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

Mental Health Coordinating Council Submission

Introduction

Mental Health Coordinating Council (MHCC) is the peak body for community-managed mental health organisations in New South Wales. We represent community-based, non-government organisations who work to support people living with mental health conditions. Our members support people to live well in the community by delivering psychosocial support and rehabilitation services. Our purpose is to support a strong and sustainable community-managed mental health sector that provides effective psychosocial, health and wellbeing programs and services to the people of New South Wales.

MHCC provides policy leadership, promotes legislative reform and systemic change, as well as develops resources to assist community organisations deliver quality services through a trauma-informed recovery-oriented practice approach. MHCC is a founding member of Community Mental Health Australia (CMHA), the alliance of seven state and territory mental health peak bodies which together represent more than 800 community-managed organisations delivering mental health and related psychosocial services nationally. MHCC's Learning and Development arm is a Registered Training Organisation providing accredited training and professional development to mental health community-managed organisations (CMOs) and other human services.

It is of great interest and importance to our members and the CMO sector more generally that public community-based services provide safe and collaborative care between themselves and CMO services.

MHCC thanks the Portfolio Committee for the opportunity to provide input into the Inquiry. We consulted our members and developed a survey to elicit specific feedback reflecting their experiences as well as consulting other interested stakeholders. This submission reflects those multiple sector perspectives.

In that context MHCC describes its views and recommendations in relation to the Inquiry questions.

Equity of access to outpatient mental health services

Access to public outpatient mental health services generally occurs either following an inpatient stay, when a consumer is on a community treatment order (CTO) oversighted by a community mental health service (CMHS) team, or when they have a referral from a GP, crisis team or other practitioner to the CMHS team.

People wanting and needing services to stay well in the community and minimise the risk of inpatient admissions also have access to community-managed organisations (CMOs) that can provide a diversity of psychosocial rehabilitation and support services outside of the NDIS.

The key to maximise the value and outcomes for consumers is the incorporation of lived experience workforce alongside clinical services. Many CMOs have a broad range of professionals and services that support transitions of treatment to care. An awareness and alignment of existing services can reduce duplication, provide better informed care, and provides long-term benefits to consumers and staff.

Some CMO programs such as the Housing and Accommodation Support Initiative and Community Living Supports (HASI/CLS) require referrals, whilst other services are accessible through self-referral. All these services offer benefits to consumers in that they support people to live the life they choose, help them stay well, maximise their independence and autonomy, and minimise the risk of hospital admissions or involuntary orders.

Clear and current evidence provided in the recent evaluation[1] of HASI/CLS services in 2022, demonstrates the effectiveness of these programs from both a cost benefit as well as an individual, family and community perspective. Based on the Kessler 10 and Health of the Nation Outcomes Scales scores, 30% of consumers on HASI/CLS had a clinically meaningful improvement in their mental health. Consumer contact with CMHS decreased by 10% in the first year in HASI/CLS and was 63.7% less if they remained in the programs for more than one year. Hospital admissions due to mental health decrease reduced by a total of 74% and the average length of stay in hospital decreased by 74.8% over two years. Despite this most recent and compelling evidence of the benefits of HASI/CLS, further expansion of these services has not been confirmed.

People may sometimes have access to 'Step-up, Step-down, (SUSD) Prevention and Recovery Centres that aim to support transition back into the community from hospital or provide extra support at times of crisis or vulnerability. Unfortunately, there is limited access to these programs particularly in rural, regional and remote locations. There are only five 'step-up, step-down' programs in NSW.

Return on Investment and reduction of readmission by participants in the SUSD services have target service outcomes including that they are readily accessible, person-centred and recovery focused, and facilitate self-directed care grounded on collaborative relationships and partnerships. The ultimate outcome of SUSD services is to keep people connected to their community. Evaluations have shown this has been achieved alongside longer-term outcomes of better connections with family, employment and community.[2]

An example of good outcomes has been demonstrated by ICLA PARC Service in South-Eastern Sydney LHD. The service captured data for the first 60 consumers and compared to their health service activity a year before they entered the program. Outcomes found that 82% of people who had completed the program had prior contact with either emergency departments or mental health inpatient units. Following the program, this rate reduced to 56% which showed a 33% reduction in emergency department or mental health inpatient unit attendances. 80% of participants presented to emergency departments only once or not at all following their PARC stay. The service cost for this PARC is $400 per night which is a significant cost saving on the $1,280 per night for a hospital bed.

The introduction of 19 Safe Havens in NSW is an important initiative providing a place to go when people feel distressed or have suicidal thoughts. These are environments where people can talk to peer workers and be connected to a mental health professional. Consumers do not need an appointment and services are free. People generally report they feel more comfortable and safer using services when they are community initiated and managed rather than services based within clinical/medical services.

Suicide Prevention Australia's annual survey[3] capturing the state of the country's suicide prevention sector found 88% of respondents reported increased demand for services in the past 12 months, leading to a 76% increase in funding required to meet the increased demand. Mental health and suicide prevention services face limitations in short funding contracts which impact their ability to recruit and retain skilled workers, evaluate service delivery and provide continuity of care to patients. Funding contracts for mental health and suicide prevention in NSW should be extended to a minimum of 3 to 5 years.

Extending contracts would align with national advice from the Select Committee on Mental Health and Suicide Prevention who called for five-year cycles for mental health and suicide prevention services (recommendation 28) in 2021[4].

Some services previously provided in NSW, such as Partners in Recovery, were transitioned into the NDIS. While the establishment of Commonwealth Head to Health centres and online services have been rolled-out in NSW, the coverage is somewhat limited. Where there are some areas of duplication of services there is clearly an opportunity for better planning, streamlining and coordination of services in local areas.

While questions in this Inquiry ask about access to public outpatient services, what MHCC wishes to highlight to the Committee is that when appropriate community-managed services are available at the right time and in the right place, there are fewer demands of public outpatient services. People require fewer inpatient admissions, leading to a reduction in costs related to public sector services. What we recommend is greater funding for community-managed mental health organisations, channelled through a reallocation of funds generated by cost savings in public services.

Recommendation 1
Expand the existing psychosocial support packages (HASI/CLS) in NSW by 2,500 in the first year, increasing to 10,000 within four years. Costing $365 million.

Recommendation 2
Establish a network of 'Step-up Step-Down' services by adding an extra 130 places for people to access residential programs that minimise the risk of hospital admission in NSW.

Recommendation 3
Extend all mental health and suicide prevention service funding cycles to a minimum of three to five years to increase recruitment, retention, evaluation of service and continuity of care for patients.

Funding psychosocial supports
The 2020 Productivity Commission Mental Health Report [5] recognised the delivery of psychosocial supports as a key enabler of mental health recovery and identified significant service gaps. The Inquiry's findings estimated that 154,000 people across Australia – approximately 50,000 people in NSW – who would benefit from psychosocial support services are currently missing out. To meet these needs, substantial increases to service funding, especially for community-based psychosocial support services are critical.

In Victoria, a Mental Health and Wellbeing Payroll Tax Surcharge commenced on 1 January 2022. The levy was a recommendation of the Royal Commission into Victoria's Mental Health System. The Victorian mental health payroll levy imposes a surcharge of 0.5% on employers whose taxable wages are more than $10 million and 1% on those with total Australian wages of more than $100 million. The money generated from the levy is pledged to mental health programs and cannot be spent on other measures.

A similar initiative was rolled out in Queensland on 1 January 2023. According to mental health advocates, the benefits of the payroll levy will ultimately far outweigh the costs.

Estimates from the Productivity Commission flag that mental illness costs Australia about $200 billion per year. The payroll levy in Victoria is projected to generate $50 billion in savings through a 25% improvement in mental health. In NSW a payroll tax levy has been initiated but not directed at any mental health services and supports.

Recommendation 4
Consider dedicated additional funding for the mental health system achieved through a surcharge raised through a payroll tax levy.

Recommendation 5
Provide adequate indexation that responds to inflationary impact on salaries and service delivery in CMOs.

Workforce pressures
MHCC acknowledge the considerable pressures on mental health outpatient services, with too few practitioners with already overwhelming caseloads. High demand and under-resourcing of CMHS can lead to workers experiencing burn out, compassion fatigue and vicarious trauma, which can have unintended consequences on the quality of care received. Many workers are uncomfortable accessing support through their Employee Assistance Program due to stigma. Mental health care workers should be well supported through employee wellbeing programs that are tailored to address barriers to help seeking specific to workers and vicarious trauma education.

Some areas report that roles go unfilled for extended periods and that building rapport with patients/consumers is difficult when only monthly or three-monthly appointments are feasible. Sometimes psychiatrists are only available by video or at very long intervals and therefore relationship building is not well supported especially in rural, regional and remote locations. Consumers often report appointments with different clinicians and the need to tell and retell their traumatic experiences and medical history multiple times.

People who have experienced trauma engaging with a mental health care service may also be less likely to seek help the next time they experience distress. A holistic and trauma-informed approach to care and treatment is required that values people with mental ill-health beyond their symptoms and addresses the social determinants of health that can increase or be the trigger for distress. This approach is of benefit to workers as well as consumers.

National Mental Health and Suicide Prevention Agreement
The National Mental Health and Suicide Prevention Agreement signed in March 2022 by the NSW and Australian Governments is a major opportunity to clarify responsibilities and additional funding for psychosocial services by each level of government.

The National Agreement recognises that psychosocial supports are an important part of a well-equipped mental health system and that governments should work together to develop and agree on future psychosocial support arrangements.

The Agreement establishes a commitment to:

- address existing gaps over time in the funding and delivery of new and additional community-based mental health services to support equitable access to treatment, care and support for people experiencing mental illness and psychological distress,

- provide psychosocial support services for people who are not supported through the NDIS, including working together to develop and agree future psychosocial support arrangements, including roles and responsibilities.[6]

In the 2022-23 Budget, $2.9 billion was invested into mental health by the NSW Government. Despite this increased funding, NSW spends less per capita than other states to support people with mental health conditions.

Recommendation 6
Work with other States and Territories and the Australian Government to address the gap in psychosocial supports outside of the NDIS as required by the National Mental Health and Suicide Prevention Agreement.

Recommendation 7
Utilise the findings from the NSW Psychosocial Research Project currently being undertaken by David McGrath under the instruction of NSW Health to direct service funding to specific needs identified.

Recommendation 8
Require all healthcare and frontline workers who engage with people with mental ill-health or suicidality to undertake education in trauma-informed practice and suicide prevention training.

Recommendation 9
Invest in wellbeing support for mental health care workers including through the provision of tailored wellbeing support programs and vicarious trauma education.

Feedback on access to services

- *"[Equity of access is] woefully inadequate. I'm on a waitlist and it's been more than two years!"*

- *"I am always told by the Acute Care Services team 'we don't have enough staff' or 'you have NDIS, ask them to help you'. I'm sick to death of saying 'the NDIS does not fund psychiatry.'"*

- *"People getting discharged from hospital are seen first, and those with GP referrals less so. Depending on the capacity of the local mental health service, some services won't see people without a diagnosed mental illness or won't see people with a borderline personality disorder diagnosis. Too many people are falling through the gaps."*

- *"It can depend on the time the GP has to make a referral and how they write that referral that will influence whether people are seen or not."*

- *"Not enough staff in outpatient services, particularly psychologists."*
- *"CMHTs were effective initially but now access to these is very limited due to under-resourcing."*
- *"My local outpatient services had very little staff and so can't access help after hospital, I have to go private even though I'm on a pension."*
- *"Regional and rural areas miss out. People on Centrelink can't afford to pay. Not enough staff."*
- *"Services seem to be kept for those that are brought in by police suffering a psychotic episode."*

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

Interactions with police
When a person experiences a mental health crisis in a community setting, they may end up being brought into an emergency department by police, ambulance, family, carers or other support persons. Often the first point of call is the police, especially as community-based crisis teams are few and far between and people know little about them. Such interactions with police can be extremely traumatic for the person and their family or carers concerned. Frequently these events lead to conflict between people and those that care for them, as well as with police. Many consumers speak about the trauma they have experienced in such escalating circumstances and how these events have impacted their ability to trust providers and develop positive engagement with services.

The Police Ambulance and Clinical Early Response (PACER) program was part of the NSW Government's COVID-19 mental health package. It involved 36 specialist mental health clinicians employed across 10 police area commands and districts in Sydney, following the strong results of a pilot program. This program not only reduces trauma for individuals but leads to early intervention and appropriate referrals that often reduce the necessity for inpatient admissions.

Navigating the system
Consumers and carers are not always provided with clear information on CMHS or treatment pathways upon leaving hospital. In circumstances where people experience co-existing conditions and complex mental ill-health, navigating treatment in the community is extremely challenging. When a person is in distress, this adds an additional layer of difficulty in trying to navigate the mental health service system. A previous suicide attempt is the strongest risk factor for a subsequent suicide death. Appropriate, timely and supported transition from hospital to community treatment is critical.

Recommendation 10
Roll out the PACER program across all police area commands and LHDs in NSW.

Recommendation 11
Develop a state-wide dedicated Community Mental Health Navigation Support Service staffed with allied health and peer workers who are equipped to help people navigate support services and other systems, such as social services, child protection and family court services, housing and unemployment services, to address the social determinants of health that can lead to suicide.

Once a person is assessed in an emergency department, they may be considered well enough to be discharged. Alternatively, they may be referred to inpatient mental health services where they may be involuntarily detained under the *Mental Health Act 2007*, if the treating team consider them to be mentally ill or disordered as defined by the Act. When someone is discharged, they may be transitioned into the care of the CMHS in their area. In such circumstances they will usually be introduced to service options in addition to supports that the public mental health service can provide in their area. The person may be referred to services such as the NDIS, supported accommodation, education and employment, day to day living and social inclusion programs and supports, including counselling and other health initiatives. However, it is entirely up to the consumer as to whether they engage in those services, unless they are subject to a substitute decision-making order (Guardianship).

The diversity and availability of services in an area is also dependent on a person's residential address. Service availability varies depending on how close a person is to services and whether the services have a workforce with the skills required to work with them.

Some areas experience workforce shortages across all disciplines including psychiatrists, social workers, occupational therapists and culturally appropriate practitioners. There is also a general shortage of mental health and peer support workers across all parts of the service system.

Role of carers

Sometimes there is little choice of either service or workers available. Often carers have little or no choice other than to be the primary carer even if this substantially comprises their ability to work and care for other family members. Carers can find themselves in caring roles well into their own old age and live with considerable anxiety as to the future care of their loved one when they die or become incapacitated. Many carers experience their own mental health challenges due to the heavy burden of the role.

Carers characteristically know little about the supports that might assist them, and there may be few available in their location. While many carers are closely involved in care and treatment planning of their loved one, many complain about receiving little or no information because the treating team defer to privacy and confidentiality laws. Carers complain that their views may not be taken seriously. The NSW Mental Health Act was amended some years ago to better include Carer Rights, however many carers still feel minimally consulted or even ignored.

Exclusion can be particularly problematic when carers are unable to get their loved one into hospital and they feel the situation is critical. This is also the case when clinical assessment is at variance to their experience. While carers report improvements, situations may be difficult when a person is unwell in the community but the criteria for mental illness has not been met. The balance between a person's right to 'least restrictive care' and how a carer experiences their loved one's level of unwellness can be challenging.

Suicide attempts and suicidal distress have significant impacts not only on the individual experiencing suicidality but also on the carers, family and friends surrounding them. Carers are often the closest support to people who have attempted suicide and who are in immediate risk of suicide. It is critical suicide prevention to ensure carers are supported in their caring roles, not only to continue to support their relatives and friends, but to help manage the impact of caring for someone experiencing suicidal behaviours on their own wellbeing. Crisis intervention training can be beneficial in supporting carers to equip them with the skills to respond to distress experienced by the person they care for.

Support provided by carers, family and friends is a key protective factor for suicide and has been shown to have a direct positive effect on suicide ideation.

Recommendation 12
Ensure funding for carer education, supports and resources, including respite services.

Recommendation 13
Suicide prevention and intervention training tailored to carers, delivered free of charge, and available via multiple modes of delivery to address the accessibility barriers carers face.

Feedback from carers

- *Hideously complex and full of closed-door approaches…"*
- *"No one ever knows who is doing what, who has funding for which program, which programs still exist, where to find program info, referrals not being acknowledged or followed up, and there is never enough skilled or compassionate staff to go around."*
- *"Difficult when mental health and drug and alcohol are seen as different services but there is so much overlap in the presentations and care delivery."*
- *"No appropriate referral system."*
- *"Not enough staff means ad hoc, reactive, inadequate care and lack of continuity or holistic care."*

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

Please refer to **Recommendations 1,2 and 4** for capacity and funding recommendations and use of the NSW Psychosocial Research Project, with reference to rural and remote access and equity.

Feedback rural and remote

- *"State/public mental health say: 'we have no staff, go private', and private mental health say: 'you're too complex, you will need to go back to public', then public direct to ED, ED direct to GP, GP calls Mental Health line who say you need to call your local mental health service – it never ends."*
- *"There are not enough clinicians employed in public mental health services to meet the demand for services. This results in substandard care for everyone as the service tries to see everyone but with not enough time to adequately meet the needs of each client. In the primary care network, there is not enough provision of services to people who cannot pay at all as there are many that cannot afford the gap fee for Medicare psychological services. There is not enough use of mental health nurses to provide mental health services including psychotherapy as they are not funded by Medicare and not regarded as the professionals that they are."*
- *"Outer metro, rural and regional areas are significantly under resourced and also struggle to attract staff."*

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

MHCC propose that collaboration and integration between physical and mental health services is often limited. However, case managers and care coordinators working in public mental health community services characteristically encourage consumers to engage with a diversity of health professionals to address their health needs more holistically.

A person may be required to undergo tests that meet the protocols necessary to conduct metabolic monitoring, measure therapeutic levels and check for iatrogenic side effects. Case managers may offer to make appointments and arrange for visits to GPs and specialists for other related medical conditions and health issues. However, when blood tests and other measurements are required because the psychiatric medications prescribed are included in a compulsory order, engagement with health providers may become problematic. Some consumers under CTOs view these additional obligations as further encroachment on their liberty and freedom to care for themselves in whatever way they chose.

It has been shown that when health providers and programs are readily available in the same location as where a person receives their psychiatric care and treatment this can improve engagement and long-term outcomes. However, evidence has shown that more positive engagement occurs when consumers are offered services in community settings that are perceived as non-coercive.

For many years MHCC has advocated for community-based service hubs to be established broadly across NSW. It is generally acknowledged that consumers feel more comfortable accessing a diversity of services in a 'one stop shop' environment independent of hospital-based services and settings.

NSW Ministry of Health established the LikeMind Pilot in 2015 as an integrated service to provide co-located mental health and other services in two metropolitan and two regional NSW locations. Approximately $27.5m has been invested in LikeMind to provide readily accessible community-based services for people with moderate to severe mental illness. Consortia of services have been established at each of the four locations. Clinical and psychosocial support services are provided to consumers across four streams: mental health, primary health, alcohol and substance use, as well as vocational and social needs. Evidence from multiple sources indicates that LikeMind is meeting genuine and previously unmet need and is well regarded in the local communities where it provides services.

Some aspects of the intended service model defined in service plans and funding agreements between the Ministry of Health and the lead CMOs were not implemented or sustained. Most significantly, the expectation that co-location of service providers in community-accessible premises would be a core feature of the model, underpinning service integration and superior outcomes for consumers, has not been realised. In practice, Local Health District mental health teams and many other consortium member organisations are not co-located at the four LikeMind sites.

While some CMO consortium members continue to be co-located on a fractional basis, their physical presence at LikeMind sites is often small, partly because of the COVID-19 pandemic. The broader service context surrounding LikeMind is also changing, including changes to Australian Government-funded mental health and related services. This includes new services, like Head to Health, established in some communities.

LikeMind services will operate for the remainder of the pilot to 30 June 2024. We understand that plans will ensure seamless service integration even where services are not co-located and that they will prioritise service gaps where best placed to improve consumer access and outcomes. However, the hubs located in NSW did not establish services with fidelity to the original conceptualised model. The evaluation of the pilot sites was disappointing. For this model to provide best outcomes, consortium members must work together to provide a truly integrated service experience. Consumers must be able to access appropriate services and supports through effective navigation and referral pathways while receiving consistent advice and support to meet their needs and goals.

Consumers must be partners in decision-making about their care and feel confident in the care they receive, including feeling safe about transfers of care and engaging with different service providers. Despite some difficult early beginnings, MHCC believe that this model has shown promise overseas and has the potential to help people stay well in the community and reduce the need for inpatient admissions including for medical emergencies. A greater fidelity to the model, will demonstrate good outcomes in the future.

Recommendation 14
Establish service hubs in each LHD across NSW to ensure equity of access across the state. Each hub to be tailored to meet the demographic population needs identified in the NSW Psychosocial Research Project.

In NSW, HASI and CLS services provide some health-related programs such as Keeping Body in Mind as delivered through one CMO, funded by SESLHD. However, these services are often not specifically funded through the HASI/CLS funding stream.

Research has been conducted by Professor Jenny Bowman and her team at Newcastle University into the extent of this work undertaken in the CMO sector [7]. Evidence from programs such as Health Prompt [8], as established by Neami National, have shown exceptional outcomes for HASI/ CLS clients.

Tackling Tobacco project
The NSW MOH has re-established the Tackling Tobacco[9] project in Mental Health Project. This was originally an initiative funded by the NSW Ministry of Health and conducted by Cancer Council NSW and MHCC between 2016 and 2019. The project involved a cluster randomised control trial and found that the Tackling Tobacco program was successful at improving the way quit smoking support was offered within participating community service organisations. Building on the results of the Tackling Tobacco project, an Action Plan has been developed to progress a coordinated and collaborative approach for CMOs, peak bodies, academic institutions, and NSW Government agencies to reduce tobacco use among people living with mental health conditions. The Action Plan is specific to NSW Mental Health HASI, CLS, and HASI Plus, and in due course, these initiatives will be extended to the Mental Health CLS for Refugees program.

MHCC is on the Tackling Tobacco Project Steering Committee which is looking to build on results from the 2018-2019 trial, and to improve physical health outcomes through smoking cessation and other health related initiatives for people participating in NSW Mental Health CLS.

We highlight the importance of viewing a person's health holistically where exercise, nutrition, substance use and misuse and better management of psychiatric medications (to minimise negative side effects such as weight gain and low energy levels) are considered as part of any program design.

NSW Health continues to demonstrate its commitment to improving physical health outcomes and reducing early mortality of people with a lived experience of mental health issues, through funding programs such as Tackling Tobacco.

Recommendation 15
That the NSW Government commit to funding physical health programs as 'business as usual' across all community-managed mental health programs, co-designed with people with lived experience to meet the needs of all ages, diversity and levels of need.

Feedback on integrated programs

- *"There is no integration. The health system is siloed within and siloed from the CMO Mental Health services and providers."*
- *"This is done very poorly, as someone who works in inpatient mental health service it is difficult to know what is available in the community to support people in discharge and ongoing."*
- *"No one talks to each other; they are still so separate and don't work together."*

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

This question refers to the workforce shortage across all public services. MHCC supports any initiative that would grow the clinical workforce to meet the needs of public outpatient services.

However, MHCC's primary concern is the expansion and sustainability of CMO services to meet current shortages and address future workforce needs for mental health services as identified by the Productivity Commission Mental Health Report. These are services required to meet the support needs of people unable to access the NDIS. These services are also required as part of the National Mental Health and Suicide Prevention Agreement.

MHCC's Workforce Profile Report (2021, p.27)[10] estimated that the CMO sector at that time represented one quarter of all mental health workers in NSW, at 4,745 paid workers (3,463.9FTE). This places the CMO sector, primarily delivering psychosocial support services, as a key part of meeting the total demand for NSW mental health workforce and services. We are currently undertaking our third workforce survey and will provide recommendations on workforce solutions in a forthcoming workforce report.

In its 2020 Mental Health Inquiry Report, the Productivity Commission recognised the crucial role of community-based supports and recommended an increase in funding to expand community services to better match demand (Rec 17, pg. 76)[11]. Increased funding is a key issue that emerges throughout the sector. Funding was considered the top concern among MHCC's member organisations, in our most recent member survey. The community mental health and lived experience (peer) workforces are under extreme pressure, but due to data gaps are invisible in national workforce planning and assessment processes.

Recommendation 16
Commit to collaborate with the Commonwealth Government through the National Mental Health Workforce Strategy to urgently address the gaps in the mental health workforce across all areas of need including CMOs.

Recommendation 17
Invest in workforce development to address current and future shortages and foster career pathways and respond to findings from MHCC's forthcoming 2023 CMO Workforce Survey Profile Report.

Recommendation 18
Provide support and resources for the Lived Experience (Peer) workforce and create employment pathways, workforce readiness and industrial protections.

Recommendation 19
Provide community-managed mental health organisations with five-year contracts based on ongoing review and achievement of objectives so that they can offer secure employment and sustainability.

Feedback on workforce

- *"There needs to be planned growth for counsellors, peer workers and carer peer workers, and they need to be remunerated equally with psychologists and social workers."*

- *"Not enough psychologists and counsellors within inpatient mental health services."*

- *"Understaffing and staffing vacancies make efficient allocation of resources extremely difficult."*

- *"Lack of qualified and continuous staffing in regional areas."*

Use of Community Treatment Orders under the *Mental Health Act 2007*(MHA)

In NSW, as in all Australian jurisdictions, legislation permits mental health service providers and mental health tribunals to review people with mental illness (as defined under the Mental Health Act) who are assessed as requiring a compulsory care and treatment order (CTO).[12] This is because they have determined that there is:

> *(a) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person and that the affected person would benefit from the order as the least restrictive alternative consistent with safe and effective care, and*
> *(b) a declared mental health facility has an appropriate treatment plan for the affected person, and is capable of implementing it; and*
> *(c) if the affected person has been previously diagnosed as suffering from a mental illness, the affected person has a previous history of refusing to accept appropriate treatment.*[13]

Despite Australia's human rights obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) Australia has rates of CTO usage that are significantly high by world standards (Light, 2019)[14]. Even within Australia, rates of CTO usage vary considerably between and within jurisdictions despite the legislation being similar (Light, 2019; Adult mental health quarterly KPI report, 2019). This occurs in the context of "mixed evidence about the efficacy of CTOs and a lack of clear understanding of their purpose (Brophy, L et al., 2021)".[15]

The use of CTOs remains one of the most contentious issues in mental health service delivery in Australia. "Not only does their efficacy remain unresolved, but these orders also raise ethical and human rights concerns. The current debates, and attempts at reform, must be informed by valid and reliable data".[16]

However, despite these concerns, many people clearly benefit from care and treatment provided by community mental health teams as directed in CTOs. Often, people are living well in the community, have had no or have had reduced hospital admissions and have demonstrated good outcomes over time, from both their own as well as the treating teams' perspectives.

The question needs to be asked as to whether supports and medication management are really needed through involuntary orders, and whether some people would have remained well with the supports provided on a voluntary basis. In the substantial research evidence describing consumer perspectives, the concept of 'dignity of risk' is cited as an important consideration when CTOs come up for renewal.

Consumers and more human rights focused practitioners suggest that a person should be able to move forward towards greater autonomy and independence when they have demonstrated understanding about their illness and their ongoing need for treatment. Consumers report that this happens all too infrequently.

Research with people with lived experience of CTOs generally points to the overuse of CTOs because of clinician risk aversion, systemic service deficiencies, lack of voluntary alternatives, legislative and policy shortcomings, and barriers to enacting criteria in the legislation.[17] People with lived experience and CMOs particularly identify the need for Supported Decision-Making to be built into the system and recognised as a core skill for the mental health workforce across the service system.

Research also indicates that deficiencies in the system give rise to concerns about continuity of care, which leads to CTOs being sought because of fears that people will be lost to follow-up. Clinicians often recommend CTOs because they enforce follow up and accommodate referral across multiple human service contexts; and are therefore in the 'best interests' of consumers.

People caught up in the mental health system frequently feel that recovery will only be possible when they are respected and trusted to make their own decisions about the support and treatment they receive. Some MHCC members consulted propose that enhanced access to CMO services would promote moves towards the reduction and eventual elimination of CTOs.

Many consumers do not attend hearings because they feel the Mental Health Review Tribunal's decision is a 'rubber stamp' and a forgone conclusion. They often voice their doubt in the partiality and independence of the Tribunal, and consider members are "as risk averse as clinicians"; only focus on their past history and will never let them move on or recognise their capacity. The research demonstrates a dominance of the medical model which together with the current legislation presents barriers to clinicians and the Tribunal working with a more rights-based orientation.

Recommendation 20
More equitably accessible CMO services across NSW to provide holistic and wrap-around care, treatment and supports to people living with mental health and co-existing conditions, thus enabling a move towards the reduction and eventual elimination of CTOs.

Recommendation 21
Mental health professionals, including psychiatrists and mental health nurses, educated to better understand human rights in a mental health context and their obligations under the UNCRPD. Training to include how alternatives to CTOs could be supported through access to wrap-around services and supported decision-making, in an integrated service delivery environment that offers safe transitions and care planning across the service system.

Statutory periods for CTO reviews provide an opportunity for people to offer their perspectives. This is particularly important when their view is at variance with that of the treating team. The NSW Mental Health Review Tribunal is an independent body that has an important role in ensuring that consumer and carer voices are heard. Their presentations assist the Tribunal make decisions about orders. The MHRT's role is to ensure consumer rights are protected and that they have the evidence they need to make decisions that ensure that they 'receive the care and treatment they require in the least restrictive environment, consistent with their safe and effective care' (s68). Tribunal panels can be greatly assisted when treating teams are able to assure them that the services people need and want in the community are available and that a consumer is willing to work with them on their personal recovery goals.

CMO services reduce the need for CTOs
A tendency towards paternalism and over caution is often based on the lack of availability of appropriate services in the community, either through the NDIS or through other CMO support services, and the poor availability of housing and homelessness options and accommodation supports and options. In our view, CTOs would be less required if community-based services were more broadly available, and clinicians felt assured that community-managed services provide safe alternatives to compulsory orders. In this way treating teams and the Tribunal could be confident that people would not be neglected or lost to services.

Some of these fears are historical and based on a poor understanding of the efficacy of CMO services, including the quality of workforce skills and services delivered, as well as known access and availability issues. Much of this information is dependent on individual knowledge and expertise and how connected case managers are to other parts of the service system in their location.

The situating of CMOs in locations which would support easy referrals for people on CTOs would be beneficial. This could facilitate coordinated care alongside existing services such as SafeHaven, drop-in services, recovery colleges, service hubs, Head to Health and Headspace. Easy access could also be expanded to align with housing, employment, and physical health, AOD and culturally appropriate connections, all of which has the potential to reduce the need for CTOs over time and address the social determinants of health.

Recommendations 1 to 6, 13 & 15 relevant here

Feedback on CTOs

- *"They are too quick to apply CTOs – there are not enough skilled and non-judgemental clinicians."*

- *"CTOs are overused, especially in under resources services. Psychiatrists see them as a way to ensure their patients jump the queue or maintain support."*

Benefits and risks of online and telehealth services

Digital service delivery can increase access to services for people living with mental health conditions. However, digital services that are poorly designed or poorly delivered may further exclude people living with mental health conditions.

Australia is a party to the UNCRPD which aims to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities. This includes the right of people with disability to access technology provided to the public. These rights to access technology supports people to realise a range of other rights. For example, the right to highest attainable standard of health can be compromised when the cost of assistive technology is prohibitive.

Trauma-informed digital services
Services should ensure that technology used to provide digital services has been designed with the needs and aspirations of people accessing the service central to all considerations. This includes that digital services are trauma informed. Mainstream technology designed for the entire community is described as 'functionally accessible' when it also meets the needs of a person's disability. This is different to assistive technology, which is specifically designed to support people with a particular disability to perform a task.[18]

The development of digital technology is outpacing laws and regulations, as well as ethical guidelines in some areas relevant to digital services. At present, there is no single Australian regulatory framework for digital services in the mental health sector.

The National Safety and Quality Digital Mental Health Standards and the principles informing them are voluntary for digital mental health service providers but represents an extremely helpful framework for service delivery.

Digital technology is beneficial and makes services more accessible to rural and remote communities, however wherever services are provided, they need to allow for a period of relationship building with service providers before moving directly to this modality of support.

Recommendation 22
Mental health workers supported to receive training about the risks and benefits of digital service delivery, as well as the National Safety and Quality Digital Mental Health Standards so that they learn about the principles of practice and standards as a framework for ethical digital service delivery.

Feedback on digital technology

- *"Problematic when the client does not have a suitable service, or suitable private place to talk, or adequate internet connection. Many clients who are on the disability pension or have low means, do not own smart phones, have prepaid phones where their time is limited etc. Telehealth where telephone is used is not as good because there is no face-to-face interaction. Telehealth with video, where both the clinician and the client are using devices with good internet connection and privacy can be very successful."*

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.

All workforces across all levels of the mental health service system should undertake cultural competence and skills training for safe practice. They should have a good understanding of diversity inclusion and an appreciation of the stigma and discrimination people with mental health conditions experience, particularly among marginalised and disadvantaged groups.

Employment of lived experience staff from diverse backgrounds and First Nations people integrated into the workforce can contribute to enhancing culturally safe mental health services. Young people supported by Youth CLS programs have identified the benefits of receiving supports from peer workers who have lived experience and are relatable.

Training should be co-designed and provided by lived experience trainers from the specific culturally diverse groups, so that they can share their lived experience of mental health in the context of their cultural groups.

Recommendation 23
Ministry of Health provide funding that appropriately supports training in cultural competence and skills for safe practice across the mental health service system. Training should be available for public and community-based workers, including the CMO sector. Ideally training should be delivered for workers across different service settings, so that they can learn from each other.

Feedback on diversity

- *"The sector lacks non- judgemental, skilled and compassionate workforce and needs more Peer Workers in these areas."*
- *"Still in infancy stages and there are not enough resources for First Nations people, LGBTQIA+ people in mental health services."*
- *"Racism, discrimination, stigma and lack of recognition is rife."*

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.)

Too many people in crisis end up in hospital when they could be better treated and cared for in the community.

Services such as Head to Health should be considered as centres from which crisis teams could operate. They could assist people with supports and referrals as appropriate to their needs.

MHCC is hopeful that the NSW Psychosocial Research Project will highlight the service gaps through which many people fall. This is particularly important in understanding early intervention strategies for young people and women with children and people at risk of interaction with the criminal justice system.

Other alternatives to police for emergency responses could include more Safe Havens as alternatives to Emergency Departments and the use of peer workers in Emergency Departments. The Urgent Mental Health Care Centre model in South Australia is an effective alternative to Emergency Departments in crises[19].

If a consumer is previously known to emergency departments and CMHSs, and can be supported in their decision-making, there could be an option is to utilise a step-up and step-down (SUSD)program to provide temporary accommodation, stability of treatment in an environment where they can be supported by social workers, nurses and lived experience peer workers for up to 4 to 6 weeks. More SUSD services provide intense support not only for consumers, but also families and carers.

Also see Recommendation 2 – in relation to Step-up, Step-Down Services relevant here

Recommendation 24
Designated multidisciplinary crisis teams available in each LHD across NSW. Number of teams to be made available as per population and demographic need as identified in gap analysis, measured by ED presentations per area.

Also see Recommendation 10 – in relation to PACER relevant here.

Feedback on policing

- *"PACER is a good service but extremely expensive. Senior nursing staff have been attracted over to work in these teams, depleting CMHTs. The majority of work that they do could be done by lower- level clinicians and health workers. They also don't have high activity levels. No evidence to date demonstrating a reduction in ED presentations. Has been good for patients and police service. Having a mental health response option within the 000 call centres would be a good option."*

- *"We need more Safe Havens and peer lead services. More training for police and ambulance officers."*

- *"Better training required all around to prevent the dependence on untrained and unskilled police."*

Other related matters

There remains a mostly siloed service delivery environment problematic for people living with co-existing conditions. Many people with mental health conditions have co-occurring difficulties related to substance use. It is important that following the ICE Inquiry, Premier and Cabinet ensure the Alcohol and other Drugs (AOD) Strategy (under development) includes actions to safeguard a strong collaborative relationship with the mental health service system.

There has been growth in co-commissioning activities through the PHNs in NSW. It is imperative that the Mental Health Branch work closely with the Department of Population Health (funding AOD services) to ensure that people receive joined up services that address a multitude of mental health, AOD and psychosocial needs resulting from the social determinants of mental health. MHCC advocate a major expansion in co-commissioning of AOD/Mental Health service programs including community based residential services for all ages and diverse groups.

Mental health challenges cannot be addressed without considering the social determinants of health. This requires cross government collaboration to address the impact of poverty, housing, homelessness, and many other social issues than impact a person's mental health and substance use.

MHCC propose that it is necessary for governments to foster a new era of acceptance of cross departmental funding and program development that understands and accepts that costs expended in one portfolio area will impact savings in other areas and vice versa. In this context we reference the work of Professor Henry Cutler who writes that, "A coordinating government department or agency representing the mental healthcare sector could help develop, communicate, and gain support for a long-term mental healthcare value-based payment reform agenda. It could also participate in the evaluation and learning phase of each trialled value-based payment model."[20]

Recommendation 25
The Mental Health Branch work closely with Premier and Cabinet on the AOD Strategy, to ensure cross government planning for collaborative implementation.

Recommendation 26
Establish a Department of Whole of Health and Wellbeing to guide cross governmental cooperation across mental health, AOD, housing and other co-existing conditions and challenges including Neurodiverse consumers.

Stigma and discrimination
In 2020, the National Federation Reform Council tasked the National Mental Health Commission with developing a national stigma-reduction strategy. This work was a response to the Productivity Commission Inquiry into Mental Health, which recommended that "the National Mental Health Commission should develop and drive the implementation of a renewed national long-term stigma reduction strategy" and is reflected in the National Mental Health and Suicide Prevention Agreement. Tackling discrimination is also consistent with actions recommended in the Fifth National Mental Health and Suicide Prevention Plan 2017-2022, including Action 18, which states that "governments will take action to reduce the stigma and discrimination experienced by people with mental illness that is poorly understood in the community."

"The need to protect and promote the human rights of people who experience mental ill-health has long been championed by the consumer and carer movement. The experience of the past three decades tells us that while some progress has been made, there is an urgent need to do more"[21].

Recommendation 27
NSW Health work with the Commonwealth Government to implement the National Stigma and Discrimination Reduction Strategy developed by the National Mental Health Commission.[22]

Other feedback

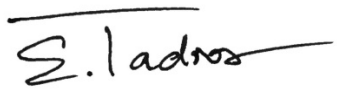
- *"Mental health nurses who are suitably qualified and experienced are being underutilised. They can work independently, don't need to be "under the direction" of a psychiatrist but can easily collaborate with GPs or psychiatrists and other allied health staff. They should be recognised as professionals and able to get Medicare rebates to see people in the community. They should also be paid as independent contractors and not seen as cheap labour. If mental health nurses were adequately utilised, we would have enough mental health clinicians to meet the needs of most of the people requiring mental health services in the whole of Australia."*

- *"Increasing community support and alternatives to GP would improve access to care significantly."*

MHCC thanks the individuals and organisations that contributed to and support this submission, including Suicide Prevention Australia, Wellways, Independent Community Living Australia (ICLA), New South Wales Council of Social Services (NCOSS)and the Western Sydney Community Forum. We acknowledge and thank those who anonymously completed the MHCC Consultation Survey as part of this submission.

We thank the Portfolio Committee for their interest in the views of our members and stakeholders and express our willingness to be further consulted.

For more information about this submission, contact MHCC Director, Policy & Systems Reform, Corinne Henderson on corinne@mhcc.org.au



Dr Evelyne Tadros
Chief Executive Officer
Mental Health Coordinating Council

1 September 2023

Recommendations to the Inquiry

Recommendation 1
Expand the existing psychosocial support packages (HASI/CLS) in NSW by 2,500 in the first year, increasing to 10,000 within four years. Costing $365 million.

Recommendation 2
Establish a network of 'Step-up Step-Down' services by adding an extra 130 places for people to access residential programs that minimise the risk of hospital admission in NSW.

Recommendation 3
Extend all mental health and suicide prevention service funding cycles to a minimum of three to five years to increase recruitment, retention, evaluation of service and continuity of care for patients.

Recommendation 4
Consider dedicated additional funding for the mental health system achieved through a surcharge raised through a payroll tax levy.

Recommendation 5
Provide adequate indexation that responds to inflationary impact on salaries and service delivery in CMOs.

Recommendation 6
Work with other States and Territories and the Australian Government to address the gap in psychosocial supports outside of the NDIS as required by the National Mental Health and Suicide Prevention Agreement.

Recommendation 7
Utilise the findings from the NSW Psychosocial Research Project currently being undertaken by David McGrath under the instruction of NSW Health to direct service funding to specific needs identified.

Recommendation 8
Require all healthcare and frontline workers who engage with people with mental ill-health or suicidality to undertake education in trauma-informed practice and suicide prevention training.

Recommendation 9
Invest in wellbeing support for mental health care workers including through the provision of tailored wellbeing support programs and vicarious trauma education.

Recommendation 10
Roll out the PACER program across all police area commands and LHDs in NSW.

Recommendation 11
Develop a state-wide dedicated Community Mental Health Navigation Support Service staffed with allied health and peer workers who are equipped to help people navigate support services and other systems, such as social services, child protection and family court services, housing and unemployment services, to address the social determinants of health that can lead to suicide.

Recommendation 12
Ensure funding for carer education, supports and resources, including respite services.

Recommendation 13
Suicide prevention and intervention training tailored to carers, delivered free of charge, and available via multiple modes of delivery to address the accessibility barriers carers face.

Recommendation 14
Establish service hubs in each LHD across NSW to ensure equity of access across the state. Each hub to be tailored to meet the demographic population needs identified in the NSW Psychosocial Research Project.

Recommendation 15
That the NSW Government commit to funding physical health programs as 'business as usual' across all community-managed mental health programs, co-designed with people with lived experience to meet the needs of all ages, diversity and levels of need.

Recommendation 16
Commit to collaborate with the Commonwealth Government through the National Mental Health Workforce Strategy to urgently address the gaps in the mental health workforce across all areas of need including CMOs.

Recommendation 17
Invest in workforce development to address current and future shortages and foster career pathways and respond to findings from MHCC's forthcoming 2023 CMO Workforce Survey Profile Report.

Recommendation 18
Provide support and resources for the Lived Experience (Peer) workforce and create employment pathways, workforce readiness and industrial protections.

Recommendation 19
Provide community-managed mental health organisations with five-year contracts based on ongoing review and achievement of objectives so that they can offer secure employment and sustainability.

Recommendation 20
More equitably accessible CMO services across NSW to provide holistic and wrap-around care, treatment and supports to people living with mental health and co-existing conditions, thus enabling a move towards the reduction and eventual elimination of CTOs.

Recommendation 21
Mental health professionals, including psychiatrists and mental health nurses, educated and trained to better understand human rights in a mental health context and their obligations under the UNCRPD. Training to include how alternatives to CTOs could be supported through access to wrap-around services and supported decision-making, in an integrated service delivery environment that offers safe transitions and care planning across the service system.

Recommendation 22
Mental health workers supported to receive training about the risks and benefits of digital service delivery, as well as the National Safety and Quality Digital Mental Health Standards so that they learn about the principles of practice and standards as a framework for ethical digital service delivery.

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NSW Health work with the Commonwealth Government to implement the National Stigma and Discrimination Reduction Strategy developed by the National Mental Health Commission.

Endnotes

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