Submission No 146

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

Organisation: New South Wales Nurses and Midwives' Association

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NSW NURSES & MIDWIVES' ASSOCIATION

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

SEPTEMBER 2023

AUSTRALIAN NURSING & MIDWIFERY FEDERATION NSW BRANCH

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Foreword

The NSW Nurses and Midwives' Association ('Association') is the registered union for all nurses and midwives in New South Wales. The membership of the Association comprises all those who perform nursing and midwifery work. This includes registered nurses, enrolled nurses and midwives at all levels including management and education, and assistants in nursing and midwifery.

The Association has approximately 75,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the Association are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

The Association exists to be a strong, influential union of members respected as a contemporary leader in society for its innovation and achievements. We welcome the opportunity to provide a response to this consultation.

This response is authorised by the Elected Officers of the New South Wales Nurses and Midwives' Association.

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Introduction

The NSW Nurses and Midwives' Association welcomes this Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW as a first step in the right direction. Anyone with a personal experience of seeking or providing community mental health care in NSW knows that it is a deteriorating, deeply fragmented system, with overly stretched resources, inaccessible to many, at times unsafe, and that it is failing to support many who need it.

There have been many public inquiries, reviews and plans, both State and Federal, over recent years that have examined how these services can be improved. While there is broad consensus about what needs to be done, and about what an effective, integrated, person centred, recovery orientated community mental health system looks like, there has been inadequate support for implementation.

The existing situation is unsustainable. Mental health spending in NSW has fallen behind significantly. We are hopeful that this new NSW Government is committed to meaningful reform and implementation of a new approach to community mental health care in NSW. We are encouraged by the work that has been undertaken in Victoria, and we urge the Minns Government to be similarly ambitious in the scope of its mental health reform agenda.

From our perspective, there are a two clear priority issues that must be attended to immediately in order to maintain a safe system while longer term reforms are developed and implemented:

1. **Safe workloads for existing community mental health nurses must be implemented in order to attract a skilled workforce and retain the existing community mental health nursing workforce.**

2. **Consistent implementation of safe systems of work so that every member of the workforce can deliver services in a way that effectively controls WHS risks.**

This submission represents the views of our members who work in a range of community mental health settings. Their feedback paints a depressing picture of a crisis driven system that is overwhelmed by demand, that relies on extreme rationing of care, where people are denied access to timely early interventions and where community mental health clinicians are unable to work to their full scope of practice due to services being overwhelmed.

As usual, many of our members expressed fears that raising their concerns would result in negative attention from their employer. This is despite our assurances that advocacy is a

professional obligation that is articulated in the nursing code of conduct[1]. For this reason, individuals, services and localities are not identified in this submission.

Recommendations

I. That the NSW Government stop tinkering around the edges of mental health services and conduct a full and thorough reform process so that an effective, integrated, person centred, recovery orientated, community based mental health system is available to every resident in NSW no matter where they live or what their income.

II. Community mental health care is underfunded, and this must be addressed. Demand for services far outstrips supply. It is a false economy to underfund community mental health care where the most cost-effective mental health interventions will occur if there are appropriate resources.

III. Appropriate investment in a workforce development plan which attracts and retains a suitably qualified mental health nursing workforce.

IV. There must be safe systems of work. There needs to be a revision of the systems in place for community nurses in keeping with chapters 16 & 17 of Protecting People and Property – NSW Health policy and standards for security risk management in NSW Health agencies.

V. A caseload management system must be established that allows clinicians to work to the top of their scope of practice in order to provide safe, effective, patient-centred care.

[1] Nursing and Midwifery Board of Australia, https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx, accessed 23/11/2020

a) Equity of access to outpatient mental health services

For many years, community mental health nurses have sought to raise the alarm about the growing mismatch between demand and the funded capacity of their services. When we asked our members to comment on the accessibility of outpatient mental health services the feedback reflected the patchy and inequitable access to services. The imbalance between demand and supply of these services means that these services must be rationed to the extent that many people who need care miss out, either due to their location or because of application of arbitrary and absurdly restrictive access criteria.

The community mental health nurses we heard from expressed deep concern for the wellbeing of their clients and reported high levels of stress and hopelessness.

The clear picture from this feedback is that rationing in the context of overwhelming demand means that the quality of services is undermined for those who are 'lucky' enough to gain some level of access and there is a growing cohort known as the 'missing middle' with needs that are too complex or severe to be supported through primary care but not severe enough to meet the restrictive access criteria for specialist mental health care.

> ***In the community mental health care team, we cannot say 'no' to clients who meet the admission criteria, and yet there aren't enough staff to cope with the numbers. This results in shortened time for clients to be seen, meaning that the service they get is minimal, and really only covers medication and medication compliance, pathology tests monitoring, a brief visit once a month where vital signs are checked and a quick hello, and appointments made to see a psychiatrist for 30 mins every 6-12 months.***

> ***Community mental health services have always focused on severe illness such as severe bi-polar disorder, schizophrenia and drug induced psychosis, yet people's mental health is a continuum. We have evidence of increased presentations of people attending ED severely distressed: the so-called 'vulnerable personalities'. These people are expected to access private services which are often not available or too expensive.***

> ***How can we provide equity of access to outpatient mental health services with current staffing levels? Our adult team is 5 FTE down and we have the same number of consumers coming through the service needing care. That means every day in our service our clients are missing out on essential care. If they lived somewhere else, they might receive a very different standard of care.***

In NSW the Safe Start Guidelines (from NSW Health/ Families NSW Supporting Families Early Package) aim to improve mental health outcomes for parents by risk prevention and early intervention. Psychosocial and depression screening is completed as part of every woman's antenatal care, as an outpatient. We know that the peripartum is the most at-risk time for a woman's mental health. Suicide kills more women in the first year postpartum than any medical condition, thus the Safe Start Policy.

In my LHD there is an obvious and significant inequity of access to outpatient mental health services. At one hospital women identified in Safe Start screening as being at risk of an exacerbation or relapse of mental illness during pregnancy or in the immediate postpartum are discussed at the Safe Start MDT (multi-disciplinary team) and then referred to and seen (as outpatients) by Consultation Liaison Psychiatrist or the Mental Health CNS. This could be a formal assessment, a medication review or Perinatal psychosocial counselling.

At another hospital in the LHD, Safe Start screening occurs, as does the antenatal Safe Start MDT, but there is no input by Consultation Liaison Psychiatry. They do not participate in Safe Start MDT and, since I joined the service in May 2021, they have not accepted one referral for mental health review/input for any antenatal outpatients who are identified at risk of exacerbation or relapse of mental illness during pregnancy, birth or postpartum.

In the same LHD the access to mental health care and treatment is unequal and unfair. It is a postcode lottery.

Within my LHD there is no publicly funded psychiatry clinic. Psychiatrist services are only available for consumers who are case managed or who are acutely unwell. There are no bulk billing psychiatrists that I know of at all.

The Child and Youth team will only see consumers who have already completed 10 sessions of primary intervention with a psychologist- thereby eliminating any service for young people who are not able to access a primary intervention. This lack of access to a primary intervention can be due to factors such as cost, or factors affecting the parents such as non-English speaking, disability, illiteracy, drug affected or have their own mental health issues.

The Child and Youth team do not consider "neuro developmental" issues (i.e., ASD, ADHD etc) to be mental health issues- instead they are directed towards the NDIS. They also consider intellectual disability to be an exclusion criterion for their service. People on the NDIS are very hard to get mental health case management as case management teams consider they already have a service even though the NDIS does not provide psychiatry services.

There is very limited access for CBT/DBT. It is not available for people who do not meet the bar for case management even though they would benefit, and it would

likely alter the trajectory of their illness. And there are limited to no services for complex trauma clients who require long-term psychotherapy/ EMDR etc.

Our department is currently being asked for feedback on a new framework being implemented that dictates we will only provide a service to the patients who will need second daily phone calls and weekly face to face visits. If they don't warrant second daily phone calls, it's discharge immediately. If we are limited in the clients we can have open files for to only highly acute / suicidal clients that need second daily monitoring that leaves a massive gap in service for people in mental health distress or with other diagnoses besides acute exacerbation or their illness or actively suicidal.

Because the public community mental health sector receives little funding, access to public community mental health services has been impeded. As a result, the range of clients meeting the now narrow criteria to receive public mental health care has diminished. We do not have the capacity to provide care to all clients requiring our services and as such are forced to redirect them out to private services and NGO's. There is inequitable access for non-public sector outpatient mental health services due to financial considerations for lower income clients. Examples of this include GP's who do not bulk bill, fees charged for gaps in mental health care plans and difficulty in accessing affordable private psychiatry and psychology. Mental Health Care Plans do not allow for enough psychology sessions to meet client requirements.

CBT & DBT groups are very limited. Only a small number of spaces are available, and the wait list is usually full.
We are encouraged to discharge people in an efficient manner, with the comment 'they can always re-refer if they're in crisis'. Patients bounce back frequently because they need supports but there are no in between services.
There are no free psychology services available. We see people for the mental health assessment, tell them to go to the GP to get a mental health care plan, but there's no free psychology options. Most of our clients are low income or Centrelink and cannot afford gap payments.
A lot of GPs aren't taking on new patients and no longer bulk bill. This puts pressure on the local mental health services for basic medication reviews. We see them, do the mental health assessment, they see the psych registrar, we give them 2 weeks of medication and discharge them because 'they are no longer acute' (meaning not actively suicidal) and we tell them to see their GP which we know they don't have! It's ridiculous.

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

Community mental health nurses report that patients and carers frequently struggle to access appropriate services and regularly voice frustration at the patchwork of services which causes confusion and inefficiency across the system. Lack of access and system complexity means that often care is not accessed in a timely way leading to crises and reliance on emergency department presentations.

> *The navigation of outpatient and community mental health services can be extremely difficult for clients and their carers due to limited knowledge of services available and how to access these required services. Services arguing over where clients should sit in terms of care provision becomes confusing and frustrating for both the client and their carers.*

> *I think that patients and carers find the process of finding mental health treatment frustrating and confusing. I have heard directly from patients and carers a dissatisfaction with trying to receive treatment. Patients are discharged prematurely and relapsing, and this is very concerning for carers, who are left to try and care for their loved ones without support.*

> *How do the community know how to contact mental health services? Are other services aware of how to contact services? People rely on the police to get assistance, but I believe that this often leads to unnecessary confrontations and critical incidents. Are GPs adequately informed with the referral pathway? Does the community have the knowledge and confidence to access services?*

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

For many years, community mental health nurses have sought to raise the alarm about the growing mismatch between demand and the funded capacity of their services. This mismatch results in excessive and unsafe workloads, inequity of access, rationing on the basis of seemingly arbitrary barriers to eligibility and it impacts on the ability of the sector to attract and retain staff. These issues are magnified in rural, regional and remote areas.

People living in regional, rural and remote parts of NSW experience mental health problems at a similar rate to those in the cities however the risk factors for poor mental health are greater and they face far greater challenges in terms of accessing the support they need in a timely way.[2]

When we sought feedback from our members in relation to their capacity constraints in rural, regional and remote NSW, they described untenable caseloads, poor staffing and skill mix, nurses frequently working in isolation, limited access to continuing education, inadequate facilities, security and transport services, and lack of medical cover.

> ***The capacity of rural, regional and remote community mental health teams is highly variable from area to area. For example, the caseloads in community mental health especially in regional and rural regions of western and far west NSW range from 20-60 clients on a list. These excessive numbers, especially once it goes over 30, is not sustainable especially if where there are clinical indications for 2/3 weekly contact. Within this caseload, mental health clinicians all have responsibilities to support patients on community treatment orders. These stressful and demoralising working conditions push nurses out of the community mental health profession.***

> ***Our Adult Acute Care Coordination Team also struggles with staffing their service. It is reported that their team consists of only a team leader, clinical nurse consultant and a new graduate nurse. Ironically, this is one of the larger regional towns with over 40 000 people and one of biggest regional mental health hospitals.***

[2] NSW Mental Health Commission, 2021, Submission to Legislative Council Portfolio Committee No.2 – Health, Inquiry into outcomes and access to health and hospital services in rural, regional and remote NSW, https://www.parliament.nsw.gov.au/lcdocs/submissions/70146/0476%20Mental%20Health%20Commission%20of%20NSW.pdf, accessed 26/08/2023

Community Treatment Order (CTO) clients are being kept on our books for over 6 months until they get allocated to the appropriate team for case management. As an acute care team, we don't provide case management, we just give the depots. It's a different clinician every time. As there is such a long wait list for CTO clients, the voluntary patients on the non-acute team waitlists rarely get picked up.

Due to the staffing crisis, we are operating with scant resources, and this is dangerous in regards of risk to clinicians, patients and the community. For example, we have only 1 mental health clinician working in a remote area that is supposed to have 4 full time mental health clinicians.

I found that clients in a rural setting really need private office waiting areas to enable their engagement with Community Mental Health teams. Clients often report that meeting someone they know or meeting an acquaintance of someone they know while in the waiting area is risky for their reputation in their small community, resulting in disengagement. For this reason, they need a confidential office space invisible to other clinics that provide dentist, wound, baby health and all other physical checks.

Clients also may lose connection with services due to employment demands on their time, often mental health appointments being held when they have work related or other daytime pressing duties. The office hours structure not always easy for clients to confidentially attend; only those who feel safe having their employer know about their Mental health needs might attend. Perhaps staff might be employed to work later and earlier days, knowing that late and early time slots are needed. This also might be gendered with men missing out more.

The public mental health services diminishing capacity to provide quality care to clients is a huge issue. For quite some time the public sector has been grossly underfunded, in favour of supporting NGO's and the private sector. Government have proposed increased funding for community mental health services and making community care a priority for years BUT nothing has come the public sectors way to provide lasting enhancement to staffing and service provision. For example, my service has not seen any enhancement of staffing numbers on the ground for non-acute mental health teams for over 20 years. Financing projects does NOT provide long term benefits for clients as they usually come and go. Caseload numbers are unmanageable, with increased acuity, complexity and risk being seen in our client

population. Without improvements, the isolation of rural areas in NSW makes attracting staff difficult.

There is increasingly less access to outpatient mental health services in our region. This is a result of an inability to retain or attract a community mental health workforce, both in the community treatment teams and acute care teams. This has resulted in a push to discharge patients that still require community mental health treatment. There are very limited options in this area for mental health treatment outside of the public mental health system.

d) Integration between physical and mental health services, and between mental health services and providers

Feedback from our members highlighted the critical role nurses play in community mental health settings. They generally comprise the majority of the healthcare workforce both in cities and in regional, rural and remote settings and the generalist foundation of nursing education uniquely prepares mental health nurses with the range of skills to ensure physical and mental health concerns are identified and addressed. Their scope of practice covers health promotion, prevention and early intervention, rehabilitation and chronic disease management across the lifespan. Community mental health nurses are a critical resource in responding to both the physical and mental health needs of consumers and are well placed to provide universal mental health and physical health screening, intervention, referral and follow-up through a range of nurse-led models of care.

Surely we have a duty of care to be more diligent in caring for the MOST disadvantaged rather than letting them die early from preventable disease that goes undiagnosed? We are caring for a very specialised group who have severe mental illness and are often disorganized and do not visit GPs. When they do visit GPs there are often issues with GP reception staff who are not unprepared to deal with mental illness. GPs generally do not follow-up clients who do not keep their appointments even though there are many reasons related to their mental health that make it difficult for clients to attend appointments on schedule. And most GPs charge and the client group we see cannot afford the fee.
Despite the fact we know consumers with mental illness die 10-25 years younger according to WHO and I would imagine this is higher for First Nations people with a

mental illness, we persist on spending millions of dollars on GP integration programs that has been a miserable failure for GPs and this client group. It's a myth that GP's can deal with every condition and unfair on many consumers to push this view. They fail to get the basic screenings for such things as breast cancer, prostate cancer and bowel cancers.
We can do better – just as many physical health conditions have pathways into the health care system so can community mental health. We could have senior medical registrars rotate through our community mental health centres who could provide screening and facilitate entry into hospitals for interventions such as colonoscopies. We often make people physically unwell with the use of our medications, but we rarely do anything about this.
We have multidisciplinary teams that take referrals and make recommendations that go nowhere because there is no GP to follow up these recommendations. It seems writing 'GP Follow-Up" absolves them of any future involvement. In my view if a team identifies an issue, it is their responsibility to see it these recommendations are completed.

We see a lot of drug use disorder in the community but there is limited drug minimisation support and it's voluntary. We are just managing antisocial drug users with antipsychotic medications so they don't misbehave due to their illicit drug use.

Substance use plays a huge part in people relapsing and this is an area we do not have control over. Perhaps better referrals to drug and alcohol rehabilitation programs post hospital would avoid people requiring mental health intervention and take a load off the community teams.

Unfortunately, since our local public hospital closed and the PPP (public private partnership) hospital opened, I have noticed poorer levels of communication from the PPP hospital for the mental health consumers who are being discharged from inpatient wards to community teams. Consumers appear to be getting poorer levels of care, discharged before they are well enough to go home, discharged without housing and inpatient staff do not listen to the concerns of community teams when trying to improve treatment outcomes for consumers. With the new PPP hospital, our community teams are unable to see ward notes (we can see their notes from any other public hospital in the LGA). The PPP hospital appears to be more focused on profit making than consumer care. All of the above has led to poorer outcomes for consumers being discharged before they are ready to cope with being back at home as well as occasions where consumers are discharged at 3 am to make their own way

home. There have been occasions where consumer's discharge details have not been passed on to community teams and people "slip through the cracks".

Government funding to NGO's (Headspace, private psychology et al) only covers the "worried well". These organisations are the first to refer to public mental health staff when there is perceived risk to the patient or the community. That's a poor use of public money and limited public resources. In that context, people with a serious mental illness are often ignored by overstretched and distracted public mental health services.

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

The mental health nursing workforce, including mental health nurse practitioners, is an affordable, high quality solution to the challenge of meeting the predicted growth of community mental health need. As described previously, they have the range within their comprehensive preparation and scope of practice to ensure that both physical and mental health needs are identified, managed or appropriately referred.

Attracting mental health nurses to community settings demands high quality clinical placements, improved conditions and safety. Transition to practice (TPP) programs for community mental health settings are critical to expanding this workforce. Community mental health nursing requires an advanced skillset and effective development of this workforce requires support and opportunities to access postgraduate specialist education.

The quality of nurses working in the mental health system - ranges from fantastic, brilliant, caring mental health nurses who are mostly undervalued and underutilised, to nurses who have come into the service with no more than their undergraduate mental health knowledge. This is a huge problem but the system does not support addressing this. With mental health nurses only seen as the same as everyone else in the multidisciplinary team whose job is to care coordinate, qualified and experienced nurses become deskilled or get frustrated and leave. The nurses without mental

health qualifications or experience often start keen, and want to help, but don't have the knowledge or experience in mental health, and then don't get adequate support to develop skills beyond administrative skills. So, they become adept at "coordinating care" but not at working collaboratively with clients to help them with setting and achieving goals for a life they are happy with.
Mental health nurses could do more if they were supported. This means being seen as a professional with a separate identity - not the same as everyone else on the multidisciplinary team.
Mental health nurses have the skills to work independently. They do not need to be "under the direction" of a psychiatrist. They need to be recognised as such. If they were recognised in this way, they could do a lot more in terms of meeting the needs of those people in the general community who need access to mental health services, both those with a diagnosed mental illness, and those who are experiencing mental health challenges without a diagnosed mental illness. It is time the government recognised the skills of qualified and experienced mental health nurses and utilised them for telehealth services to people in rural and remote communities. Mental health nurses are good at collaborating with GPs, psychiatrists, and other allied health professionals. However, they do more than coordinate care. They can also do therapy! This, of course, should be remunerated at the same rates as general psychologists - which in the public system and NGOs is currently between $135 - $193 per face to face hour - which equates to about $60-$70 per hour for the actual time put in.

We are in severe workforce crisis. There is a lack of mental health nurses and despite employment advertised, there are no clinicians applying for roles in the community. To attract mental health clinicians to community mental health there needs to be higher grade positions offered. Community mental health clinicians need to be paid better. We don't receive penalties, but we have more responsibility and autonomy. This needs to be acknowledged. The staffing crisis will continue unless we start to appreciate community mental health clinicians as a specialist service and pay clinicians what they deserve. There is a constant turnover of locum Psychiatrists, which is very unsettling for our patients and makes it incredibly difficult for clinicians and having consistency of care for patients.

In community mental health we are seeing an increase in non-nursing mental health professionals managing clients on complex medication regimes leading to relapse and readmission that could have been avoided, as well as staff not backfilled when on leave.

The capacity and the allocation of mental health care workers within a community mental health team varies considerably as recruitment and retention becomes increasingly difficult. In border towns such as Broken Hill and Tweed Heads, neighbouring states pay more, which encourages nurses to move over the border for the benefits including better staffing, ratios and incentives. In towns such as Bourke, there have been multiple attempts to advertise roles for mental health clinicians with vacancies lasting over a year. If rural incentives for nurses were improved, this has potentially positively encouraged local nurses and midwives to stay in the regions and a greater interest in building up local nurses.

Caseloads are based on numbers not acuity – you can have a psychologist having a case load of 30 compliant consumers and seeing these clients every two – three or four weeks and then you can have a nurse with the same number but will need to do several home visits to give medications or chase up consumers for appointments some several times a week. This has been an ongoing issue for years which seemingly is put in the too hard basket.

Lack of Psychiatrist especially in some of the western Sydney and rural areas means a lack of access to treatments to prevent hospitalisations. Nurse Practitioners could easily be used to manage this situation. Unlike physical health where a doctor may need to touch a patient, mental health lends itself well to virtual interventions. Why don't we have a registrar from larger teaching hospitals attached to allocated regions as happens with other specialities such as paediatrics?

So called "multidisciplinary teams" do not work as a team. They are only called that because the workers are made up of different disciplines, but they are all expected to do the same work - which is basically manage a caseload of clients, and just do care coordination. Coordinating care is basically administrative and does not involve any type of therapy or counselling or other type of beneficial care for clients. Clients are allocated according to who has space, not according to the skill set of the clinician and needs of the client. So even the clients in the system don't get equity of access because it depends on the discipline of the clinician to whom they have been allocated.

The public mental health system has been grossly underfunded and understaffed for quite some time. It is often hard to attract the kind of experienced staff needed for such a vital service. Compared to other allied health professionals, mental health

nurses are paid significantly less. There is a significant loss of income for nurses working a Monday to Friday job between 8:30am – 5pm, as there are no penalty rates. There is difficulty attracting permanent staff specialists (psychiatry) as most will earn more money acting as locums. Too much money is spent in the creation of senior management positions rather than on frontline services who provide the direct client care. NGO's and private sector are often unable to manage complexity of this client group and will still want to engage public mental health service support. It would be more economically viable to fund the public sector adequately. Note mental health nurses, and other disciplines, in private sector or under NDIS are being paid over 3x the amount (193.99 / hour) as public sector registered nurses.

The capacity of services is overwhelmed. Clinicians (occupational therapists, social workers, psychologists and nurses) are all given he same role as care coordinators - yet the nurses do more (all of the physical health needs, depot injections and clinics e.g., Clozapine clinic) and yet the nurses get less pay than other professions for work of higher value.

In the absence of experienced and available staff in the LHD, the existing staff work increased overtime. I've suggested that staff, with the experience to work in the consult liaison (CL) crisis space, get acknowledgment and pay commensurate with the experience they bring to the position. In my view that would increase staff retention and decrease overtime. By "acknowledgment and pay" I mean re-classifying some of the positions as at least CNS 2. Current practitioners get paid as RNs and many current community nurses are reluctant to do CL work (face to face or virtual). This due to high acuity and a lack of skills on the part of the community nurses. They need support and training to become confident and that takes time.

There also continues to be models of "multidisciplinary teams"-which in theory appears to be a great idea. When I started most of the community team was RNs with a social worker, psychologist and occupational therapist. Over the years as RNs leave, they have been replaced by more allied health staff. So now RNs are scarce, community teams appear to be mainly made up of allied health staff. This becomes a problem when 4 staff are allocated on an afternoon shift in the community to home visit consumers, only one is an RN, who is responsible for giving out all IMI's. This can involve covering 40-60 kms in a pool vehicle-in attempt to see 10 consumers. This becomes a safety issue for consumers because allied health staff often have little to no knowledge of medications, they may not recognise adverse drug reactions or respond appropriately to physical health concerns. It also means that consumers may not have access to an RN

for timely PRN (as needed) medication. We need 2-3 RNs on a shift of 4 people in the community. On community teams there needs to be 70-80% RNs and the rest allied health. Currently on some teams RNs make up only 30%. Aside from the increased workloads for the RNs in community MH teams as outlined above, when working in the community centre, again RNs are carrying a heavier load than their multidisciplinary counterparts, as we assist running clozapine clinics, relprevv clinics and depot clinics on top of carrying a caseload of MH consumers who have complex physical issues as well as MH issues, as opposed to a social worker who are allocated less complex client groups. There have been a vast number of RNs who having seen the inequity of working in multidisciplinary teams, have left community MH or left MH nursing all together. I also resigned from one team after 17 years to go and work on a team in community MH that has 90% RNs. The workload is much more equitable and MH consumers have better access to RNs and can still be referred on to allied health according to their needs.

The State Government has the capacity to regrade how community mental health services are funded to ensure it is a specialist service. This would improve access to services outside Monday to Friday 9-5. We know staff recruitment and retention is difficult especially for nurses who find it impossible to survive on basic income while other nurses who work in inpatient settings receive penalty rates. The risk and skill required to work in community mental health is substantial, but we must accept a cut to our take home pay to work here.

The adult community mental health sector seems to be the service that is neglected the most, with funding tending to be more directed to child and adolescent mental health services and outpatient mental health services. Community mental health is a highly specialised area of care, where case managers need a to have a high level of clinical expertise as they are working for the most part independently and carry a considerable amount of responsibility.

Community mental health is modelled on a multi-disciplinary team whereby CTOs are shared however the nursing staff are expected to carry the medical component which grossly impacts on their workload leading to burnout and inequity.

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

Overall the feedback we received from our members in the community mental health sector did not raise major concerns about the of Community Treatment Orders (CTOs). However, some questions were asked about whether the current approach to CTOs remains in line with the principles of least restrictive approach, recovery and community expectations in relation to human rights and coercive treatment. What is the evidence that the current approach in NSW to CTOs is correct? Does the approach in NSW ensure that compulsory treatment is only used as a last resort?

Our view is that the prevalence of CTOs should certainly be included in the comprehensive review of the entire mental health system recommended by this submission.

> ***There tends to be an overuse of CTOs as there are not enough staff to provide the assertive case management that many clients require. Sometimes we see CTOs being used as a guarantee of service rather than for the purpose they were originally intended.***

g) Benefits and risks of online and telehealth services

Online and telehealth services and innovations will be an important part of the solution but cannot be considered a panacea. There are a wide range of new and emerging digital technologies that should be carefully considered in terms of evidence-based quality and safety. Our members' feedback highlights some of the practical considerations.

> ***Telehealth services are very helpful and successful for people who have devices on which they can receive these services, can find a private place to talk, have good internet reception and have the mental capacity to use the service.***
> ***A lot of clients don't have devices, or smart phones. Most, but not all, clients have phones. However, most are on prepaid plans and are reluctant to use up their phone time. While they can access a computer in a library this is not private. So, for the people who are living on disability pensions or have little means, this is not a useful service.***

Telephone rather than video is not as good because the clinician is unable to observe the client; these observations providing many clues as to mental status. It is also harder to help regulate a client's emotions if the client cannot see the clinician's face. So video is far preferable to telephone. However, even where the client has the capacity to take video calls, many clinicians do not access the video telehealth services because it is either not supported well enough for them to learn and use it, or they feel they don't have the time to use it.
Where the client has the devices and internet capacity for telehealth via video, and has the capacity to interact this way, telehealth is a very safe and successful way to communicate and deliver care, except for crisis or emergency care. Obviously, you can't administer medication over telehealth, and currently there is no capacity to monitor vital signs over telehealth, but if this became available to mental health services, then it would certainly be possible.

In relation to the use of outside contractors to provide mental health services: A case in point in the 1800 mental health line which has been privatised to Medibank solutions (MS) within our LHD and I believe 5 others. This phone line is a central call-in line for consumers and transfer of care between area health services across the state. Privatising it has been disastrous within our LHD and not provided a single benefit to staff or consumers.

MS have no access to NSW health records. That means that they treat every call as a new triage. Consumers with extensive history are asked to tell their entire story all over again which is not consistent with a trauma informed approach.

MS clinicians are working from home from all over Australia and have no idea of local services and teams. Known consumers who call are confused thinking they are speaking to their known MH team, not a privately contracted service.

There are frequently delays in transfer of care between one LHD to another, and the loss of consumer information via the "Chinese whisper" effect of the information being passed through many hands. Other LHDs regularly complain about how difficult it is to refer someone to our LHD.

Online and telehealth services have been beneficial to regional areas in increasing accessibility; however, it is much more difficult for nurses working in a virtual capacity to develop meaningful rapport over videoconference and it does not reach highly marginalised communities such as First Nations people living in missions and remote areas. Online and telehealth service should not displace or be a replacement for on the ground clinicians. Reception continues to be a major challenge. For the virtual or phone-based mental health team, the opportunity to work from home

occasionally has helped improve staff retention and reduce some issues with rostering. Remote access to electronic medical records and the use of Microsoft teams helps mitigate risks associated with privacy and confidentiality. However, it is important to note that smaller and tight- knit communities are also reluctant to accept new services without proper consultation and the benefits of online and telehealth services have not reached these communities.

Beneficial for younger people as allows easy access and is useful in rural areas where there is limited to no access to specialist services. Risks include difficulties associated with conducting a comprehensive assessment for clients via telehealth and possibility of consultations being recorded without consent. Post covid it has been difficult to have clients return back into the outpatient clinics Many of our clients don't have IT access or the skills to navigate these pathways.

Benefits of telephone assessments could be cost effectiveness and time saving in term of travel and expense associated. The person may feel more comfortable in their own environment with support from significant other/s. Staff can work from home if there were work restrictions in the current environment. Risks include that telephone assessments could lead to missing vital information and nuances, loss of qualitative aspects of assessment which could lead to adverse outcomes, person feeling devalued and not wanting follow-up. Telehealth has the benefits of seeing a person in their own environment or in a place where distance is an issue to a major facility. Also had benefits during pandemic. Ensuring follow-up is essential Advice to "go to your GP" should not be used if the person financial situation is problematic.

The Ministry of Health is Sydney centric, in focus and background, and keep insisting on one size fits all solutions. At the LHD level our senior management are fatally attracted to the allure of AVL (audio visual link) as a solution to ever shrinking experienced staff numbers as CMHT numbers slowly shrink towards the larger population centres. COVID just gave a boost to an existing trend. The other allure is cost savings and two or three people on AVL in a regional centre seeing customers all over Western LHD (up to the QLD border), is far cheaper than boots on the ground in those communities. From a management point of view, "what's not to like" and the Virtual team receives extra funding from Sydney while the Community based teams are allowed to continue to shrink.

I work for a community mental health team that uses Medibank for the mental health line. We have repeated concerns about this service, and it is good to have a chance to voice them, as our local LHD have no interest in our concerns.

The consistency of referrals is poor, and it seems the training they have is minimal at best. The clinicians on the line promise clients a service that we can't offer. Probably because they aren't even based in the state, so they genuinely don't know what we do or don't do. We've had referrals, for example, for people wanting an ADHD assessment and treatment; these people get very frustrated learning that they have wasted their time.

The clinicians lie to get the referral outcomes they want. For example, a category D referral with no acute risks will be refused but then they send it back 10 minutes later with different risk information so that we have to accept it.

Running a service that has no access to public health records causes more inconsistencies. Clients with management plans phone MHTAL who don't have access to the plans, so they add confusion and complications to the plans we're trying to implement.

The introduction of the mental health access line has significantly increased our workload, meaning we spend more time doing meaningless work (e.g., re-triaging seems to be my main job), and the public are paying more for the privilege. Another issue brought on by privatisation.
Management continues to try to band aid over these problems, instead of listening to the workers on the ground. They have "monthly feedback meetings "to discuss issues", but after 2 years these meetings have not addressed our concerns.

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

The nurses who provided feedback shared significant concerns about the inclusivity and responsiveness to diversity of community mental health services. It is apparent that in the face of the overwhelming demand for services, the special needs of many groups fall through the cracks.

> *The cultural safety of mental health services for First Nations is improving; however, there are significant gaps due to lack of meaningful commitment from Executive leadership of Mental Health Services to improve the cultural safety and inclusivity of health services. There is a very basic generic online training moue about cultural safety when a staff member starts a new job with the health service. However, it is important to recognise the different demographics a local health district can cover. Also in some local health districts, there can be multiple indigenous families/groups in a region and at times, these First Nations families are in conflict with each other. Therefore, it is helpful to have this more specific, localised knowledge before working if we want to work towards cultural safety. The health system is getting better at recognising domestic violence between men and women. However, it continues to be poor for people who identify as LGBTQIA+.*

> *We see a lot of Autism and ADHD diagnoses of adults or adults seeking diagnoses, but the current public system is so outdated in their knowledge/training they don't believe it exists. There are no support's available for low-income earners to access these diagnoses in the public system.*

> *Aboriginal mental health teams tend to be used in a consultative role only and do not manage clients. There is difficulty in accessing transcultural mental health services and interpreters, especially outside of Sydney. The dissolving of specialist disability services such as ADHC and the subsequent engagement of NDIS with little to no governance has left this client group bereft of adequate comprehensive service provision.*

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)

Overall the feedback we received was positive about the PACER model. There was however a clear view that the failure to adequately resource the community mental health system means that people with mental illness or psychological distress cannot access services in a timely way to avoid a crisis necessitating an emergency response.

> *Understaffing makes management of crisis in the community challenging. If there was adequate staffing, then early intervention in averting crisis would be possible thereby easing strain on our overburdened emergency services. The introduction of PACER clinicians has been an invaluable resource and should be rolled out statewide.*

> *PACER does NOT work in Rural and Remote. There are too few experienced staff available to staff PACER, let alone our existing services, and the population base is spread too thinly.*

> *This is a good imitative but comes with some restrictions. Many years ago, when I worked overseas – if the police were needed to assist with a mental health issue they would arrive in unmarked cars and NOT in police uniforms. They would also have some training regarding mental illness. I feel not only does it cause stigma to the person to see police car and uniformed police outside their home but it also has the potential to inflame the situation. This is especially true for many of the people listed in H, especially First Nations people, LGBTQIA+ and some cultures where police brutality was a part of their life.*

> *PACER is in place, but we can't refer clients to them, only the police can. So if there's a high risk patient in the community that isn't actively threatening suicide the police won't refer to PACER. Th family keep referring them to us via the mental health line, but we can't go out to the house because it's too dangerous for us.*

j) any other related matter

All nurses and midwives, regardless of where they are working, must have access to suitable duress arrangements in the event of an emergency. It is appreciated that these arrangements will look different according to the type of workplace and its location, however staff must have the capacity to call for support when required and to receive a timely and effective duress response.

It must be recognised that people will not always be able to make a telephone call in the event of a violent episode and so this method cannot be relied on to call for assistance, particularly when nurses are working in isolation in the community.

We are deeply concerned about the safety of community mental health nurses who have a different set of risks than other nurses, with community centres rarely purpose built, and unlikely to have access to security or sufficient staffing numbers for a duress response.

Nurses visiting mental health consumers in their homes are often working in isolation in environments not controlled by NSW Health, where risk can vary markedly from one visit to the next and where often the risk of violence relates to the presence of friends and family members.

We receive reports of incredibly unsafe practices including:

- **Poor/no initial risk assessment prior to home visits**
- **Poor communication of emerging risk**
- **No access to duress beyond a mobile phone (which cannot always be accessed in an emergency and does not always have signal coverage)**
- **Nurses working in isolation in high-risk environments**
- **No system to ensure nurses and midwives have safely exited the home at the conclusion of the home visit.**

There needs to be a revision of the systems in place for community mental health nurses in keeping with chapters 16 & 17 of Protecting People and Property – NSW Health policy and standards for security risk management in NSW Health agencies.