Submission No 138

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

Organisation: Black Dog Institute

Date Received: 13 September 2023

Science.
Compassion.
Action.

Equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW

September 2023

Black Dog Institute

About the Black Dog Institute

The Black Dog Institute is a global leader in mental health research and the only Medical Research Institute (MRI) in Australia to investigate mental health across the lifespan.

Areas of strength include suicide prevention, digital mental health, workplace mental health, new treatments, and prevention in young people.

Our unique translational approach allows us to quickly turn our world-class scientific findings into clinical services, educational programs and e-health products that improve the lives of people with mental illness.

We join the dots, connecting research answers, expert knowledge and the voices of lived experience to deliver solutions that work across the health care system for patients and practitioners alike.

The Institute is proud to be a trusted partner of government, universities, health services, clinicians, industry, workplaces, schools and philanthropists across the country.

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Executive summary

The New South Wales (hereafter NSW) mental health system is caught in a vicious cycle of underinvestment. A decade of funding acute services at the expense of community-based mental health services created a system that can only respond to people after they have reached a point of crisis. Urgent reform is required and the longer it takes, the more costly it will be.

Currently, NSW invests the least into mental health services per capita, compared to all other Australian States and Territories, and is the only State where mental health spending per capita has decreased in the past decade.[1] This gap that will only widen further after new reform commitments made by State governments in Victoria, Queensland and Western Australia.

In the past decade, the majority of NSW's mental health funding has gone to acute psychiatric units, as opposed to community care. This is despite the evidence that community mental health care provides consumers with better outcomes, at a fraction of the cost.[2]

The effect of underfunding community mental health is that services are stretched beyond capacity, frontline mental health workers are burnt out, and, most importantly, people who need mental health care have to wait longer, pay more out of pocket and, those who need it the most, often cannot access care until it's too late.[3]

Underinvestment in community mental health has direct costs. Lack of community mental health services lead to higher demand for acute in-patient services, increased presentations to emergency departments (hereafter EDs), and increased pressure onto other State-funded services, that are less equipped to care for people with mental illness, including police, prisons and housing and homelessness services.[4]

Despite the current state of affairs, the good news is that NSW has a clear pathway to reform. The NSW Mental Health Commission's roadmap for reform, the Living Well Strategy, first launched in 2014, is just as relevant today as when it was developed. Similarly, reports like the Productivity Commission's Inquiry into Mental Health and the Victorian Royal Commission, provide a trove of recommendations that can be implemented here in NSW.

New technologies and programs also represent an opportunity to not only rebuild but transform the NSW mental health system. With the following recommendations, our hope is that NSW can move from a laggard to a leader in evidence-based, person-centred mental health care.

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[1] Productivity Commission. (2023). Table 13A.2
[2] NSW Health. (2022 -2).
[3] Mental Health Coordinating Council. (2023).
[4] Mental Health Coordinating Council. (2022).

Summary of recommendations

Based on the most recent evidence and the lived experience of consumers, carers and clinicians, the Black Dog Institute recommends:

1. **Appropriate funding for mental health:** NSW Health allocate funding for mental health proportionate burden of disease, with year-on-year funding increases based on projected population growth and mental health demand.
2. **More equitable allocation of mental health funding:** NSW Health prioritise funding community-based mental health services, particularly in rural, regional and remote areas and areas of low socio-economic status.
3. **Comprehensive gap analysis:** NSW Government conduct a regular independent gap analysis of State-funded mental health services in NSW to identify funding and workforce gaps, including providing a clear view on service demand and role vacancies in NSW, publishing annually at a region-level, by PHN–LHN groupings.
4. **Coordination with Commonwealth funding:** the NSW Government work with the Australian Government, as outlined in the National Mental Health and Suicide Prevention Strategy and the National Mental Health Workforce Strategy, to address the gaps in funding and workforce for community-based mental health services.
5. **Mental health payroll tax surcharge:** the NSW Government implement a mental health payroll tax surcharge, similar to that implemented in Victoria and Queensland, to provide ongoing revenue to fund mental health services.
6. **Service navigation:** NSW Health develop a State-wide Community Mental Health Navigation Support Service to help consumers access services and psychosocial support, including a user-friendly digital interface to support consumers on their care pathway.
7. **Mental health training for emergency department staff:** NSW Health provide mental health training for all ED staff, especially on suicide prevention, as specified in the Black Dog Institute's ED guidelines.
8. **Safe Havens:** NSW Health expand the Safe Haven program to be a 24/7 service, with a view of opening additional Safe Havens in high-need rural, regional and remote areas.
9. **Cultural adaptiveness for First Nations populations**: NSW Health provide to all staff in the NSW healthcare workforce Aboriginal Cultural Training each financial year, with the training content reviewed every two years to ensure continued community support.
10. **Community supported housing:** the NSW Government expand the Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS) programs to ensure consumers are discharged into secure and supported accommodation.
11. **Digital mental health and telehealth**: NSW Health provide State mental health workforce with training on digital mental health and telehealth tools, in accordance with the National Safety and Quality Digital Mental Health Standards, to increase trust, uptake and quality of care.

State of mental health in NSW

Prevalence of mental illness

An estimated 1 in 6 people, or 1.3 million people, in NSW experience mental illness in any given year.[5] In the last 20 years, the level of high or very high psychological distress in adults in NSW has increased from 10% to 17%.[6] This increase has been unusually steep for young people, particularly young women, a trend that started before and continues after the COVID pandemic.

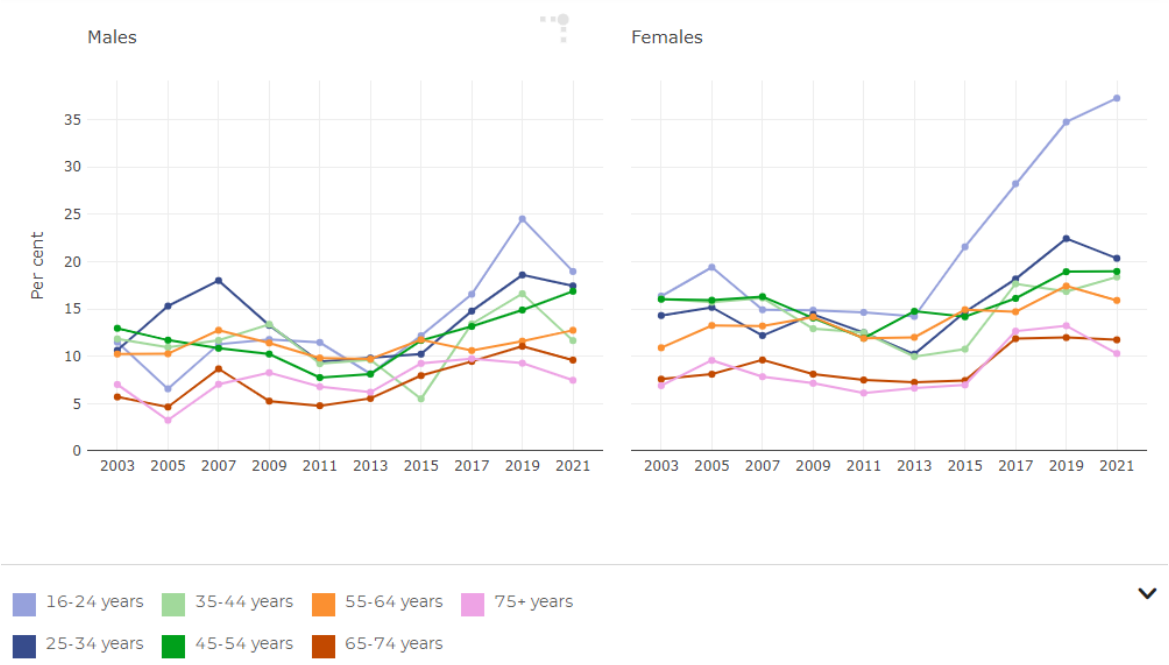

Figure 1: High or very high psychological distress in adults. HealthStats NSW (2021).

Types of mental health services

Mental health, like physical health, exists on a spectrum of wellness. The greater the severity of symptoms, the higher the need for more intensive services. State-funded services exist, alongside Federally-funded services to, theoretically, meet the needs of all people across the mental health spectrum.

Broadly, Federally-funded services, like Medicare Benefits Scheme (MBS) subsidised psychological sessions and Public Health Network (PNH) commissioned services, cater to the more mild-to-moderate severity cases. Whereas State-funded services, like community

[5] HealthStats NSW. (2021).
[6] Ibid

mental health service (CMHS) teams, acute units and Es, often cater to the more moderate-to-severe and complex cases.

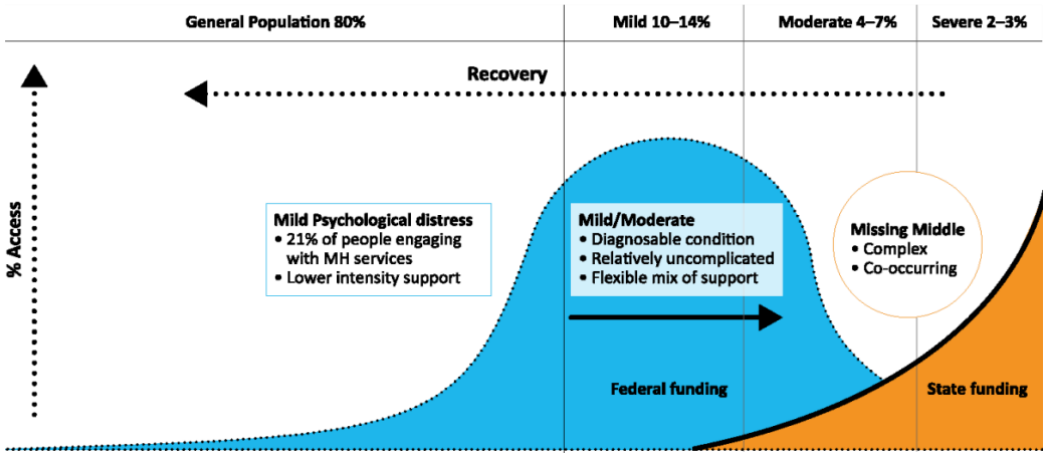

Figure 2: The 'Missing Middle'. National Mental Health Commission. (2017).

However, this distinction is not so clear in practice. The recent MBS Better Access evaluation showed that co-payments and long wait times made MBS-subsidised sessions inaccessible for many consumers, particularly those in rural, regional and remote areas, and those of low socio-economic backgrounds.[7] This meant that people needing help would go untreated, with symptoms worsening, until they reached crisis-point and presented at either emergency or at an acute unit.

Conversely, with insufficient funding in community mental health and only limited beds in acute units, State-funded services are only available to those in the most desperate circumstances, and even then, many consumers report difficulty getting appropriate care close to home.

Primary Health Networks are tasked with increasing access to treatment and support for underserviced groups, including people who may not be able to afford co-payments associated with therapy funded through the MBS. Specialist services like headspace and the adult and child Head to Health centres are often entry-points for consumers to access the mental health system but often cannot cater to those with more severe, acute and complex needs.

Similarly, the Federally-funded National Disability Insurance Scheme, provides psychosocial support to people with long-term mental health issues. However, consumers report difficulties qualifying for the scheme and often face barriers to receive ongoing support, given the episodic nature of many mental health issues.[8]

The gap that exists between Federally-funded and State-funded services is what's called 'the missing middle'. Consumers can often find themselves here when they are too unwell or

[7] Pirkis, J., Currier, D., Harris, M & Mihalopoulos, C. (2022)
[8] NDIS Review Panel (2023)

unable to access limited State-funded services or NDIS support, but 'too well' to qualify for the Medicare-funded services.

> *People from low socio-economic backgrounds cannot afford to access private psychologists, private psychologists, or private inpatient admissions. Headspace and Community Health services often have prohibitively long wait lists and even though they are more accessible financially, are not practical for people who need timely support.*
> *– Psychologist (regional)*

Community mental health services in NSW

Community mental health services provide an essential bridge between Medicare-funded services and State-funded acute services. They are critical to provide preventative care, early intervention, and wrap-around psychosocial support with a focus on person-centred recovery and connection with community.

Consumers consistently rate community mental health services as being a better overall experience for them, with significantly higher ratings in the domains of respect, safety & fairness, individuality, participation, information & support, and making a difference in their lives.[9]

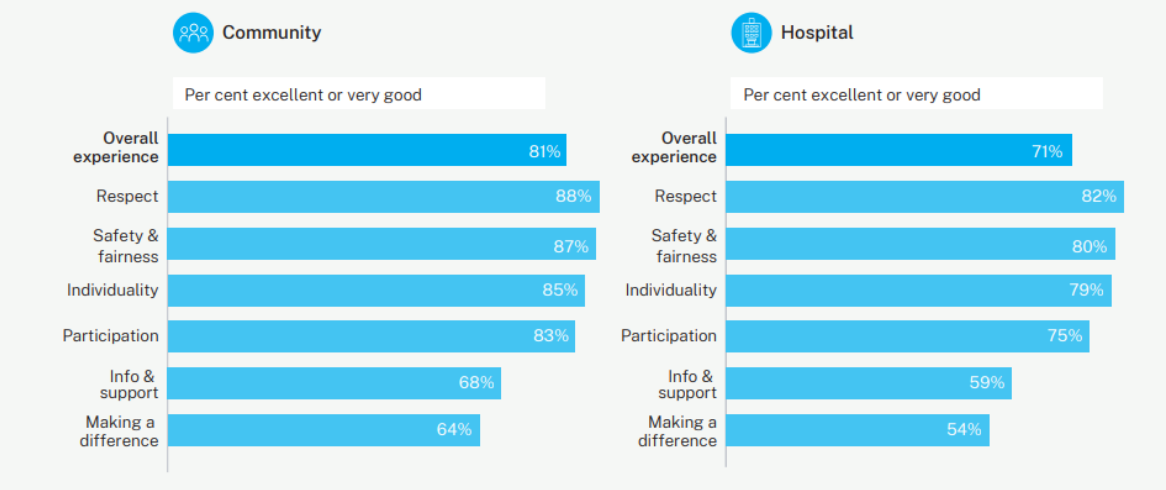

Figure 3: Consumer ratings of service experience, community and hospital. NSW Health. (2022).

Despite this, community mental health services in NSW have been underfunded for more than a decade. The extent of this underfunding is outlined in the following section on 'System capacity and resource allocation'.

[9] NSW Health. (2022 – 2).

"Community mental health are under-resourced and cannot cope with the amount of people in need, leaving them to fend for themselves as far as obtaining adequate clinical mental health care. They end up falling through the cracks until they end up at emergency department or being referred to the Acute Care Team or taken into an inpatient unit."
- Community mental health worker (Regional town)

System capacity and resource allocation

Overall mental health funding

There is a marked disparity between mental health need in NSW and the funding given to it. Despite mental health representing 13% of NSW's total burden of disease, investment into mental health only represents 7% of NSW's total health budget.[10]

The growth of this funding over time has not kept up with the increasing demand. In the past decade, mental health funding has increased at a rate of 1.9% per year. In contrast, the demand for mental health services have grown, on average, by 5.45% year on year, inflation by 1.88% and the NSW population has grown by 1.2%.[11] Without urgent investment, the gap between what is needed and what is provided will continue to grow year on year.

Recommendation 1

NSW Health allocate funding for mental health proportionate burden of disease, with year-on-year funding increases based on projected population growth, mental health demand and inflation.

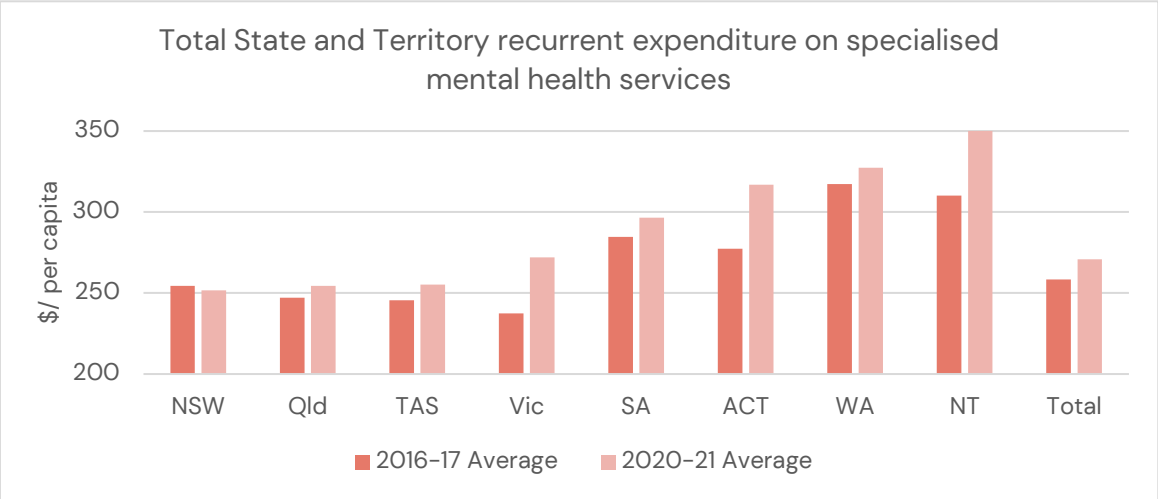

Figure 4: Total State and Territory recurrent expenditure on specialised mental health services. Productivity Commission. (2023). Table 13A.2

NSW is falling behind other States and Territories when it comes to mental health funding. In 2021, NSW invested the least per capita into mental health compared to all other jurisdictions, a gap that will have only widened with recent funding commitments by the Victorian and

[10] Australian Institute of Health and Welfare. (2021).
[11] HealthStats NSW. (2021). & Reserve Bank of Australia (2023) & Australian Bureau of Statistics. (2022).

Queensland State Governments. In fact, NSW is the only State in which public spending on specialised mental health services per capita has gone backwards since 2016-17 (See Figure 4 above).

Community mental health funding

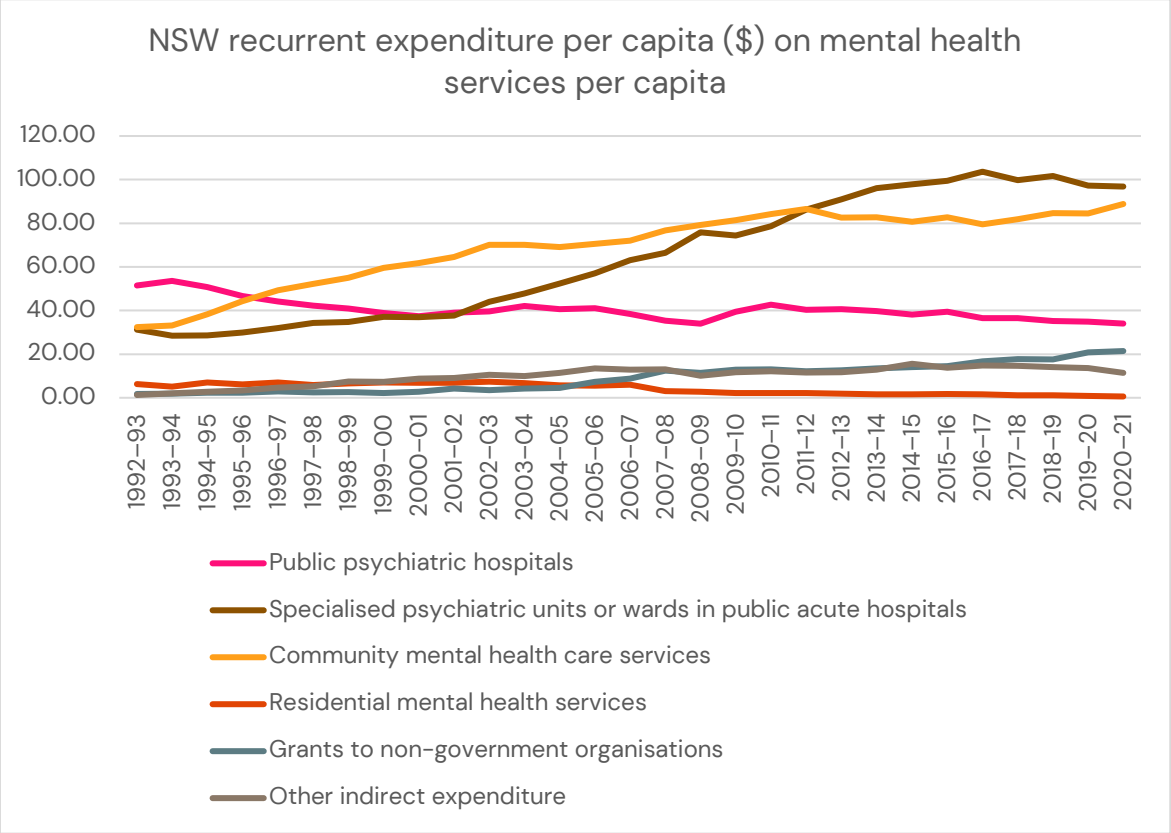

Figure 5: NSW recurrent expenditure per capita ($) on mental health services per capita. Productivity Commission. (2023). Table 13A.3

NSW spends a higher proportion of its mental health budget on in-patient acute care vs community mental health services.

This is in contrast to the strategic aims of the NSW Living Well in Focus 2020-2024, which specifically calls out "strengthening community recovery and wellbeing" and "strategically investing in community wellbeing and mental health" as two of its three strategic priorities.[12] Given that the proportion of expenditure on community mental health remains lower than the national average, it is clear that the Living Well Strategy has not had the impact it was designed too.

[12] NSW Mental Health Commission. (2020).

The proportion of expenditure in NSW on community mental health is still well below the national average. Furthermore, the proportion of expenditure allocated to community residential services continues to slowly decline in NSW and remains substantially lower than the national average, 0.2% for NSW compared to 6.2% nationally in 2020-21 (see Figure 5 above).

Recommendation 2

NSW Health prioritise funding community-based mental health services, particularly in rural, regional and remote areas and areas of low socio-economic status.

Workforce

This lack of funding for community mental healthcare has translated to a workforce that is under resourced and therefore increasingly unable to adequately meet the needs of consumers. The employment rate for mental health direct care staff, including in both ambulatory and residential care in NSW is lowest in comparison to other States and territories.[13] Especially in residential care, employment rates have drastically declined since 2011.[14] This is particularly worrying when the trend for mental illness in NSW is increasing, but the availability of the workforce is decreasing. This is leading to more pressure being put on the existing workforce to meet the needs of more people with less resources – leading to a burned-out workforce and a system in crisis.

We know that rates of burnout and PTSD have risen dramatically in the context of these workforce pressures and the aftermath of COVID, and this is driving workforce absenteeism and attrition in the mental health sector. A recent Australian study of nurses found a high prevalence of depression (32%), anxiety (41%) and stress (41%).[15] Concerningly, there has also been a rise in the percentage of nurses and midwives with clinically significant symptoms of PTSD. These worrying statistics correspond to the growing number of nurses considering leaving the profession, as experiences of work stress, burnout, and mental illness being known risks for absenteeism and workforce exodus.[16]

Whilst the data above on workforce is concerning in itself, it does not even describe the full extent and impact of the workforce shortages faced by the sector. Available data does not show the vacancy rates in these jobs, which according to public healthcare professionals, have reached an all-time high. This means that even when the official data says that there are enough FTE allocated to a certain service, the reality is that these services are still under resourced. Without consistent and transparent data on the mental health workforce, it is difficult to understand the full extent of the problem.

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[13] Productivity Commission. (2023). Table 13A.12.
[14] Ibid
[15] Maharaj, S., T. Lees, and S. Lal, (2018.)
[16] Sharpin, G., M. Brinn, and M. Eckert, (2023)

Frontline staff in NSW mental health services describe the near futility of recruiting specialised mental health staff into permanent roles or even attracting visiting medical officers, in part due to appalling conditions, and in part due to salary caps that do not exist in private practice. Telemedicine has increased consumer access to care but also reportedly incentivised practitioners to leave public health positions in favour of more lucrative and less stressful private care. Caseloads for staff psychiatrists are described as unrealistic to the point of dangerous for both patients and practitioners, and vital clinical time is taken up by psychiatrists responding to coronial investigations where the focus is reportedly not on systemic failures that contribute to mortality, but solely on the decision-making of under-resourced doctors. Taken together, these factors can only provide massive disincentive for psychiatrists and other specialised mental health workers to remain in dwindling public health roles.

I have been working in public mental health services for over 10 years in NSW. I feel the morale now in the frontline is the lowest I have ever seen or experienced. The main concern I have is that of workforce shortage, particularly of consultants. We have a brand new hospital but not enough staff to open the units.- Psychiatrist (regional)

Understanding the gaps

An independent gap analysis, already committed to in principle by this Government, is required to ascertain a full picture of where the most critical issues are, and the steps needed to fill these 'gaps.[17] Whether that be more psychologists in Wollongong or community mental health care services in Dubbo, a gap analysis will shine light on where the system is falling short and what practical steps are needed. We suggest that the gap analysis is done using the National Mental Health Service Planning Framework.[18] This is a proven, credible methodology to undertake the gap analysis and will provide the best results.

The gap analysis will provide the best indication of where the current shortfalls are, allowing NSW to act in close coordination with the Commonwealth MBS and NDIS reforms to achieve meaningful change. There is appetite within the Commonwealth for MBS reform and changes to NDIS psychosocial support, demonstrated in two recent inquiries into the respective subject matters.[19] This provides a perfect opportunity for a gap analysis to demonstrate precisely how MBS reform and NDIS psychosocial support can help to plug the gaps that exist in the NSW healthcare sector.

[17] Mental Health Coordinating Council. (2023).
[18] Australian Institute of Health and Welfare. (2023).
[19] Australian Government Department of Health and Aged Care. (2023). & National Disability Insurance Scheme. (2022).

Additionally, conducting this gap analysis on a regular basis and publishing its findings, by PHN–LHN groupings, in accordance with the Productivity Commission recommendation, would facilitate better workforce planning at both State and Federal levels[20].

Recommendation 3

The NSW Government conduct a regular independent gap analysis of State-funded mental health services in NSW to identify funding and workforce gaps, including providing a clear view on service demand and role vacancies in NSW, publishing annually at a region-level, by PHN–LHN groupings.

Bridging the gaps

Providing the right mental health care at the right time for all NSW citizens will require coordinated reform efforts at both State and Federal levels. It is not enough to just adequately resource State-funded services alone, if there is not continuity of care with Medicare and NDIS funded services. The National Mental Health and Suicide Prevention Strategy and the National Mental Health Workforce Strategy provide frameworks for collaboration between State and Federal jurisdictions.

Recommendation 4

The NSW Government work with the Australian Government, as outlined in the National Mental Health and Suicide Prevention Strategy and the National Mental Health Workforce Strategy, to address the gaps in funding and workforce for community-based mental health services.

Funding the reform

The persistent question, when suggesting large-scale reforms and investments, is always "how do we pay for it?". Here, the example of the Victorian and Queensland State governments serves as a useful precedent.

On 1 January 2022, the Victorian State government implemented a Mental Health and Wellbeing Payroll Tax Surcharge, as recommended by the Royal Commission into Victoria's Mental Health System. The levy imposes a surcharge of 0.5% on employers whose taxable wages are more than $10 million and 1% on those with total Australian wages of more than $100 million.

[20] Productivity Commission (2021)

In the 2023-24 financial year, the Victorian State Government raised $912 million for mental health services through its Mental Health and Wellbeing Levy. The Queensland State government implemented a similar levy on 1 January 2023.

To raise funds for the critical investments into mental health recommended in this submission, the NSW government could implement a similar payroll tax surcharge, providing a dedicated stream of funding for mental health services in NSW.

Recommendation 5

The NSW Government implement a mental health payroll tax surcharge, similar to that implemented in Victoria and Queensland, to provide ongoing revenue to fund mental health services.

Equity, accessibility and cultural safety

Navigating the NSW mental health system

Given the complexity of the NSW mental health system, it is unsurprising that consumers and carers often report difficulty finding and accessing the services they need. System navigation is a skill many consumers and carers have to learn through trial and error.

23% of people discharged from a mental health hospital do not receive follow-up from a community mental health team.[21] Even those who do receive timely follow-up do not always receive clear information on how to access the right services. A person's level of distress may also exacerbate difficulties in navigating the system. Timely and appropriate support is required for a successful transition from hospital to community services, such that no one falls through the cracks.

Recommendation 6

NSW Health develop a State-wide Community Mental Health Navigation Support Service to help consumers access services and psychosocial support, including a user-friendly digital interface to support consumers on their care pathway.

Rural, regional and remote

A quarter of people in NSW live outside of major cities but this huge portion of the population face increased barriers to accessing mental health care.[22] The long distances between regional centres and fewer services available leads to people having to travel for hours to access services that aren't available to them locally or not being able to access them at all. For example, 91% of psychiatrists in NSW have their main practice in a major city, leading to people having to travel from regional areas into major centres just to access the same treatment available to people who live in major metropolitan areas.[23]

Patients are driving from Newcastle to Sydney to get a private psychiatrist appointment after trying to get it locally for more than 6 months.
– Psychiatrist (Sydney)

Fewer available services lead to more people accessing them, blowing out wait times. About 1 in 3 people (36%) in NSW with a mental health condition waited longer than they felt

[21] Productivity Commission. (2023). Table 13A.31.
[22] NSW Mental Health Commission. (2023).
[23] Ibid

acceptable to get an appointment with a medical specialist compared to nearly 1 in 4 (26.2%) people without a mental health condition (See Figure 6 below).

Figure: People who waited longer than felt acceptable to get an appointment with a health professional by mental health status, NSW.

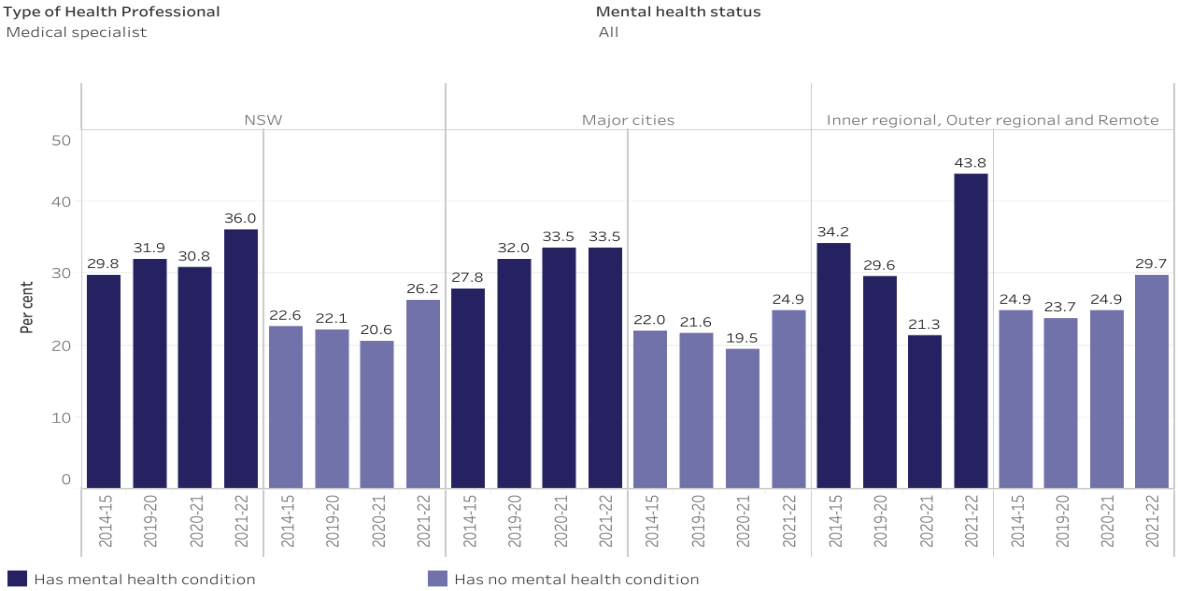

Figure 6: Hospital wait times by regionality and mental health. *Australian Bureau of Statistics. (2021 – 2).*

The lack of service provision is having an impact on the mental health of people in rural, regional and remote NSW. Whilst rates of psychological distress remain consistent with metropolitan areas, people in regional areas have a far higher rate of death by suicide than in metropolitan areas, see Figure 7 below.

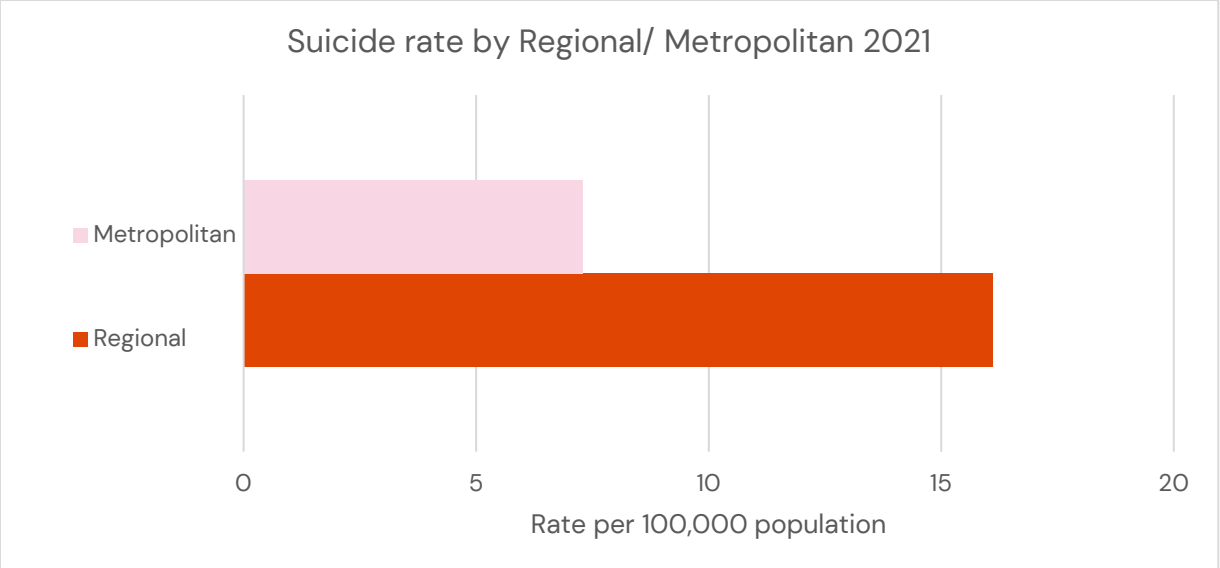

Figure 7: Suicide Rate by Regional/ Metropolitan HealthStats NSW. (2021).

What these alarming statistics speak to is the lack of mental health service provision for people experiencing suicidal crisis in our regional, rural, and remote areas. Emergency departments are usually the only place for people to go in rural/ regional NSW when they are experiencing a crisis. Hospitals can sometimes be many hours away and they often aren't set up to deal with someone who is having a crisis – leading to negative experiences which make people less likely to seek care in the future.

> I will never go back again (to an ED) because they make me feel unsafe, I feel like I never will be able to get help and I have to sit there, manage an acute active crisis and hope that I have the strength to get out of it.
> Anonymous (Advisor)

To address this, at the Black Dog Institute, we have developed a set of best practice ED guidelines, informed by stakeholders from across the mental health sector for how EDs should adequately treat someone in a mental health crisis. If these guidelines were rolled out Statewide, they have the potential to greatly improve the experience of people presenting to EDs in suicidal crisis.[24]

Recommendation 7

NSW Health provide mental health training for all emergency department staff, especially on suicide prevention, as specified in the Black Dog Institute's ED guidelines.

A pre-existing alternative to EDs are Safe Havens. Safe Havens provide an effective, evidence based alternative that if rolled out comprehensively across rural/ regional NSW, could greatly improve access to services for people in suicidal crisis. Safe Spaces are operated by peer workers with a lived experience of suicide and offer care and treatment in a non-threatening environment. There are safe havens in towns across NSW but they are only open for a few hours a day, sometimes for only a few days in a week which means people are at risk of still not getting the service when they really need it.[25] The NSW Government has set aside $25 million for the Safe Haven Program to be rolled out fully over three years, this should be finished as a matter of priority, and further funding made available to extend the program.

Recommendation 8

NSW Health expand the Safe Haven program to be a 24/7 service, with a view of opening additional Safe Havens in high-need rural, regional and remote areas.

[24] Black Dog Institute. (2023). Available on request.
[25] NSW Health. (2022 -1).

Low socio-economic status

Unless you are very wealthy, which most of us are not nor ever likely to be, you cannot get the care you need in the public system, when you need it, for as long as you need it, throughout your life, not even in Sydney."
– Stephen (Consumer)

People in lower socioeconomic groups experience mental ill health at a substantially higher rate than other socioeconomic groups in Australia. For people who may initially be in the mild/ moderate category of psychological distress, the Medicare co-payment can be prohibitive to them seeking care. This leads to substantially lower rates of people who are in a low socioeconomic group seeking care through the Better Access service. [26] With waiting lists for public services growing longer each year, it can leave the person unable to seek care when they need it.[27] Furthermore there are a lack of free, State funded services available in NSW for someone who may need care for a more complex/ severe mental health condition, as discussed above. Therefore, people in lower socio-economic groups cannot get the care they need at a time when they need it and this leads to substantially higher levels of psychological distress in these groups, see Figure 8 below.

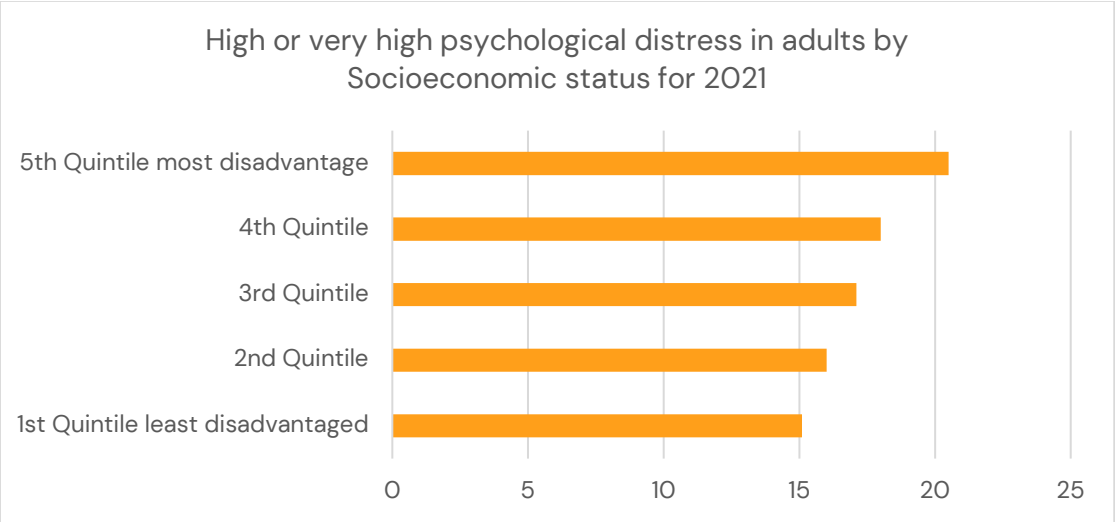

Figure 8: Psychological Distress by Socio-economic group. HealthStats NSW (2021).

[26] Pirkis, J., Currier, D., Harris, M & Mihalopoulos, C. (2022)
[27] Kinsella. E (2021).

First Nations people

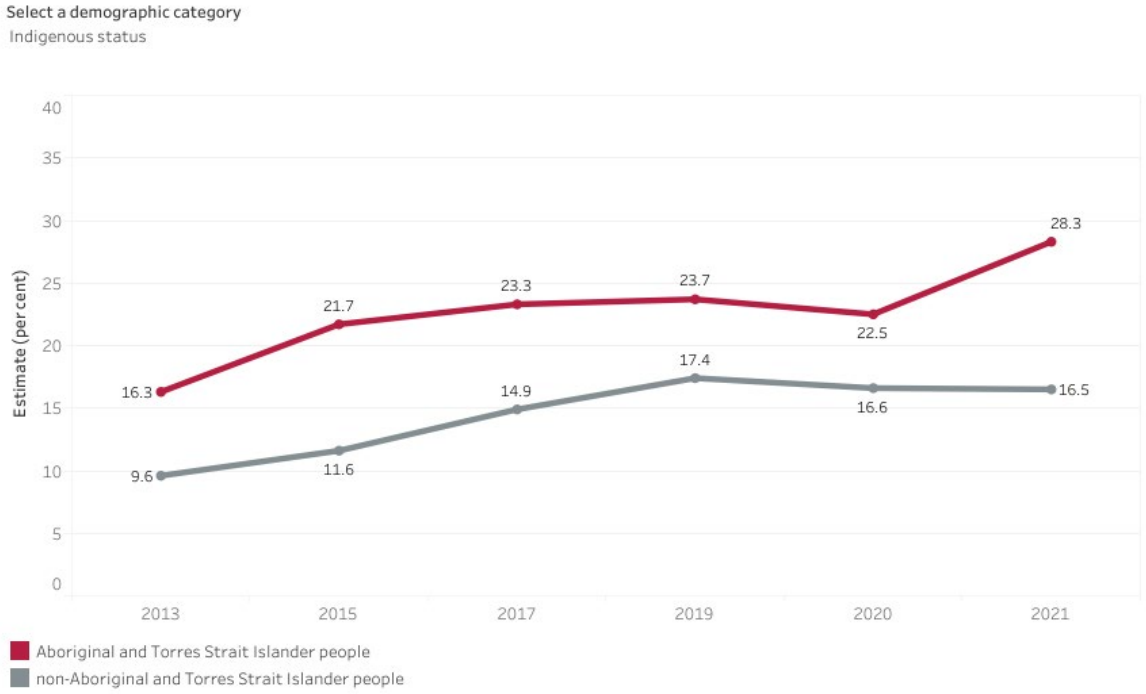

Figure 9: Psychological Distress Indicator. HealthStats NSW. (2021).

First Nations peoples in Australia have a disproportionately higher rate of social and emotional wellbeing disturbance, including mental health. As of 2019, the rates of First Nations people experiencing high or very high levels of psychological distress was almost 1 in 3.[28] The levels of First Nations people accessing public mental health services was only 6.2% in 2020-21 however. Whilst this was above the non First Nations average of 1.7%, it is still far lower than the rates of psychological distress in the community.[29]

The low proportion of service use speaks to the barriers faced by First Nations people in accessing appropriate service delivery. Many of these barriers are interconnected and rarely exist in isolation. Those barriers frequently include:

- Service delivery that is not culturally responsive
- Historical and ongoing trauma from generations of marginalisation, racism and discrimination
- Stigma around mental health in First Nations communities

[28] HealthStats NSW. (2021).
[29] Productivity Commission. (2023). Table 13A.17

A First Nations view of social and emotional wellbeing recognises the interconnected relationship between physical, mental, and spiritual wellbeing. Culturally inappropriate service delivery frequently goes hand in hand with a gap in cultural capacity from health professionals who are ill equipped to deliver care that holistic, integrated and generally in line with First Nations perspectives on social and emotional wellbeing. Service provisions that do not operate from a social and emotional wellbeing framework and fail to take into consideration the wider social determinants that are known to have significant impact upon many First Nations wellbeing (including mental health) such as financial and housing insecurity, along with cultural and community determinants.

Lack of interdisciplinary care approaches that are inclusive of not only mental health professionals, but further utilised the expertise, cultural and lived experiences of Elders, family members, and wider community members to contribute to the care and wellbeing of First Nations individuals.

Secondly, historical (and ongoing) trauma from generations of marginalisation, racism, and discrimination from health care services in general, but particularly that of mental health, have resulted in ongoing fear of accessing services today. This is often exacerbated by culturally insensitive care and a bias towards Western diagnosis criteria and clinical processes.

A further significant barrier is that of the stigma that can surround mental ill health within the First Nations community. The prospect of feeling 'shame' regarding a diagnosis and/ or fear of discrimination from others is a significant an ongoing barrier for many. This is often exacerbated by cultural beliefs regarding what mental ill health may mean for individuals and their families.

Recommendation 9

NSW Health provide to all staff in the NSW healthcare workforce Aboriginal Cultural Training each financial year, with the training content reviewed every two years to ensure continued community support.

People experiencing homelessness

Mental health and housing insecurity share a complex yet persistent relationship. People who are homeless are more likely to have a mental health condition and people who experience a mental health condition are more at risk of experiencing homelessness.[30] Research has shown that mental ill-health can make sustaining a tenancy more difficult.[31] Behaviours associated with a mental health condition such as anti-social behaviour, cognitive difficulties, and the inability to prioritise finances make it harder for people to find secure housing and stay there.[32]

[30] Australian Institute of Health and Welfare. (2021).
[31] Australian Housing and Urban Research Institute (AHURI). (2023).
[32] NSW Family and Community Services (FACS). (2023.)

On the other hand, experiencing homelessness and housing insecurity can cause significant stress and trauma, leading to increased risk of mental health conditions.[33] Suicide rates rise dramatically amongst individuals facing housing insecurity, as the financial distress, prospect of eviction and the impact on families can heighten psychosocial risk factors for suicide for the individual.[34]

The more support someone receives to stay in their current situation, the less chance they have of living in insecure housing and becoming homeless and therefore avoid the associated negative impacts on their mental health. This could be done by expanding existing programs such as the Housing and Accommodation Support Initiative (HASI) or Pathways to Community Living Initiative (PCLI). These programs have been proven to be effective in reducing both mental health related hospital admissions and presentations to EDs, leading to a saving of $31 million in savings for the NSW Health budget.[35]

Recommendation 10

The NSW Government expand the Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS) programs to ensure consumers are discharged into secure and supported accommodation.

[33] National Homelessness Collective. (2023)
[34] Fowler K, Gladden R, Vagi K, Barnes J, Frazier L. (2015)
[35] NSW Health. (2022 - 3).

Digital and telehealth services

Capacity, availability, navigability and upskilling of the mental health workforce can be simultaneously addressed by models of care that fuse digital and person-to-person services – known as "blended care". When digital therapeutics are blended with therapist-delivered care, health outcomes are equivalent to those seen in traditional face-to-face therapies for many patients while lowering costs and increasing the capacity of mental health professionals. Yet adoption of blended care requires a thoughtful approach that weights the benefits and risks on online and telehealth services.

Online mental health services (defined here as treatments delivered by apps or websites) are empirically effective for people with milder symptoms, offer 24/7 access to low-cost care, and can be quickly adapted and deployed in times of crisis. Yet both consumers and practitioners remain vulnerable to poor quality online services with no evidence base that have flourished in the currently unregulated digital therapeutics market. Digital tools can boost clinician capacity yet are mostly studied in common mental health disorders such as anxiety and depression, and blended care may not be suitable for complex mental health issues.

Data from Black Dog Institute clinical services indicate that telehealth is well received by most consumers, who list benefits such as convenience, flexibility within a busy schedule, improved continuity of care, and fewer incidental costs, such as travel costs. Moreover, consumers with special needs reported increased physical and psychological accessibility, especially those who are housebound due to illness or disability.

> *"I love telehealth and being able to do it from home and being comfortable and safe in a known space." (Anonymous)*

While telehealth holds promise for equitable mental health care without borders, telehealth patients are largely higher-income city dwellers, and Medicare funding channels these patients exclusively into individual treatment, overwhelming clinics, and worsening waitlists for urban and rural telehealth patients alike. As discussed above, practitioners need appropriate incentives to balance practice across telehealth and face-to-face services to ensure those with complex needs can access high-intensity care in-person.

> "I think Telehealth has been a very valuable means of accessing services and I think it should continue however it doesn't work for everyone. People often need to establish a face-to-face relationship first. It is possibly worth considering if allowing more subsidised Telehealth sessions to allow people to establish a relationship."

Recommendation 11

NSW Health provide State mental health workforce with training on digital mental health and telehealth tools, in accordance with the National Safety and Quality Digital Mental Health Standards, to increase trust, uptake and quality of care.

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