Submission No 135

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

Organisation: Community Restorative Centre

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

NSW Legislative Council

Submission of the Community Restorative Centre

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13 September 2023

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CRC acknowledges the Traditional Custodians of the land on which we work and live. The offices of CRC stand on the lands of the Gadigal, Wiljkali, Baarkintji, Darug, Wiradjuri, Dharawal, Awabakal, and Worimi Peoples. We recognise their continuing connection to land, water, and community and pay respects to Elders, past and present. We particularly acknowledge their ongoing advocacy on social justice matters such as those discussed in this submission.

This always was, always will be Aboriginal Land.

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1. INTRODUCTION

Thank you for the opportunity to provide information to this important inquiry into *Accessibility and Appropriate Delivery of Outpatient and Community Mental Health Care in New South Wales*. The focus of this submission is on people who use community mental health services and who have come into contact with the criminal justice system, or who are at risk of coming into contact with it.

This submission is informed by our practice and experience as a non-government organisation working at the intersection of mental health and the criminal justice system. It is our hope that future planning of the community mental health sector incorporates the experiences of those at this intersection. We focus our submission on the following areas:

- We would like to present the perspective of people who have become criminalised in the context of untreated and unsupported mental health concerns.
- We highlight the various ways criminalised populations are frequently excluded from community mental health services, and as a result, end up being 'managed' by criminal justice institutions. This is especially the case for First Nations people.
- We welcome the opportunity to share our expertise with regard to what we have found to work in assisting people with complex support needs to build pathways out of the criminal justice system, specifically highlighting CRC's Extended Reintegration Service as a model of good practice in supporting people with complex support needs in the community.

In writing this submission, consultations took place with several frontline CRC staff across a range of our programs including with our Transition Team, Women's Transition, Far West Transition, The Reintegration Housing Support Program, the Extended Reintegration Service, and our Families Casework Service.

2. ABOUT THE COMMUNITY RESTORATIVE CENTRE (CRC)

The Community Restorative Centre (CRC) is the lead NGO in New South Wales (NSW) providing specialist support to people affected by the criminal justice system, with a particular emphasis on the provision of reintegration programs for people with multiple and complex needs who have recently been released from prison.

As a part of the CRC model of care, our support workers connect their clients with any supports they need, including Community Mental Health Services. Overall, CRC's model of support includes outreach and intensive case-management, which is holistic, relational, client centred (needs-based), flexible, and long-term (up to 12 months). Many of CRC's programs are based on a *throughcare* model, which means we begin working with clients while they are still in prison. Engaging with clients prior to their release from prison (ideally 3 months prior) improves their engagement and facilitates smoother transition from prison into community. However, CRC also accepts clients from the community who have exited prison in the past 6 months, have complex needs and who experience a high level of disadvantage which puts them at risk of returning to prison. Client needs are met through the provision of both practical and relational supports which work symbiotically together. The practical supports assist with housing, finances, health, or legal issues. The relational supports are based on non-judgmental and unconditional support.

CRC has over 70 years specialist experience in this area. All CRC programs aim to reduce recidivism, break entrenched cycles of criminal justice system involvement, and build pathways out of the criminal justice system. CRC works holistically to do this, addressing issues such as homelessness, drug and alcohol use, social isolation, physical and mental health, disability, employment, education, family relationships, financial hardship, and histories of trauma. All CRC services utilise a human rights framework which recognise the inherent value of all people and aim to create genuine opportunities for people affected by the criminal justice system. People leaving prison and their families have the right to be treated fairly and have the ability to make genuine choices about building pathways out of the criminal justice system and into the community.

2.1. Extended Reintegration Service (ERS)

All CRC clients experience high levels of needs, often across several domains including mental health. **CRC's Extended Reintegration Service (ERS) works specifically with clients who have complex support needs, including cognitive disability and mental illness, and who are homeless or at risk of homelessness**. ERS is a holistic, outreach case management and multi-agency service, comprising a partnership with NSW Corrective Services, South Western Sydney Area Health Service and NSW Housing. CRC caseworkers practice the CRC model of care, i.e. offer up to 3 months pre-release support and planning, and intensive holistic case management for up to nine months post-release from prison. CRC's ERS program provides an example of good practice in community-based collaboration in supporting people with mental health concerns and who also have histories of contact with the criminal justice system.

3. THE INTERSECTION BETWEEN MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM

In order to respond to the Terms of Reference for this inquiry, it is necessary to provide some context to the intersection between mental health and the criminal justice system. **People who have come into contact with the criminal justice system, and particularly those who have experienced imprisonment, have a high prevalence of mental health diagnoses.** For example, the NSW Network Patient Health Survey found that 63% of people in prison had previously received at least one mental health diagnosis.[1] An Australian study that screened for mental illness found its prevalence to be 80% in prison population compared to 31% in the community.[2] Acute mental illness is also more likely amongst those who have long histories of criminal justice system contact.[3] Those who have a history of mental health disorders experience poorer outcomes related to housing, employment, substance use, and contact with the criminal justice system.[4] It is therefore imperative that formerly imprisoned people with mental health issues are appropriately supported in the community.

Alongside high levels of mental illness, people who have experienced prison are also more likely to experience co-occurring complex support needs. Complex and co-occurring physical and mental health conditions (including substance use) are a defining characteristic of CRC clients.[5] All CRC clients

[1] Justice Health & Forensic Mental Health Network 2017a
[2] Butler et al. 2006
[3] Fazel et al. 2016
[4] Cutcher et al. 2014
[5] Sotiri et al. 2021

experience multiple forms of disadvantage, with mental illness and homelessness often closely related to a person's contact with the criminal justice system. Research has found that more than half (54%) of people exiting prisons in Australia expect to be homeless upon release.[6]

Table 1: The social context of imprisonment and disadvantage in NSW[7]

Disadvantage	Prevalence in NSW prisons
Mental health diagnosis	63%
Disability	28%
Homelessness (primary or secondary)	15%
Experienced a traumatic event	65%
Have been in an abusive relationship	28% men and 71% women
Committed current* offence while intoxicated	60%
Placed in care <16 years	14%
Left school by year 10	72%
Experienced youth justice	33%
Prior imprisonment	60%

* Offence for which the survey participants were currently imprisoned.

There are also differential impacts for different groups of people. For example, research has found that women in prison are more likely to experience mental illness alongside other forms of intersecting disadvantage[8], as are First Nations people.[9] Young people in youth custody have a particularly high rate of mental illness. For example, the most recent NSW Young People in Custody Health Survey revealed the complexity of physical and psychosocial health needs of young people in custody. The survey revealed that 83% of young people in custody met the threshold for at least one psychological disorder and 63% have two or more disorders, with higher figures for girls and young women and for First Nations children and young people.[10]

4. ACCESSING COMMUNITY MENTAL HEALTH SERVICES

4.1. 'Falling through the cracks': The prevalence of co-occurring complex support needs and the need for holistic support

The high prevalence of people with complex support needs in prison can often be a result from a failure to adequately support the needs of people in the community.[11] **Almost all CRC clients have experienced regular exclusion from services *because* of the complexity of their support needs**. This results too frequently in populations who require support and treatment in the community being 'managed' in criminal justice system settings.

[6] Australian Institute of Health and Welfare 2019

[7] Justice Health & Forensic Mental Health Network 2017a

[8] Australian Institute of Health and Welfare 2019; Justice Health & Forensic Mental Health Network 2017a

[9] Justice Health & Forensic Mental Health Network 2017b

[10] Justice Health & Forensic Mental Health Network and Juvenile Justice NSW 2017, 65

[11] Baldry et al. 2015; McCausland, McEntyre, and Baldry 2018

In particular, **there is a high prevalence of co-occurring substance use and (other) mental health disorders amongst people who have experienced prison.**[12] As noted in Table 1, about two thirds of people who are in NSW prisons committed an offence while being under the influence of drugs or alcohol. Indeed, about 12 % of their most serious offences where for drug crimes.[13] Often, for instance, CRC clients are not able to access community mental health services because they are actively using drugs and/or alcohol, or conversely, they are not able to access alcohol and other drug services because they also have a mental health condition. **For many of our clients, mental health and substance use needs cannot be separated, and both must be treated at the same time**. Being excluded from support services, often in combination with criminalisation of drug-related behaviours, results too frequently in populations who require treatment in the community being 'managed' in prison settings. Frequently, these CRC clients will come into contact with the criminal justice system in ways that can be predicted and could have been avoided.

Many CRC clients use substances in order to cope with their mental health conditions and related trauma. Pre-existing, and particularly childhood trauma, is common among people in prison[14] and people in prison experience further traumatisation while incarcerated.[15] It is important to recognise that the experience of criminalisation and imprisonment can be extremely traumatising for people and can greatly exacerbate a person's mental illness. Formerly imprisoned people are often dealing with the effects of institutionalisation following their release from prison. **There is an interrelationship between experiences of *trauma*, mental illness, substance use and criminalisation.** One CRC worker who currently has 9 male clients on his caseload, reported that every single client has experienced institutional sexual abuse as a child and is receiving support through the National Redress Scheme, and all have varying degrees of mental illness and substance use concerns. A failure to address mental health concerns can propel people on trajectories into the criminal justice system and create perpetuating cycles of re-incarceration. An example of how such cycle can look like is presented below upon a recent story of CRC's client Mark (all client names have been changed for this submission).

Case study: Mark

Mark (42) lives in inner Sydney. He has a substance use disorder and a diagnosis of schizophrenia. At the time of coming into contact with police, Mark was in active psychosis for untreated mental health concerns. Mark spent time in prison but was released without adequate medication or mental health support. His caseworker had attempted to link him in with Community Mental Health Services but was told his needs were related to his substance use, not his diagnosed mental health condition. Mark's CRC caseworker advocated for him to receive support through Community Mental Health, stating that his substance use was a response to his schizophrenic disorder and that he required holistic support. Unfortunately, Mark did not receive any additional support and was (again) arrested the following week while in active psychosis.

Indeed, CRC workers reported similar experiences for clients who have **co-occurring mental health and cognitive disability diagnoses**. In some cases, clients with an Acquired Brain Injury (ABI) have

[12] Butler et al. 2011

[13] Justice Health & Forensic Mental Health Network 2017b

[14] Honorato, Caltabiano, and Clough 2016; Larney et al. 2012

[15] Sindicich et al. 2014

been denied treatment because they have been told their needs are not related to their mental health but are in fact related to their ABI. CRC caseworkers often feel that for clients with co-occurring complex support needs they are put in the 'too hard basket' by Community Mental Health Services.

An evaluation of CRC's AOD and reintegration programs found that supporting clients with mental health issues is often central to assisting their transition from prison to the community.[16] It is crucial that people are connected with health care professionals including GPs, psychologists, psychiatrists and community mental health teams.[17] However, it can be exceptionally challenging for people with criminal histories to receive appropriate support to suit their needs. **Health professionals frequently set high expectations for clients to attend appointments frequently, which may not be realistic for some people.** It is often the case that clients have to change and adjust to supports rather than support services being flexible and adjusting to the needs of clients. Person-centred, individualised and holistic case management and care is necessary.

4.2. The stigma of criminalisation and mental illness

People who have come into contact with the criminal justice system experience social stigma due to their criminalisation[18], and often feel as though they are being judged by service providers. This can impact on their capacity to access and engage with community-based mental health support. In our experience, often a client's mental health concerns are not taken seriously and are attributed to 'behavioural problems' related to 'jail mentality' (see Tarin's case study below). First Nations people, and particularly those who may have histories of violence, experience additional levels of stigma when accessing mental health support. This can have particularly harmful consequences for clients and mean they are less likely to engage with services in the future.

[16] Sotiri et al. 2021

[17] Sotiri et al. 2021, 38

[18] Keene, Smoyer, and Blankenship 2018

Case study: Tarin

Tarin (26) is a proud First Nations woman. She has a long history of engagement with Community Mental Health and of contact with the criminal justice system, including imprisonment. She has been diagnosed with a schizo-affective disorder. Her reports from prison outline that she requires ongoing and intensive treatment in the community. Tarin takes medication for her mental illness which helps stabilise her, but during the COVID-19 lockdowns, the reduction in face-to-face contact in care led Tarin to stop taking her medication. During this period, Tarin's mental health declined significantly and her untreated mental health presented as violent and erratic behaviour. Tarin's caseworker at CRC contacted Community Mental Health Services several times over a period of months as her condition continued to decline and expressed concern about Tarin's pattern of violent behaviour when she would become unwell. Her living conditions had also declined considerably. Tarin's neighbour observed her behaviour and called Community Mental Health Services to report she was very unwell. She was assessed by Community Mental Health, but then deemed that she was 'not unwell enough' to be hospitalised (despite reporting the continued risk to support staff, the community, and herself). Tarin's CRC caseworker communicated to the mental health team that her behaviour would likely be criminalised without a more intensive mental health intervention. Despite this, no intensive mental health intervention was provided. Tarin was eventually re-imprisoned for violence-related offences.

4.3. Access to services in rural and remote locations

There is a scarcity of mental health services in rural and remote locations[19], which has a disproportionate impact on First Nations people. The lack of services within these areas means that frequently people don't get diagnosed and, in some cases, their mental health condition goes untreated. In order to receive support, some First Nations people need to go off Country and this separation from family can cause significant grief.

Alongside a general dearth of mental health services, CRC particularly noted a lack of access for acute mental health beds in hospitals, particularly in Far West NSW. Alongside this, there are very few First Nations health workers at hospitals. There is also often a high turnover of staff in rural and remote regions, and this can contribute to difficulties in building safety, trust, and rapport with mental health staff.

5. NAVIGATING COMMUNITY MENTAL HEALTH SERVICES

The community mental health system can be complex, and unless a person has a caseworker (or in some cases a family member with knowledge of these systems) these systems can be very difficult to navigate. Frontline workers explained that they themselves experienced difficulties in navigating the system, even as professionals working in the community sector. Also, the mental health system is not always set up to accommodate support workers assisting their clients who are in an acute mental health crisis, as can be seen in the case study of Ben described below.

Getting referrals into the system can sometimes be challenging. In order to make a referral to community mental health services, a patient is required to have an address and the reality for many

[19] Justice Health & Forensic Mental Health Network 2017b

people leaving prison and requiring mental health support is that they do not have somewhere stable to live. **Being homeless or in unstable housing which is very common for people recently leaving prison can substantially hinder mental health supports they can receive**.

One challenge for CRC workers which hinders efforts to collaborate on outcomes for clients is that **community mental health clinicians do not give out their work email address**. This can make it very difficult to get and maintain contact with a caseworker or clinician. In order to get in contact with a clinician from community mental health, CRC caseworkers must call a generic phone number - and sometimes it can be very slow to receive a response, or they may not receive a response at all.

Case study: Ben

Ben (50) was released from prison and was supported by a CRC caseworker. He has a significant experience of early childhood trauma and complex mental health needs. Ben was connected to his CRC caseworker and things were going well, until he became unwell and disconnected from his support services. Ben's caseworker was in frequent contact with his mother who was concerned for his health. Ben's neighbours were also concerned for his wellbeing after seeing him damaging his property. Ben checked himself into a mental health unit at his local hospital and his CRC caseworker continued seeing him there. By this stage, Ben's mental health had declined considerably, and he was extremely paranoid. Despite this, he was discharged from hospital without a release plan, or any follow up support from Community Mental Health. During this time, Ben's health continued to decline significantly, and his CRC caseworker could see that unless he received appropriate support and intervention, he was likely to end up in trouble. Ben's caseworker called the NSW Mental Health Line on his behalf, stating that his client needed intervention and asking whether any outreach support could be provided, given his recent history of hospitalisation. As Ben was not physically present with his caseworker at the time, he was told that he could not be triaged. Ben's mental health has remained untreated. If Ben had received follow-up treatment and home visits from Community Mental Health to see how they, as specialists, could provide him with support, it may have led to better outcomes for Ben.

CRC workers often have to advocate very hard on behalf of their clients in order to receive fair and just outcomes. In one case, a client of CRC required a medical supporting document in order to retain his temporary housing. The CRC worker had to advocate on behalf of the client in order to receive this document, and felt that if they weren't present, the client would not have been able to obtain the document, which would have had a considerable negative outcome for the client.

There is also a need to more frequently review risk assessments completed by community mental health practitioners to ensure they adequately reflect clients' current circumstances. **Risk assessment scores can determine how people receive and are treated within services, but in the experience of some CRC workers, once these scores are in place they are rarely reviewed**. In one case, a client who had a previous violent incident at a Community Mental Health Service many years ago is still required to receive his depot injections at the police station. At the same time, this client has a negative history with police, and attending the police station causes additional paranoia and anxiety. This scenario has had the effect on the client of creating a negative association with receiving Community Mental Health treatment.

6. APPROPRIATE AND EFFICIENT ALLOCATION OF MENTAL HEALTH CARE WORKERS

Many CRC clients have formal diagnoses of illnesses such as bipolar disorder, schizophrenia, or borderline personality disorder. **Some participants report that the first time they received a formal diagnosis, and therefore medication, is in prison**. This suggests there is a lack of pathways into (community) mental health services leading up to offending and incarceration.

Staff reported that despite sometimes getting diagnosed in prison without a pathway to community based mental health support[20]. CRC workers have reported that **there are no referral pathways from prison into health care in the community**. This is particularly complicated for clients who seek treatment as a part of satisfying conditions of their bail or parole orders, and notably in relation to seeking residential rehabilitation for substance use disorders.

Also, **very often no medical reports are provided upon discharge from prison**. It can be incredibly challenging to receive any medical documentation from the time a person was in prison. Clients often need to start their health journey from scratch when they return to the community, including getting the official diagnoses they've once received. This means that people are often leaving prison with pressing medical needs and there is no system in place that could link them into community or other health supports. People who come into contact with the criminal justice system often cannot afford private healthcare providers such as counsellors, psychologists or psychiatrists. As a result, they must wait long periods of time before they are able to access support.

Medication can play a critical role in stabilising mental health and/or illness. **People are often released from prison without scripts for medication needed for mental illness, and therefore urgently need to visit a GP or psychiatrist when first exiting prison to secure the correct medication.**[21] In some cases, they may be waiting up to 6 weeks for an appointment while unmedicated. Most psychiatrists and psychologists who specialise in AOD have waiting lists of up to 6 months.

There is also **opportunity for improvement in collaboration between NSW Justice Health and community mental health services**. Such collaboration could provide a better continuity of care and involve creating referral pathways from both Community Mental Health Services into prison and the other way around, passing on medical records, and transferring the medication scripts. This could notably improve outcomes for people leaving prison and minimise the risk of repeated imprisonment as a result of insufficient care.

It should also be noted that in the experience of CRC's frontline workers, **mental health services across our service delivery locations (Inner-West, Western Sydney, Coniston, and Far Western NSW) are frequently understaffed, under-resourced, and overworked**. This has been particularly apparent since COVID-19, which saw an increased demand on community mental health services. Several CRC workers noted a decline in the number of bulk billing GPs their clients can access.

As is described in Jesse's case study below, sometimes compliance with a Community Treatment Orders (CTOs) is hindered by the lack of adequate mental health supports available in the community. **A combination of a CTO and long wait times to see specialists/psychiatrists can yield police**

[20] Sotiri et al. 2021, 29
[21] Sotiri et al. 2021, 38

interventions and potentially negative outcomes on the clients, such as being seen as non-compliant with the order and bearing the consequences of such.

Case study: Jesse

> Jesse (29) is required to take medication as part of his CTO. The side effects from the medication are painful and cause aching muscles, migraines, and insomnia. Jesse would like to get his medication adjusted by a psychiatrist, however the wait time for Jesse to see a psychiatrist is several weeks. Jesse decides to stop taking his medication to reduce the side effects and is considered 'non-compliant' with his CTO. As a result, Jesse is scheduled under the *Mental Health Act*, with police attending and using force in order to transfer him to a mental health facility. This causes considerable trauma for Jesse.

7. BENEFITS AND RISKS OF ONLINE AND TELEHEALTH SERVICES

7.1. Accessibility, flexibility and timeliness

In general, the **expansion of telehealth services have been a positive development for community mental health treatment in NSW**. It has increased accessibility for clients who would otherwise not be able to engage with community mental health services. Telehealth provides more flexibility, allowing people to engage with services in a place that this comfortable to them, such as their home. It has been particularly positive for those living outside metropolitan areas where there is limited access to mental health services, allowing them to receive mental health support in a timelier manner.

7.2. Protecting confidentiality

Telehealth also offers benefits in terms of protecting confidentiality for those living in rural and remote regions. Frontline workers noted that some clients may be reluctant to access local mental health services if they have friends or family working in the service, which is not unusual in small towns. Online telehealth services allow these clients to access confidential support which can reduce stigma, shame and social isolation in the community, and encourage people to engage with services when required.

7.3. The necessity for in-person services

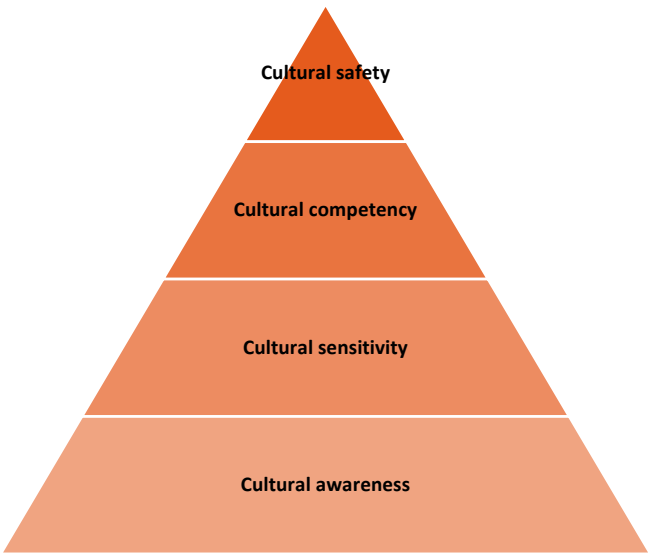
While there have been notable benefits of telehealth, telehealth services should not completely replace in-person services. **There are several drawbacks to telehealth that need to be acknowledged**. Firstly, it can be very difficult to appropriately assess a person's needs based on interactions which have taken place online. In-person assessments allow clinicians to gather more information necessary for appropriate treatment and this remains necessary. Second, it can also be difficult to build rapport with a person virtually and is not appropriate for people who are experiencing an acute mental health crisis. Finally, several CRC workers noted that telehealth services may not be appropriate for people who are experiencing paranoid schizophrenia and whose paranoia may be associated with virtual communication. For such clients, engaging them and building rapport through telehealth may provide particularly challenging. Others who have co-occurring disabilities and who are hard of hearing may also face additional challenges in engaging with telehealth services.

8. ACCESSIBILITY AND CULTURAL SAFETY OF MENTAL HEALTH SERVICES FOR FIRST NATIONS PEOPLE

First Nations people with mental health concerns are significantly overrepresented in the criminal justice system in NSW.[22] First Nations people also experience very high rates of intergenerational trauma due to the historical and contemporary impacts of colonisation[23], which may be linked to higher levels of substance use.[24] **First Nations people have lower access to mental health treatment[25], despite a higher prevalence of need**. Due to Australia's violent history of colonisation, some First Nations people are reluctant to engage with mental health services that are grounded in individualising and pathologising mental illness, especially if they do not consider such services to be culturally safe. There can be a genuine concern that engagement with mental health services will bring government surveillance, monitoring and intervention into their lives and may be used as an excuse to remove children or further separate the individual from their family through processes of institutionalisation.

8.1. Enhancing cultural safety

Cultural safety has been defined as 'an environment which is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity and truly listening'.[26] The *National Aboriginal and Torres Strait Islander Health Plan 2021-2023* notes that cultural safety is 'about *how* care is provided, rather than *what* care is provided. It requires practitioners to deliver safe, accessible and responsive health care that is free of racism by recognising and responding to the power imbalance between practitioner and patient; [and] reflecting on their knowledge skills, attitudes, practising behaviours, and conscious and unconscious bias'[27]. The National Collaborating Centre for Indigenous Health in Canada notes that cultural safety is established through a continuum of core concepts as building blocks, with cultural awareness at the bottom, followed by cultural sensitivity, cultural competency and cultural safety at the top.[28]



In consultation with First Nations frontline staff, **community mental health services were not considered to be culturally safe and recommended**

[22] Justice Health & Forensic Mental Health Network 2017b
[23] Anthony, Sentance, and Bartels 2020
[24] Australian Institute of Health and Welfare 2017
[25] Justice Health & Forensic Mental Health Network 2017b
[26] Eckermann, Dowd, and Martin 1994
[27] Department of Health 2021, 52
[28] Johnson and Sutherland 2022

that community mental health services require additional training in cultural competency.

We provide several recommendations for how cultural safety can be improved in community mental health services:

- **Provide genuine compassion, empathy and care for clients:** In order for services to be culturally safe, there must be genuine compassion and care for clients. In the experience of CRC workers, too often First Nations clients are not treated with empathy, kindness and compassion.[29]
- **Appropriately listen and take time to understand the concerns of individuals, families, and First Nations health workers:** CRC workers noted that too often, First Nations people who are experiencing mental health concerns, their families, First Nations health workers, and CRC caseworkers are not appropriately listened to. They spoke of the importance of taking adequate time to speak with, listen and understand the concerns of the person and those around them. CRC workers spoke of instances where they have informed clinicians about a clients' trauma history and how to engage appropriately with them, such as not touching them unexpectedly, but have been ignored, resulting in an escalation of the client's behaviour and disengagement from services.[30]
- **Involve and adequately support family:** For First Nations people, family and culture are inseparable. There is a need to include family in treatment plans for First Nations people, but to also adequately support family members who are supporting family members experiencing mental health crises.[31]
- **Employ and adequately support First Nations health practitioners:** Cultural safety can also be enhanced by employing First Nations workers in community mental health services and ensuring that they are adequately supported to work in a culturally safe environment. Several CRC workers spoke of the importance of having a First Nations person there in order to de-escalate situations and to provide safety for the person requiring mental health support.
- **Enhance the physical environment of community mental health services:** CRC workers described some community mental health services as clinical, grey and characteristic of other government services such as hospitals and parole offices. Assertive outreach and providing support to First Nations people outside clinical environments is important.
- **Ensure services are trauma-informed:** There is cumulative and intergenerational trauma in the lives of many First Nations people and families. As one First Nations CRC frontline worker explained '*all Aboriginal people in Broken Hill have experienced or are connected to some form of trauma*'. Recognising the ongoing role of colonisation in perpetuating this trauma is also critical.[32] This needs to be taken into consideration if a person is not engaging with a service.
- **Shift power imbalances:** CRC workers spoke of many instances where community mental health clinicians speak in medical language and jargon that can be difficult for many to follow. Such practices have the effect of upholding power imbalances between patient and clinician. Cultural safety involves shifting power from provider to client. Another factor highlighted by

[29] See also Johnson and Sutherland 2022, p. 24
[30] See also Johnson and Sutherland 2022, p. 24
[31] See also Cullen et al. 2022, p. 1212
[32] See also Cullen et al. 2022

CRC workers is that community mental health clinicians do not carry mobile phones which can make it very difficult to contact and can have the effect of upholding power dynamics.

9. ALTERNATIVES TO POLICE FOR EMERGENCY RESPONSES

Many CRC clients are criminalised in the context of untreated mental health concerns. **It is our view that there is a critical need for alternatives to police for emergency responses**. Police attending to a mental health crisis can trigger a rather negative response due to client's history of police contact or incarceration. At the same time, clients of CRC who are experiencing an acute mental health crisis are more likely to have the police called of them because they are known to the police.

Police as first responders to mental health crises is particularly inappropriate for First Nations people, who over-policed and over-surveilled. CRC caseworkers highlighted inappropriate responses to First Nations people who are experiencing mental health crises. They spoke of a frequent scenario, where a First Nations person who is experiencing an acute mental health crisis and who may have a cognitive disability or have hearing loss will become distressed and raise their voice, leading to security or police being called. This can then further escalate the situation and cause significant distress to the client and reduce the likelihood of further engagement with mental health services.

Case study: Steve

Steve (31) has previously been in contact with the criminal justice system and has a diagnosis of paranoid schizophrenia. Steve was in active psychosis and yelling loudly on the street, prompting a community member to call the police. Steve, who has a history of police contact, felt scared and threatened when the police turned up and continued yelling. The police response escalated the situation and Steve was charged with offensive language and resist arrest. Steve was arrested, and due to his previous criminal history, was refused bail and re-imprisoned.

The PACER (Police, Ambulance, Clinical, Early Response) Program was highlighted by several CRC frontline workers as an example of good practice operating in NSW. PACER is a joint crises response from police and mental health clinicians to people experiencing a mental health crisis in the community, providing on-scene and telephone assistance. The program began as a pilot in 2018, and was expanded in 2020 following positive results[33], with the NSW government committing to employ 36 specialist mental health clinicians across 10 Police Area Commands and Districts in NSW.[34]

However, **CRC workers highlighted that the PACER teams appear to be under-resourced and noted some concerns that even under the PACER model, the response is activated by the police and police are still the first responders**. CRC First Nations staff also recommended that any alternative to police for emergency responses should include an Aboriginal health practitioner.

The CAHOOTs model (described below) is an example of a non-police emergency response in Oregon, USA.

[33] NSW Health 2020a

[34] NSW Health 2020b

Case Study: A model for mental health crisis intervention: Crisis Assistance Helping out on the Streets (CAHOOTS)

CAHOOTS is a 24-hour mobile mental health crisis intervention program based in Oregon in the USA which has received global attention as a well-established alternative to police emergency responses[1]. The program dispatches two unarmed crisis workers and medics to respond to 911 and non-emergency calls involving people experiencing a mental health crisis – calls that in other cases may go to the police. If the situation involves a crime, violence or life-threatening emergencies, police will attend as co-responders. The primary goal is to create an alternative to police for people experiencing social and behavioural health crisis. The CAHOOTS team delivers person-centred interventions including: unarmed de-escalation; crisis counselling; suicide prevention; conflict mediation; grief and loss support; welfare checks; substance abuse support; housing crisis support; harm reduction; information and referral; transportation to hospitals and social services; as well as first aid and non-emergency medical care[1]. The efficacy of the program is dependent on existing social, health and welfare services within the community.

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