and run by local Aboriginal and Torres Strait Islander communities. Anything other than this risks doing harm.

(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)

I have no specific comments other than to note the importance of alternatives to police responses for mental health crises. The presence of the police, however well-intentioned, is likely to inflame circumstances in a mental health crisis, when stories and experiences of Aboriginal and Torres Strait

Islander people are damaging and harmful. Similarly, the restrictions during the COVID lockdowns showed disproportionate responses in the multicultural communities across west and southwest Sydney. There's no reason to believe that a system that sees responses to mental health crises as a matter for police will result in harmful responses that disproportionately affect Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities.

(j) any other related matter.

The public system has completely opted out of any diagnosis and management of adult ADHD. There is a cohort of children with ADHD and other neurodevelopmental diagnoses who are reaching adulthood and will be unable to access appropriate treatment. Similarly, increasing numbers of people are needing assessment for ADHD and Autism Spectrum Disorder in adulthood, but this is only available to people who can pay the large sums of money required for these assessments. Adult health services in the public system and those contracted out by the Primary Health Networks will refuse to see patients where there may be a diagnosis of ADHD.

The cause of many people's mental health problems is very frequently their social circumstances. Every day I see people who's mental health is deteriorating because they are living in inadequate housing and the public housing system is unable to repair or move people somewhere suitable in a timely way, and private accommodation is hugely beyond people's means. Other people have significant mental health problems arising from casual, insecure, poorly paid work, others from inadequate welfare payments in a cost of living crisis. It is impossible to treat people's mental health problems when they are just returning to the same conditions which caused their problems. We are attempting to use the health system as a band aid to severe problems caused by the social circumstances that make people unwell. Without policy on housing and other social circumstances, the need for mental health services will keep increasing and mental health services will always be overwhelmed by this need, no matter what systems changes are made.

Most people will recover from mental health problems, and their recovery is greatly aided by community participation and activities. While the mental health system itself is geared around health professionals and health services, it is important to acknowledge that community activities, involving the arts, sports, religious worship, and hobbies are crucial for recovery and maintaining people's health. Any programs that facilitate these activities, including helping with transport and costs, will be beneficial to people's mental health. Initiatives that do this might include, but aren't limited to, social prescribing.

Mental health work is cognitively hard and emotionally draining. Without adequate support, both in terms of funding and workforce capacity, and psychological supervision for the workforce, future workforce problems will be exacerbated, as people leave due to psychological burnout. In developing a mental health system that is fit for purpose, then health professionals need to be supported and find joy in their work. This is consistent with ensuring that the Quadruple aim is met – that the patient experience is excellent, that the health professional experience is meaningful, that care is effective, and that care is cost efficient.

Summary

The mental health system currently struggles to provide adequate care to people, and any changes to the system, must be built with those who need the mental health system most at the forefront of thinking. This means that any service must be accessible for those who are least able to pay.

The general practice workforce is the mainstay of the mental health system, and any system reform should support GPs in providing this care. Any system not based around the principles of primary care is likely to be more expensive, less effective and less equitable.

Both patients and health professionals need to have positive experiences in the mental health system.

I am grateful for the opportunity to submit to the inquiry, and I am happy to provide further clarification or detail, or present at the inquiry should the committee wish.

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This means that service provision for mental health needs to be higher where the need is highest, which is where people can least afford to pay for services, wherever they live. Any system that does not take account of this will fail.