The Royal Australian & New Zealand College of Psychiatrists

Upper House Inquiry into Mental Health Services in NSW

Equity, accessibility, and appropriate delivery of outpatient and community mental health care in New South Wales

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1. About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrist (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand providing access to Fellowship of the College to medical practitioners. The RANZCP has approximately 8000 members bi-nationally. The NSW Branch represents over 2000 members, including over 1400 qualified psychiatrists.

The NSW Branch offers a substantial resource of distinguished experts – academics, researchers, clinicians, and leaders dedicated to developing expertise in understanding the risk factors of mental disorders, treating individuals and families, developing models of care and promoting public health measures that will reduce the personal suffering, loss of potential and huge economic costs caused by mental disorders in our community.

2. Foreword

Mental Health Services in NSW are at a crossroads. This submission is not a comprehensive review of the difficulties the sector faces nor a comprehensive solutions white paper. Rather it seeks to compel the NSW Parliament to rise to the challenge and champion prioritisation of investment in, and reform of, the mental health sector.

There are many priorities for State Governments, and all portfolios have legitimate needs for investment and reform. But none have the range of challenges the Mental Health Sector faces and none can claim the same level of historical neglect or governance chaos.

The tragedy is that escalation of some mental illness is preventable, but governments have been unwilling to link mental health strategic policy and investment decisions with evidence-based interventions and services that are proven to work (1).

The issues have been articulated ad infinitum in comprehensive reports and inquiries. It is now time for the Parliament to exhort Government to put in place the means by which reform and investment become a reality, not just another plan or vision.

3. Recommendations

Recommendation 1:

As announced in the on the brink: Evidence from the frontline report, the RANZCP calls on the Parliament to exhort the Government to commission a high level taskforce to develop a blueprint for the reform of the sector, focussed specifically on models of integration, in the context of the Commonwealth/State intersection.

Recommendation 2:

We ask: That the inquiry urge the Government to establish a Mental Health Workforce Taskforce

Recommendation 3:

We call on the Inquiry to exhort the Government to invest in a Centre of Excellence in Trauma-Related Disorders, with the broad aims of education, training and supervision of Health and sector staff, as well as tertiary level clinical service provision to those with the most severe disorders.

Recommendation 4:

We call on the Inquiry to exhort the Government to develop and invest in alternatives to ED's, where feasible, and invest in ED's where not, to ensure the most person-centred and appropriate environments for those presenting with a mental health crisis. The RANZCP's specialist Emergency Psychiatry network can be enlisted to provide expert input. We also call for the expansion of the successful Police, Ambulance, Clinical, Early Response (PACER) intervention, which has led to positive upstream effects, reducing ED presentations.

4. The Big Picture

The gap between what should the mental health sector could look like, and what it is, has been highlighted in a number of inquiries and reports in this State and others.

a) The first step – A Gap Analysis

The NSW Government, in response to pre-election advocacy (2), is embarking on a Gap analysis of State-funded mental health services, with a focus on community mental health services.

It is anticipated that this will highlight the yawning gaps that are known and provide an estimate of the investment in human and other capital required to fill the gaps. ***The RANZCP commend the Government's commitment to this critical step in system reform.***

This submission will not focus on the gaps, and their extent, as this body of work is under way, but the RANZCP see this as the first step in NSW's real reform process. State sector Mental Health Services provide the bedrock for clinical service delivery to those most severely affected by mental disorder.

b) **The second step is to commit to major investment.**

Other states have seen unprecedented new investment in Mental Health Services over the last 2 years (Qld, Victoria, SA, and WA). The NSW Government will need to look beyond 'business as usual' requests to Treasury for enhancements, to new sources of revenue to meet these requirements. Nothing short of historical investment will stem the tide of sector fragmentation, where gaps are becoming chasms.

c) **The third step is to figure out how we fill the gaps between State, Community Managed, PHN commissioned, Medicare funded (primary and secondary) and Private Hospital services.**

What can service integration look like at a State and Regional level?

Integrated models have been proposed including Regional Commissioning Authorities (3), Collaborative Commissioning arrangements (4), and pooled funding arrangements - Aboriginal Community Controlled Health Organisations being an example.

In redesigning a mental health 'system' with multiple, independent parts. It is critical to:

- Define the strengths and expertise to each part of the sector.
- Define their agreed roles within the integrated framework.
- Develop coherent regionalised entry points and triage systems so that:
    - people receive the timely, quality multidisciplinary assessment often so lacking in the person's clinical journey and.
    - are then directed to the most appropriate services to meet their requirements.

Only these levels of cooperation and shared governance will bring coherence to the sector, and lead to a system that is navigable, accessible, and, hopefully, more equitable.

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The RANZCP believes there is a unique opportunity for States, especially the most populous State of NSW, to work with/influence the Commonwealth to rationalise the sector, specifically in the context of negotiations of the next Commonwealth/State Mental Health Agreement. Any reform of regional systems must occur in the context of, and inform, the next Agreement.

5. The Current Landscape

Despite the expectation that the current Gap Analysis will deliver specific data on what gaps exist and their extent, we note the following for the purposes of background, scope, and scale:

- That despite mental health problems being on the rise in NSW and the rest of the country, and despite the clear evidence of comorbidity with physical conditions, the proportion of health spending on Mental Health has not risen in decades (2).
- That NSW spends relatively more (compared with other States) on mental health inpatient beds than community resources.
- That despite commendable recent NSW Government investment in clinical services including Safeguards (multidisciplinary extended hours acute community based teams), Headspace (enhanced psychiatric, allied health and GP capacity so that headspace services can deal with more and more complex presentations) , Perinatal services (State's first public mother-baby units), NSW is the laggard in community mental health sector spending (spending proportionally more on inpatient services than other States).
- NSW is the laggard on mental health spending generally (2), falling behind as other States commit to critical investment and reform.
- That the range of services delivered by NSW Health, Community Mental Health Services has narrowed, so that it services two core populations:

    - Those with severe chronic mental illness requiring ongoing care under the Mental Health Act (Community Treatment Orders) and those requiring crisis follow-up after emergency department presentations.
    - There are services for specific age groups, Child, and Adolescent (including the recent Safeguards investment), Youth, and Older Persons Mental Health Services, but these are generally narrow in focus, feature exclusion criteria, and take no responsibility for those who do not meet criteria.
- That the community mental health sector is under siege, with the Productivity Commission noting that community clinicians spend only 29% of their working time in clinical contacts (3).
- That there is a well-documented 'missing middle' of those with severe mental health problems who are too complex for management by the primary health sector, unable to access the overwhelmed and narrowly focussed public mental health system and lacking the financial resources to access private sector services.
- Services commissioned by PHNs are insufficient or too poorly targeted to make inroads on 'missing middle' care needs or filling other gaps, as proposed. PHN funding accounts for only 10% of all Federal funding on mental health.
- GPs are becoming increasingly difficult to access for those with severe mental illness, as practices move away from bulkbilling, general practice becoming a less attractive career option and practices plagued by costs and closures.
- That the Emergency Departments have become the front door of public community Mental Health Services, in the absence of a navigable and robust community response.
- Spending on essential residential and community Mental Health Services in NSW is well below spending on the same services in other states (5).
- That there is no part of the sector that is not under stress, and in survival mode, tend to be defined by what they don't do, rather than what they do, and for whom.

6. The Workforce

No inquiry into any part of the mental health sector can ignore the elephant in the room: Workforce. There are extraordinary workforce challenges facing the sector in NSW. The medical workforce is under unprecedented strain, with public services at risk of shrinking or closing due to lack of medical workforce - either because of insufficient psychiatrists to deliver clinical care, or to supervise junior medical staff.

We know there are no quick fixes for the workforce issues, and many issues involve cooperation with other jurisdictions (6), but the College and other stakeholders are committed to working with Government to ensure a sustainable workforce.

We know that:

- The psychiatric workforce is ageing (see several NSW psychiatric workforce surveys, conducted in 2013, 2015 and 2018).
- We have had an efflux of nurses and psychiatrists from the public sector post-covid.
- We have missed years of International Medical Graduates entering the system, due to Covid and the complexities with Immigration, College and AMC/AHPRA requirements.
- We have the lowest paying employment awards for junior medical and senior specialist staff in Australia.
- We have high rates of locum utilisation.
- We have increasing difficulties appointing to staff specialist positions, even at major inner-city hospitals, that were once magnets for junior specialists.
- NSW Health keeps no 'live' data on vacancy rates, nature of VMO contracts (short-term or quinquennial) or locum utilisation.
- That LHD's are in bidding wars for VMO's, pushing contracted rates in some locations toward locum rates.
- That NSW Health either lacks, or chooses not to exercise, the governance influence over the LHD's to bring coherence, cooperation, and consistency to medical recruitment.
- There is demoralisation in the sector, particularly medical, as clinical engagement and leadership is seen as less of a priority and clinical decisions at the frontline being made by less qualified and experienced clinicians, even non-clinicians.
- Staff are also suffering burn-out, not able to access existing conditions like non-face to face clinical time to participate in supervision, teaching, research, quality improvement, clinical leadership.
- That there will be increasing demands on clinical supervisors as RANZCP specialty training moves to workplace-based assessment models.

a) Then there are things we don't know for sure about workforce, but need to know, by collecting up-to-date data:

- That Junior Specialists are bypassing appointments in the public health system to enter private practice: better remunerated, less stressful, and much more flexible, with the advent of telehealth.
- That Registrars are taking breaks in training to work as highly-paid locums to take a break from the stress of working in an overwhelmed system, to have time to study to pass their Fellowship, and to be able to afford the costs of living in Sydney.
- That psychiatrists feel disenfranchised, disrespected, and disconnected within Mental Health Services, making the pull to private practice magnetic.

- Governed by the Ministry with stakeholders including all LHDs, HETI, University of Sydney Brain and Mind, RANZCP, APS, Australian College of Mental Health Nursing and Rural Doctors Network.
- There will need to be a commitment to collecting and sharing live employment data; vacancy rates; moratoriums on bidding wars; exploration and funding of innovative workforce pilots: for example, evening shifts in ED's, peak time for mental health presentations; tendered psychiatrist on-call services, as on-call identified as a major cause of burn-out and system egress; novel training experiences, consistent with the FATES program.
- Expansion of nurse practitioner programs and peer sector training and supervision.

Recommendation 2:

We ask:
That the inquiry urge the Government to establish a Mental Health Workforce Taskforce

7. Feedback from our membership

a) Lack of access to services for those with trauma-related disorders

Victoria has two Statewide services focussed on research, education, training, supervision and intervention for Borderline Personality Disorder (Spectrum) and PTSD (Phoenix).

NSW has Project Air, which has minimal funding and capacity to provide the range of services and interventions available in Victoria. Most NSW Health services will advertise that they are 'trauma-informed' but the capacity to deliver specific evidence-based therapies to those experiencing these disorders is negligible. These are serious mental disorders with significant morbidity and mortality, and those suffering are frequently engaged with community services in crisis and emergency services.

Recommendation 3:

We call on the Inquiry to exhort the Government to invest in a Centre of Excellence in Trauma-Related Disorders, with the broad aims of education, training and supervision of Health and sector staff, as well as tertiary level clinical service provision to those with the most severe disorders.

b) Emergency Departments (ED's) have become the main entry point into the mental health system for many people

- Chronic underinvestment, particularly in the sector's workforce, and an unwillingness to resource community Mental Health Services (7, 8) have depleted the system to such an extent that hospital emergency departments (EDs) have become the main entry point into the mental health system for many people.
- EDs have become de-facto mental health clinics where consumers experience lengthy waits to be assessed by clinicians, the level of mental health training of many staff in these roles is limited (9).
- Mental health related ED presentations to public hospitals in NSW rose from 81,000 in 2017-2018 to 85,281 in 2021-2022 – an increase of 5%. Since 2020, when Covid 19 was declared a pandemic, Sydney Local Health District hospitals have experienced a greater than 10% increase in mental health related ED presentations (10). And so far in 2023 (data to 17 Jun) we've seen a 7% increase in all NSW mental health ED presentations compared to the same time in 2022.
- ED presentations per 10,000 of population in NSW have risen from 87.7 in 2004-5 to 114 in 2021-2022 (11). A high proportion of those patients were delivered into hospital by ambulance (49%) or Police (6%) for lack of an alternative or appropriate mental health service to direct them to (12). The proportion of arrivals via ambulance or police to NSW EDs is higher than the national proportion and double the proportion of all presentation to EDs by ambulance or police (12).

Recommendation 4:

We call on the Inquiry to exhort the Government to develop and invest in alternatives to ED's, where feasible, and invest in ED's where not, to ensure the most person-centred and appropriate environments for those presenting with a mental health crisis. The RANZCP's specialist Emergency Psychiatry network can be enlisted to provide expert input. We also call for the expansion of the successful Police, Ambulance, Clinical, Early, Response (PACER) intervention, which has led to positive upstream effects, reducing ED presentations.

c) Specific populations requiring targeted intervention and investment.

We know the knock-on effect of a failing mental health system and the plight of people who fall through the gaps. Many suffer chronic illness, intergenerational trauma, preventable incarceration, long-term unemployment, and homelessness.

As people become increasingly disenfranchised and disadvantaged the pressure on the mental health system spills over onto other services.

In NSW, police spend 10% of their time responding to mental health related incidents. Of all people detained by police, 43% of men and 55% of women have previously been diagnosed with a mental health condition (3).

The proportion of people with a mental health condition being detained by police strongly reflects the representation of people with a mental health condition entering the criminal justice system. Even though disaggregated data on NSW prisoners is dated, we do know that people with a mental health condition, particularly severe conditions like psychosis and co-morbidity with intellectual disability, are over-represented in NSW prisons. In 2018, nationally, 65% of female entrants and 36% of male entrants reported having a mental health condition (3).

The RANZCP position statement on involuntary mental health treatment in custody makes recommendations to ensure that prisoners receive mental health treatment in appropriate settings. Currently in NSW prisons treatment during incarceration and after release is poor (3). ABC news referenced a survey conducted in NSW by the Queensland Centre for Mental Health Research which revealed that NSW only funded 0.83 full-time positions for every 550 prisoners. The recommended number is 11 clinicians for every 550 prisoners (13).

And to prove the correlation between mental illness and reoffending – 30% of people with an intellectual disability released from prison between July 2005 and June 2015, had a serious mental illness diagnosis in the 5 years prior to their first recorded prison episode (14).

We also know that poor mental health is a key risk factor for homelessness and being homeless is often the catalyst for poor mental health (15). People with a mental health condition are one of the fastest growing groups of clients accessing specialist homelessness services (SHS) in NSW. In 2020-21, one-third or 32% of people who sought SHS had a current mental health condition. Just a decade ago in 2011-12, it was one-fifth or 19%.

8. Accessible and culturally safe services for Aboriginal and Torres Strait Islander people

The RANZCP recognises that historical legacies of violence, social marginalisation, cultural dislocation, discrimination, stolen generations, and the inordinately high rates of incarceration and premature mortality are all symptomatic of the intergenerational trauma experienced by Aboriginal and Torres Strait Islander people in NSW (16, 17).

The overall suicide rate among Aboriginal and Torres Strait Islander people in NSW is twice the rate of other Australians and three times the rate for people aged between 25 and 44 (18).

There are causes and risk factors associated with the suicide rate of Aboriginal and Torres Strait Islander people that are the same as those experienced by other Australians. The 62% of Aboriginal and Torres Strait Islander people who live in regional or remote communities (19) are marginalised for reasons we have already described: the distances that people need to travel to services; population density; and the poor availability of trained and culturally appropriate staff.

Geographic remoteness is not a factor for Aboriginal and Torres Strait Islander people in urban areas, but affordability, access, equity, racism, and the availability of culturally appropriate services are, and the impact on their mental health is just as profound.

The interconnection of these marginalising factors with the historical, political, and social contexts that characterise the post-colonial experience of Aboriginal and Torres Strait Islander people increases the risk factors for poor mental health.

Health interventions that do not consider the social and emotional wellbeing of Aboriginal and Torres Strait Islander people can evoke painful memories and retraumatise in the same way that intervention by social welfare agencies can (16).

There is substantial evidence to support greater investment in services and activities that promote cultural connection and cultural continuity. There are 37% fewer deaths by suicide in communities where cultural connection is prioritised (16).

The RANZCP provides resources, programs and educational material brought together by psychiatrists who have direct experience working in Aboriginal and Torres Strait Islander mental health.

That experience, and the knowledge of Aboriginal and Torres Strait Islander people must be the foundation for interventions that can address the legacies of intergenerational trauma and the challenges brought about by remoteness and workforce pressures.

9. Conclusion

Ahead of the last State election, we called on both sides of politics to commit to improving equity and access to mental health care services for all NSW residents. We proposed a gap analysis, service reform and new funding streams. Genuine reform needs to be informed by best-practice and evidence-based care, i.e. meaningful engagement of those working and living on the frontline, including the College and other key stakeholders.

The NSW Branch of the RANZCP, and the broader mental health care sector, are ready and willing to work with Parliament and Government to achieve real improvement in mental health care outcomes for the consumers.

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