Submission No 155

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

Organisation: Full Stop Australia

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

Full Stop Australia submission

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Full Stop Australia is working to put a full stop to sexual, domestic, and family violence through **support, education, and advocacy**.

About Full Stop Australia

Full Stop Australia (FSA) thank you to the Portfolio Committee for the opportunity to provide input in the *Equity, Accessibility And Appropriate Delivery Of Outpatient And Community Mental Health Care In New South Wales Inquiry*.

FSA is an accredited, nationally focused, not-for-profit organisation that has been working in the field of sexual, domestic, and family violence since 1971. We perform the following functions:

- Provide specialised and confidential telephone, online and face-to-face counselling to people of all genders who have experienced sexual, domestic, or family violence and specialist help for their supporters and those experiencing vicarious trauma.
- Conduct best practice training and professional services to support frontline workers, government, the corporate and not-for-profit sector, and
- Advocate with governments, the media, and the community to prevent and put a full stop to sexual, domestic and family violence.

FSA, as a national service, draws upon the experiences of our trauma-specialist counsellors to support people impacted by sexual, domestic and family violence across jurisdictions, as well as our clients and other survivor advocates who are part of our National Survivor Advocate Program, to advocate for victim focussed laws and consistent approaches to family, domestic and sexual violence nationally.

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Executive summary

Trauma is a pressing issue in Australia, posing both significant health and economic challenges. A considerable portion of the Australian population grapples with complex trauma, often stemming from experiences of domestic, family, and sexual violence. Survivors face an array of enduring mental health needs. The impact of trauma reaches far and wide, affecting not only the individuals directly involved but also their families, communities, and the broader healthcare and social systems. The mental health and welfare sectors are overburdened and focused primarily on responding to crisis presentations. Trauma survivors often 'fall through the gaps', which compounds their trauma and exacerbates their psychological, physical, social and economic needs. An integrated model which provides a 'safety net' for trauma survivors is needed.

Summary of recommendations

1. Invest in specialist mental health recovery services:
    a. Invest in and expand holistic specialist mental health recovery services for trauma survivors.
    b. Develop integrated care and referral pathways.
    c. Incorporate trauma-informed principles into mental health policies and the Mental Health Act.
    d. Mandate ongoing training in trauma-informed care for mental health providers.
    e. Expand alternatives to Community Treatment Orders (CTOs).
2. Develop survivor-centred services:
    a. Sustain funding for trauma-responsive services integrated with domestic, family and sexual violence (DFSV) and mental health services.
    b. Prioritise co-design and co-development of services and interventions with survivors and communities.
    c. Promote support service integration between mental health and welfare support systems to streamline access and reduce wait times.
    d. Leverage technology for enhanced service delivery.
3. Support and develop workforce and services:
    a. Invest in specialised training embedded with lived expertise for a trauma-informed and trauma-specialist workforce.
    b. Support the development and the sustainability of the lived experience peer-support workforce.
    c. Embed trauma-informed practices as a standard component of mental health care, which may include trauma screening protocols, integrated referrals to trauma specialist services and protocols for decreasing traumatisation related to engagement with mental health services.
4. Increase funding and subsidies:
    a. Allocate additional funding to mental health non-government organisations (NGOs).
    b. Boost Medicare subsidies for private practitioners to reduce consumer out-of-pocket expenses.
5. Focus on cultural safety and equity:
    a. Develop and support policies prioritising cultural safety, trauma-informed care, and equity.
    b. Create specific initiatives for diverse populations, such as culturally specific services and referral pathways.
    c. Develop targeted recruitment of mental health professionals from diverse communities.
    d. Allocate resources to enhance mental health service availability in rural areas.
    e. Implement trauma-informed and age-appropriate services to cater to diverse needs in underserved regions.

Background

Trauma as a result of domestic, family and sexual violence (DFSV) is a significant national health and welfare issue. It affects people of all ages and backgrounds but predominantly affects women and children. For example, the Personal Safety Survey (PSS) found that in Australia since the age of 15:

- One in 4 women experienced violence by an intimate partner or family member (27%)
- One in 5 women experienced sexual violence (22%)
- One in 16 men experienced sexual violence (6.1%) (ABS 2023).

Furthermore, the PSS reported that an estimated 8 million Australians (41%) had experienced violence (physical and/or sexual) before the age of 15 (ABS 2023).

Trauma survivors frequently seek support from mental health services (O'Dwyer et al. 2019; Oram et al. 2013). For example, a systematic review found that one out of every three women seeking inpatient or outpatient mental health services has a history of DFSV (Oram et al., 2018). Furthermore, a study of a Sydney-based mental health service revealed that a significant majority of those assessed (88%) had experienced at least one traumatic event in their lifetime. Moreover, a notable proportion (79%) reported experiencing two or more such traumatic events. These traumatic experiences spanned various domains, such as war, accidents, illness, natural disasters, sexual and physical assault, as well as witnessing distressing incidents (Phipps et al. 2019).

Trauma survivors often experience repetitious and multiple forms of victimisation. The connection between DFSV and mental health is intricate and reciprocal. Studies indicate that sexual violence can increase vulnerability to and exacerbate mental health issues (Khalifeh et al., 2015; Rees et al., 2011). Mental health issues may also mean the survivor is at increased risk of self-harm, hospitalisation or suicide. Sexual violence is linked explicitly to health issues and fatalities, such as substance abuse, psychological disorders, and suicidality (O'Dwyer et al., 2019). Simultaneously, mental health issues can be a barrier to trauma survivors accessing help and impact the clinical course and treatment responses (AIHW 2020a; Ferrari et al. 2016).

Terms used:

Throughout this submission, we have used the following terms:

Complex trauma: Complex trauma is the result of prolonged exposure to multiple traumatic events, especially during childhood, involving violence, abuse or neglect. The concept of "complex trauma" is not a diagnostic term but a reference to a range of particular symptoms and connected social issues often apparent for many survivors. The psychological and adverse mental health issues, particularly those associated with complex trauma, can persist throughout a person's life after the violence has ceased (Moulding et al., 2020; Cloitre, 2011).

Domestic, family and sexual violence: A range of behaviours a person uses to dominate and control another in the context of an intimate partner or familial relationship.

Trauma survivor: While trauma survivor is a broad descriptor, we have used this term to specifically describe those who are or have experienced domestic, family and sexual violence and or complex trauma.

Trauma-informed care: Trauma-informed care revolves around recognising the prevalence of trauma. It acknowledges the neurological, biological, psychological, and social consequences of trauma and violence, as well as the potential for continued victimisation. This approach prioritises redesigning services to ensure they are safe and responsive.

Trauma specialist care: Trauma specialist care has the distinct goals of working with survivors to alleviate the impact of traumatic experiences, aid recovery, and assist in recognising the link between present difficulties and past traumas.

Responses to the Terms of Reference

a) Equity of access to outpatient mental health services

Recommendations

1. Increase funding and Medicare subsidies:
    a. Allocate additional funding to non-government organisations (NGOs) in the mental health sector.
    b. Increase access to telehealth services.
    c. Increase Medicare subsidies for private practitioners to reduce out-of-pocket expenses for consumers.
2. Streamline access and reduce wait times:
    a. Implement strategies, including care coordination, to streamline access to mental health outpatient services and reduce wait times. This includes the recruitment of more mental health professionals and the use of technology to enhance service delivery.
3. Promote cultural competence and equity:
    a. Develop and enforce policies prioritising cultural safety, trauma-informed and trauma specialist practice and equity in mental health care delivery.
    b. Develop specific initiatives to address the unique needs of culturally and linguistically diverse people, First Nations people, lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people, children, young people, and those in regional and remote areas, such as targeted outreach programs and cultural safety training for mental health professionals.
    c. Devise specific targeted recruitment of mental health practitioners from diverse populations.
    d. Investment in specialist services for diverse populations, for example, a state-wide mental health service that specifically provides care to Aboriginal people.

The New South Wales (NSW) mental health outpatient system grapples with several critical challenges that collectively contribute to its state of being overwhelmed, expensive, and highly inaccessible. The overwhelming demand for mental health outpatient services has reached a crisis point. A surge in individuals seeking support, compounded by the long-lasting impacts of the COVID-19 pandemic and the increased cost of living, has stretched the system's capacity to its limits. This surge has led to extended waiting lists and compromised the quality of care, leaving those in need waiting for essential services.

Currently, the affordability of mental health outpatient services is a significant concern. The lack of funding for non-government organisations (NGOs) and insufficient Medicare subsidies for private practitioners places a substantial financial burden on individuals seeking mental health care. This leads to many out-of-pocket expenses that can be prohibitively expensive, deterring consumers from seeking help. For example, in a recent Medicare Better Access Scheme evaluation, the primary obstacle to seeking treatment was the cost (Pirkis et al., 2022).

These issues are of particular concern for trauma survivors. The combination of cost barriers, lengthy wait lists, and a shortage of care coordinators exacerbate complex mental health issues. Additionally, survivors from marginalised communities, including culturally and linguistically diverse people, First Nations people, lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) individuals, children, young people, and

those in regional and remote areas, confront additional barriers such as cultural insensitivity, language barriers, and geographical limitations that further restrict their access to vital mental health support.

The NSW mental health outpatient system's overwhelming demand, lack of funding and cost of private services, and accessibility barriers underscore the pressing need for comprehensive reforms. Addressing these issues is crucial to ensure equitable and affordable mental health care for all residents, regardless of their background or location.

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

Recommendations

1. Create interconnected care coordination and support networks:
   a. Promote the integration of mental health, welfare, and support systems for trauma survivors with complex mental health needs.
2. Expand trauma and violence specialist mental health recovery services:
   a. Invest in and expand trauma and violence specialist mental health recovery services that offer a "whole of life" approach to complex and intergenerational trauma.
   b. Focus on embedding lived experience into service design and providing multifaceted, coordinated care that addresses personal circumstances and symptoms.

Mental health services often have inadequate support systems in place for trauma survivors. Trauma survivors with complex psychosocial, mental and physical health needs will present at a range of entry points to the health and welfare systems (Salter et al., 2020). When their needs are not met, it can lead to:

- an exacerbation of unmet needs, including health and psychosocial issues
- an increased risk of further victimisation
- a compounding of existing trauma-related mental health problems (Salter, 2017).

In our experience, people with complex and competing needs often fall through the cracks or receive inadequate care. Despite the significant mental health impacts on people with complex trauma, there are few trauma and violence specialist recovery services. In most cases, the treatment focuses on one incident (or the "problem") rather than offering a "whole of life" response to complex and intergenerational trauma (ANROWS 2020a). Trauma survivors need multifaceted and varied support that accounts for their unique personal circumstances and symptoms (Wall & Quadara, 2014). While support services exist for people impacted by DFSV, mental health treatment and support services are fragmented and siloed. For example, most DFSV support systems are predominately geared towards providing an emergency crisis response or a needs-specific response (such as housing or court support). As a result, there are significant gaps in holistic complex trauma responses, particularly trauma specialist counselling and ongoing care navigation services for people with ongoing needs. Concurrently, mental health outpatient services often fall short in addressing the comprehensive needs of trauma survivors, focusing on isolated incidents rather than a holistic response to complex and intergenerational trauma. This fragmented approach leaves survivors navigating a disjointed system, prioritising immediate needs, and potentially delaying the resolution of underlying issues, ultimately impacting their healing journey. For example, survivor-advocates at the Voices of Survivors event in NSW Parliament House (August 2023) described being turned away from services, with counsellors not taking new clients or placing them on 6-month waiting lists. There was significant consensus among the roundtable discussion that the health system is challenging to navigate, describing the experience of retelling their story as "re-traumatising". One survivor-advocate expressed this frustration: "We are sent from pillar to post trying to find the right service: it's exhausting". Survivor-advocates also pointed to the insufficient number of trauma-specialist-trained staff equipped to facilitate victim-survivor recovery. Generalist mental health services lack the capacity and skills to provide trauma-specialist care to victim-survivors.

Building interconnected care coordination networks and expanding specialist mental health recovery services for trauma survivors is critical. We advocate for a holistic "whole of life" approach that integrates mental health, welfare, and support systems; comprehensive and practical support can be provided by investing in multifaceted, coordinated care that considers individual circumstances and symptoms. This approach promotes healing and enhances the overall wellbeing of survivors.

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

Recommendations

1. Enhance mental health service availability in rural areas:
   a. Allocate increased resources and funding to expand the availability of mental health services, especially in rural, regional, and remote areas of New South Wales.
   b. Develop strategies to recruit and retain mental health professionals in underserved regions to reduce waiting lists and improve access to timely care.
2. Implement trauma-informed and age-appropriate services:
   a. Introduce trauma-informed and trauma specialist care models within the mental health system, specifically addressing complex trauma and the unique needs of DFSV survivors, including children and young people.
   b. Develop age-appropriate and tailored programs to cater to the distinct needs of these groups, ensuring that services are comprehensive and responsive to their experiences.

The capacity of state and community mental health services in NSW, especially in rural, regional, and remote areas, is marred by significant limitations. These areas often face a shortage of mental health professionals, resulting in long waiting lists and difficulty accessing timely care. The disparity in service provision between urban and non-urban regions exacerbates the challenges faced by consumers living outside major metropolitan areas.

Mental health outpatient services in NSW often lack a holistic approach to care. Trauma survivors' mental health and psychosocial needs can be multifaceted and require specialised care that integrates trauma-informed and trauma-specialist practices. Many current mental health outpatient services are not equipped to provide this level of comprehensive support, particularly in rural and remote areas. Moreover, the needs of children and young people who have experienced DFSV can be distinct from those of adults, necessitating age-appropriate and tailored services. The limited capacity and resources in the mental health system can hinder the development and implementation of such specialised programs.

Addressing these limitations through increased funding, workforce development, and trauma-informed care models is essential to ensure that all individuals, regardless of their location or experiences, can access the mental health support they need.

D) integration between physical and mental health services and between mental health services and providers

Recommendations

1. Sustained funding and ongoing investment into developing trauma-responsive services across NSW, integrated with current specialist DFSV services, mental health and related multidisciplinary health services.
2. Prioritise the co-design and co-development of services with trauma survivors, mental health practitioners and communities.

Mainstream mental health, counselling, general practice, hospital, and drug and alcohol services have been found to operate from a biomedical perspective, whereby psychological deficits are pathologised and labelled (Salter et al. 2020). These services primarily operate in silos, resulting in a lack of care coordination. Encountering these systems has been shown to re-traumatise people impacted by complex trauma and create additional recovery and wellbeing barriers (ANROWS 2020b). For example, findings from the Royal Commission into Victoria's Mental Health System (2021) found that mental health services:

- are undersupplied and overburdened and are unable to deal with the level of complexity that a trauma survivor may present with
- have become imbalanced, with an over-reliance on medication
- present a range of difficulties and barriers for people when accessing support.

As a result, trauma survivors are often in frequent contact with police and other crisis services and are regularly hospitalised (ANROWS 2020a, b). This highlights the need for integrated service delivery, including support to assist survivors in navigating multiple systems simultaneously. We propose establishing an integrated mental health care outpatient model that focuses on local systems coordination. This model should be co-designed, co-developed, and implemented with trauma survivors, aiming to engage local communities, enhance support for individuals needing targeted and coordinated care and be culturally safe. To maximise its effectiveness, this model should integrate into current healthcare pathways, offer support to general practitioners (GPs) providing community-based care, and operate in tandem with existing mental health and welfare agencies.

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

Recommendations

1. Expand trauma-informed and trauma specialist workforce:
   a. Invest in specialised training and workforce development programs to increase the number of mental health professionals with expertise in trauma-informed and trauma-specialist care. This should include nurses, GPs, psychologists, counsellors, social workers, and allied health professionals.
   b. Support the development and the sustainability of the lived experience peer-support workforce.
2. Incorporate trauma-informed practices into standard care:
   a. Embed trauma-informed and trauma specialist practices as a standard component of mental health assessment and care across all levels of mental health services.
   b. Ensure that mental health policies include clear guidance and recommendations for trauma-informed care within clinical settings, prioritising the psychosocial aspects of care.
3. Increase funding for existing trauma support telehealth:
   a. Increase funding for accessible telehealth options for priority populations and individuals residing in areas with limited access to trauma specialist care.

There is an insufficient number of specialists in trauma-informed or trauma-specific mental health care, which presents a significant challenge for many survivors. While research suggests that mental health professionals are aware of the necessity to respond to people who have encountered DFSV in a manner that is sensitive to gender and ensures safety (Khalifeh et al. 2015). The reality is that mental health services often fail to identify and appropriately respond to experiences of interpersonal violence (Howard et al., 2010). Mental health practitioners frequently refrain from inquiring about a history of DFSV due to their limited knowledge, confidence, and skills in responding effectively to such disclosures (Hepworth et al., 2013; Nyame et al., 2013; Rose et al., 2011). Alternatively, disclosures of DFSV are frequently dismissed or disregarded. It is common for experiences of violence to be seen as secondary to an already diagnosed psychiatric disorder, dismissed as a symptom of psychosis, or downplayed as a historical event considered irrelevant to the consumer's current condition (Ashmore et al., 2015; Frueh et al., 2015; O'Dwyer et al., 2019). These practices can exacerbate the re-victimisation of survivors (Frueh et al., 2015; Robins et al., 2005).

Additionally, while mental health policies increasingly recognise the link between experiences of trauma, violence, and mental health issues, they often lack clear guidance or specific recommendations for action within mental health services and clinical care (O'Dwyer et al., 2019). These practices are aligned with the prevailing biomedical model of care in psychiatric settings, which prioritises addressing the biological symptoms of mental illness over the psychosocial aspects and healing.

Addressing survivors' current challenges within the mental health system necessitates a comprehensive approach. Investments in specialised training and workforce development programs are crucial to bridge the gap between awareness and practice. This includes expanding the pool of trauma-informed professionals across various disciplines, from nurses to GPs, psychologists, counsellors, social workers, and allied health professionals. Furthermore, embedding trauma-informed practices as standard components of mental health assessment and care is imperative. Mental health policies should provide clear guidance for trauma-informed and trauma-specialist care within clinical settings, prioritising psychosocial and healing aspects. Finally, increased funding for accessible telehealth options is vital, especially for priority populations and those in underserved areas. These measures collectively aim to provide more holistic and practical support for survivors within the mental health system.

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

Recommendations

1. Implement Trauma-Informed Legislation and Practices:
   a. This includes changes incorporating trauma-informed principles within mental health policies and the Mental Health Act. These changes should explicitly recognise the impact of trauma from interpersonal violence or abuse, including domestic, family, and sexual violence (DFSV).
   b. Mandate that mental health care providers receive ongoing training in trauma-informed care to better understand and address the unique needs of trauma survivors.
2. Expand Alternatives to Community Treatment Orders (CTOs):
   a. Encourage the development and expansion of alternative community-based support services that offer voluntary, trauma-informed care options for individuals facing mental health challenges related to DFSV—Prioritise survivor autonomy and wellbeing in these alternatives.
   b. Allocate additional government funding to better support mental health crisis intervention teams that can respond swiftly to mental health crises within the community.
3. Cultural Competency and Inclusivity:
   a. Enforce guidelines that require mental health service providers to adopt culturally sensitive and inclusive practices when implementing CTOs or alternative care options. This should consider diverse communities' cultural norms and practices, ensuring mental health care is accessible, respectful, and responsive.
   b. Invest in cultural safety training for mental health professionals to enhance their ability to provide culturally sensitive care and support to individuals from culturally and linguistically diverse backgrounds.
   c. Devise a targeted recruitment of mental health professionals from diverse communities.

For trauma survivors, the use of Community Treatment Orders (CTOs) under the Mental Health Act 2007 can raise significant concerns and issues. We are acutely aware that mental health issues can result from interpersonal violence or abuse and can also be used as a mechanism of coercive control (ANROWS 2020b). CTOs can be experienced as losing autonomy and control over one's mental health treatment. For trauma survivors who have already experienced coercive control, CTOs may feel like an extension of that control. CTOs involve mandated treatment and supervision, often within the community. For trauma survivors, the imposition of such orders can be re-traumatising and trigger memories of past experiences of abuse. The use of CTOs can also stigmatise individuals, marking them as "mentally ill" or "non-compliant". This labelling can further isolate survivors and hinder their recovery.

The effectiveness of CTOs in promoting mental health recovery is debated (Edan et al., 2019). For trauma survivors, forced treatment may not address the underlying trauma issues, and compliance may not necessarily equate to improved wellbeing. Additionally, CTOs may not adequately consider a trauma-informed care approach essential for those who have experienced interpersonal violence or abuse. Trauma-informed care focuses on safety, trust, and empowerment, which are crucial for survivors. In some cases, CTOs may place individuals in situations or environments that could expose them to further victimisation or abuse, especially if their support networks are not adequately considered. For individuals

from culturally and linguistically diverse backgrounds, CTOs should be culturally sensitive and consider cultural norms and practices regarding mental health care and treatment.

Therefore, it is essential to explore alternative approaches to CTOs, such as intensive community-based support services and voluntary treatment options, which may better align with trauma-informed and survivor-centred care. While CTOs may be intended to provide necessary treatment and support, they can be fraught with issues and challenges, especially for trauma survivors. Balancing the need for care and safety with preserving autonomy and avoiding re-traumatisation is a difficult task that requires careful consideration and incorporating trauma-informed principles into mental health practices.

(g) benefits and risks of online and telehealth services

Recommendations

1. Invest in telehealth infrastructure and training:
   a. Advocate for increased funding and resources to enhance telehealth infrastructure, ensuring that individuals, including trauma survivors, can access stable and reliable digital and telehealth mental health services.
   b. Promote comprehensive training programs for mental health professionals, focusing on trauma-informed and trauma specialist care and the effective use of telehealth technology to address the unique needs of trauma survivors.
2. Enhance data security and privacy protections:
   a. Provide funding and support for NGOs to develop policies and procedures – such as secure, encrypted platforms and data storage solutions to protect clients' personal information to safeguard the confidentiality and privacy of individuals utilising telehealth services, particularly when discussing sensitive issues like DFSV.
3. Tailor telehealth services to survivor needs:
   a. Encourage mental health organisations to develop specialised telehealth programs and resources for trauma survivors.
   b. Invest in research and developing best practices to ensure that telehealth services effectively address the unique needs and challenges survivors face.
4. Address digital divide and equity:
   a. Develop and fund policies that bridge the digital divide by providing access to technology and internet services for underserved communities, ensuring that economic disparities do not hinder access to mental health care.
   b. Promote initiatives that address digital literacy barriers and assist those struggling with technology, such as older adults or people experiencing economic hardship.

Online and telehealth services have become increasingly popular in providing mental health support, including for trauma survivors. Telehealth can help to reduce geographical barriers, ensuring that individuals, even those in remote or underserved areas, can access mental health services. This is especially important for trauma survivors, who may experience a range of help-seeking barriers. Online services offer flexibility in scheduling appointments and can be less time-consuming than in-person visits. Survivors may find it more convenient to access tele-mental health care, particularly around their care responsibilities (such as caring for children). Telehealth allows individuals to receive mental health care services from the comfort and privacy of their homes. This can be particularly reassuring for trauma survivors, who may feel safer discussing their experiences in familiar surroundings. Alternatively, online services can ensure continuity of care for survivors who have moved or are in transition, allowing them to continue accessing support. Telehealth can reduce the perceived stigma associated with mental health care. Trauma survivors may be more likely to seek help online, as it offers a level of confidentiality, anonymity and separation from traditional healthcare settings.

However, there are also some potential risks of telehealth services. Lack of funding and service availability can be a significant problem for trauma survivors. For example, a trauma survivor told the *Voices of Survivors* event in NSW Parliament (August 2023) reported being left on hold for long periods when attempting to contact a mental health crisis line *"when you're sitting in the car, and you're unsure whether you will even make it home safe, it is crushing when no one picks up on the other end of the line."*

Affordability, lack of digital literacy, and technical glitches or connectivity problems can disrupt attempts to access help, leading to frustration and potential interruptions in care. While Some survivors may benefit from an in-person practitioner's physical presence and reassurance. Telehealth may not provide the same level of comfort for everyone. Online platforms may raise concerns about data security and privacy, particularly when discussing sensitive issues like DFSV. Ensuring secure and confidential communication is essential. Not all individuals, particularly older adults or those from disadvantaged backgrounds, may be comfortable or proficient with technology, potentially limiting their access to online mental health services.

Online mental health and telehealth services offer valuable advantages in accessibility and convenience for people with mental health issues, including trauma survivors. However, telehealth is not the complete answer, and given some of the potential barriers that telehealth poses, we advocate for a mixed model of in-person and telehealth.

(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

Recommendations

1. Implement culturally competent care practices:
    a. Develop enhanced community consultation processes to co-design and co-deliver services.
    b. Mandate cultural safety training for all mental health professionals. This training should focus on understanding and addressing the specific needs of diverse communities, including First Nations, CALD, and LGBTQIA+.
    c. Establish clear guidelines for mental health service providers to ensure respectful and culturally safe care. This includes incorporating traditional healing practices and acknowledging the impact of colonisation on trauma for First Nations people.
2. Increase accessibility and outreach efforts:
    a. Allocate funding to expand mental health services in underserved and remote areas, recognising the higher prevalence of family, domestic, and sexual violence in these regions.
    b. Develop targeted outreach programs that provide mental health support to marginalised populations, particularly in rural and remote areas, including refugees, asylum seekers, and people living with disabilities, who often face substantial barriers in accessing services. These programs should be culturally safe and LGBTQIA+ inclusive.
3. Integrate trauma-informed care across services:
    c. Promote trauma-informed care as a standard practice within mental health services. This approach should recognise the impact of complex trauma, childhood abuse, and intergenerational trauma on individuals' mental health.
    d. Encourage interdisciplinary collaboration between mental health providers, disability services, and family violence support agencies to address the compounding effects of trauma and structural inequities. Ensure that services are trauma-informed and accessible to individuals with diverse needs.

People who experience trauma alongside other structural inequities experience a range of additional intersecting and compounding issues. This might include service access issues, poverty, and discrimination. This is particularly relevant for Aboriginal and or Torres Strait Islander women, refugees and asylum seekers, culturally and linguistically diverse women, LGBTIQ people, children, young people and people living with a disability. For example, Aboriginal and Torres Strait Islander women are 32 times more likely to be hospitalised after family violence. Furthermore, they are 11 times more likely to be killed in a domestic homicide (Steering Committee for the Review of Government Service Provision (SCRGSP) (2016). Women with a disability are more likely to experience violence than those without a disability. One in 2 (47% or 2.7 million) people with a disability have experienced family, domestic and sexual violence (Australian Institute of Health and Welfare (AIHW) 2020b). Migrant and refugee women are also more likely to be subjected to family, domestic and sexual violence and face substantial barriers to accessing safety and support (Segrave et al., 2021). People in remote areas are 12 times more likely to be hospitalised due to intimate partner violence than people in metropolitan or regional areas. A recent survey of trans and gender-diverse people found that 53.2 % of respondents had experienced sexual

violence compared to 13.3 % of the broader Australian population (Callander et al., 2019). Trans women of colour from culturally and linguistically diverse backgrounds experience additional forms of violence, discrimination, and other service barriers (Usher et al., 2020).

Despite the growing recognition of the need for culturally specific and safe mental health services, services for First Nations people, culturally and linguistically diverse people, LGBTQIA+ people, young people, and people with disabilities in New South Wales (NSW) remains limited with a number of access issues. Trauma-informed care should be promoted as a standard practice within mental health services, acknowledging the impact of complex trauma, DFSV, and intergenerational trauma. Interdisciplinary co-designed and delivered services between survivors/ consumers, community, mental health providers, culturally specific services, and DFSV support agencies are crucial to address the compounding effects of trauma and ongoing structural inequities.

(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)

Recommendations

1. Community-based crisis response services:
   a. Develop community-based crisis response services staffed by mental health clinicians and peer support workers who can respond quickly to emergency calls related to mental health crises. These teams can provide on-site assessment, crisis intervention, and referrals to appropriate care. Interventions should be co-designed and developed with local communities.
2. Better funding for telehealth crisis lines:
   a. Increase funding to existing 24/7 telehealth crisis lines staffed by mental health professionals to provide real-time support and guidance to individuals in distress. These services can offer immediate counselling, safety planning, and connections to local resources.
3. Peer-led navigation services:
   a. Develop peer-led navigation services staffed by individuals with lived experience. Peers can provide empathetic and relatable support to those in crisis, helping consumers navigate available resources.
4. Trauma-informed training for first responders:
   a. Train police officers, ambulance personnel, and other first responders in trauma-informed care to ensure they can recognise signs of trauma and respond with sensitivity, de-escalation techniques, and referrals to mental health services.
5. Data collection and evaluation:
   a. Establish systems for collecting data and evaluating the effectiveness of alternative crisis response models, ensuring that they meet the needs of trauma survivors.

There is a growing recognition that alternative crisis response models, such as PACER, are needed to ensure the safety and wellbeing of individuals in crisis while addressing the unique challenges trauma survivors face. Using police for emergency responses to individuals experiencing acute mental distress, particularly trauma survivors, can pose challenges. Law enforcement officers often lack specialised training in mental health crisis intervention, potentially escalating situations instead of providing appropriate care. This can lead to further traumatisation, especially for those with a history of complex trauma or DFSV. Additionally, using police for emergency mental health presentations may deter individuals from seeking help, particularly those from marginalised communities who may have negative experiences with law enforcement. We do not support an either/or approach but rather suggest broadening out the range of crisis response models beyond the current emergency services only model.

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