Submission
No 54

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

Organisation: Uniting NSW.ACT

Date Received: 6 September 2023

Parliament of New South Wales
Legislative Council
Portfolio Committee No. 2 – Health

Dear Committee,

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

Uniting NSW.ACT (Uniting) is the social services and advocacy arm of the Synod of the Uniting Church in New South Wales and Australian Capital Territory. Our purpose is to inspire people, enliven communities and confront injustice. We recognise the essential worth and rights of every person, especially those whose rights are discounted, or who are excluded from full participation in society.

We welcome the opportunity to contribute to the work of the review into the Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales (the Inquiry).

This submission is informed from our experience as a specialist mental health provider with over 40 years' experience working across the Lifespan and the stepped care continuum. We have drawn on the work of Dr Paul Fung (Clinical Director of Uniting Recovery, Uniting) who undertook a Churchill Fellowship to investigate clinical service models that integrate mental health care with General Practice. We have provided this as a supplementary document.

Uniting recommends that the NSW Government:

- Adopt and implement the models of support provided by the Personal Helpers and Mentors Program (PHAMS), Partners in Recovery (PIR) and Day to Day Living (DTDL) programs for people with mental illness who are not eligible for the NDIS;
- Increase funding for the CLS-HASI program to improve outcomes for people with psychosocial disability in NSW;
- Consider the recommendations provided by Dr Paul Fung in his report *More is not better, better is better: A blueprint for an integrated and connected primary care system that delivers better mental health and wellbeing for all;*
- Fund a trial and evaluation of the Primary Care Behavioural Health model across a range of General Practice providers in both metropolitan, regional and remote areas;
- Commit to funding new AOD treatment services in high need rural and regional areas identified in previous inquiries; and

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- Development of a state-wide needs-based planning process, in line with the recommendation of the *Parliamentary Inquiry into the Provision of Drug Rehabilitation Services in Rural, Regional and Remote NSW*. The planning process should include both residential and non-residential services and address the needs of specific population groups such as women with children.

Uniting would appreciate the opportunity to meet with the Committee to discuss the services we provide, our expertise in mental health, and our recommendations for the inquiry. If we can assist the Committee, please contact Clark Cooley, Government Relations, to discuss possible meeting dates.
Yours sincerely,

Chantal Nagib
Head of Uniting Recovery

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

Uniting welcomes the opportunity to contribute to the work of the Committee, and welcome the opportunity to contribute to reforms in mental health care in NSW. This submission is informed by our experiences as a provider of supports for people with mental illness across NSW.

National Disability Insurance Scheme

In addition to our Recovery services, Uniting also provides supports to NDIS participants through our Local Area Coordination and Support Coordination services. As such, we have a unique perspective on the experiences of people with psychosocial disability interacting with the NDIS.

We note that the interim report from the NDIS Review found that the scheme does not adequately support the needs of people with psychosocial disability.[i] We agree with this finding. While the premise of the NDIS is to provide support for permanent and untreatable disability, the purpose of mental health support is broadly to provide treatment which leads to improved functioning. There is a fundamental incompatibility between the objectives of the NDIS and the purpose of mental health recovery services.

We believe that people with psychosocial disability should be supported through enhanced and accessible community mental health services. Currently, people with psychosocial disability who are unable to access the NDIS are dependent upon an under-resourced community mental health system which fails to meet their needs. As of September 2022, there were 58,122 participants on the NDIS who identify their primary disability as being psychosocial, making it the third most common disability for NDIS participants.[ii] Comparatively, the 2018 Survey of Disability, Ageing and Carers estimated that 1.1 million Australians had a psychosocial disability, a rate which is continuing to rise.[iii]

The gap between the estimated prevalence of psychosocial disability in the community and number of participants accessing funding for psychosocial disability through the NDIS, indicates the need for services and supports outside of the scheme. We do not believe that this is currently being met by the mental health system. We believe that there has been inadequate support for both primary and acute mental health care, creating a crisis for people with psychosocial disability who are not accessing supports through the NDIS. We strongly encourage that NSW government to invest in mental health services to ensure that the NDIS is not the only option for people with psychosocial disability. We believe that doing so will reduce the burden on the scheme and improve outcomes for all people with psychosocial disability, not just those who are current participants. We have provided recommendations for how this can be achieved through this paper.

MyAgedCare

The interaction between the NDIS and MyAgedCare is poor with participants who age out of the scheme struggling to access services and supports. This is a cohort which is at risk of falling between service systems and faces multiple barriers to care.

As NDIS participants age, there is an urgent need to consider the assistance available to enable older participants to transition safety from the scheme to alternative supports including MyAgedCare.

Pre-NDIS services

As a provider, we have seen the impact of the defunding of community based mental health services following the introduction of the NDIS.

Prior to the introduction of the NDIS, the Personal Helpers and Mentors Program (PHAMS), Partners in Recovery (PIR) and Day to Day Living (DTDL) programs provided support for people with mental illness within the community. These three programs each ceased on 30 June 2019, to coincide with the anticipated full operation of the NDIS. The funding for these three programs was transferred to the NDIS in anticipation that the people supported by these programs would be eligible for NDIS supports.

As previously demonstrated, the significant gap between the number of people living with psychosocial disability who are receiving NDIS supports and those who are not, indicates that there is an unmet need within the community. It is evident that not all people requiring support for complex mental illness are receiving support through the scheme.

These programs had demonstrated success in supporting participants with mental illness to build capacity, participate in the community and contribute to their recovery. For example, an evaluation of the South Eastern Sydney Partners in Recovery (SESPIR) program completed by the Social Policy Research Centre in 2016 found that the program strengthened the support provided by community mental health and non-government organisations, improved individual outcomes for participants and provided a culturally safe service to both First Nations and culturally and linguistically diverse communities.[iv]

The cost of delivering supports through the PHAMS, PIR and DTDL programs is significantly lower than through individual NDIS plans. The 2022 National Psychosocial Support Program Final Report found the following (inflated to 2019 dollars):

- The average cost per participant in the PHAMS program was $7,208 which allowed a participant to develop and Individual Recovery Plan and receive supports from a personal helper/mentor.
- The cost of the PIR program for a consumer per year (set-up and ongoing) was estimated to be $15,755 and the ongoing cost per year was estimated to be $13,434. This allowed a participant to receive wrap-around support for people with complex needs, their friends, families and other support people.
- The average cost per client in the DTDL program was $2,421 which allowed a participant to access 100 hours of low or medium level support.

Comparatively, the current average NDIS psychosocial disability support package is $77,000.

The NDIS Review noted that “supports for people who aren’t eligible for the NIDS, such as Home and Community Care programs and psychosocial support services, are provided insufficiently and inconsistently across jurisdictions”.[v] We agree with this finding and believe that this inquiry represents an opportunity to review and enhance the supports for people experiencing mental illness in NSW who are not eligible for the NDIS.

Recommendation

- That the NSW Government adopt and implement the models of support provided by the Personal Helpers and Mentors Program (PHAMS), Partners in Recovery (PIR) and Day to Day Living (DTDL) programs for people with mental illness who are not eligible for the NDIS.

Community Living Supports and Housing and Accommodation Support Initiative

Uniting supports the continuation of the Community Living Supports (CLS) program and Accommodation Support Initiative (HASI).

We note that the evaluation of the programs in 2022 by the Social Policy Research Centre (SPRC Review) found that the program is working effectively to support people with severe mental illness, including reducing improved wellbeing and social inclusion, reduced hospital admission and contact with community mental health services.[vi] The review also found that the programs are generating more in cost offsets than the cost of the programs, with a net cost saving per person of about $86,000 over 5 years.

The CLS and HASI programs play a significant role in supporting people with complex mental illness to live and participate in the community. The person-centred approach allows each participant to receive the supports they require and work towards their recovery goals. The program represents a critical resource for people with psychosocial disability who are not eligible or who do not wish to apply for the NDIS. Should the NDIS seek to tighten eligibility for people with psychosocial disability (as foreshadowed by the NDIS Review), this program will become even more essential.

The SPRC Review found that the CLS and HASI programs supported 5,533 consumers in the study period from 2015 to 2019 with approximately 150 participants entering the program each month.[vii] We believe that additional funding should be provided to expand the reach of the CLS-HASI program and ensure that those most at risk have access to individualised, evidence-based recovery supports.

We strongly encourage the NSW Government to implement the recommendations of the SPRC Review including the facilitators of good practice to enhance the delivery of the CLS-HASI programs. We believe that this will allow the programs to continue to deliver best-practice support and improve outcomes for people with complex mental illness.

Recommendation

- That the NSW Government action the recommendations of the SPRC Review of the CLS-HASI programs.
- That the NSW Government increase funding for the CLS-HASI programs to improve outcomes for people with psychosocial disability in NSW.

Equitable access to mental health services through integration with General Practice

Primary healthcare providers (GPs) are a key resource in recognising and responding to the needs of people experiencing poor mental health, yet the integration between primary healthcare and mental health systems remains ineffective.

We believe that the NSW Government must adopt an integrated model of care which provides consistent and effective support for people experiencing mental illness. We have drawn this analysis from the findings and recommendations of Dr Paul Fung (Clinical Director of Uniting Recovery, Uniting) who undertook a Churchill Fellowship to consider improved interaction between primary and mental healthcare systems.

Australia has a health system that predominantly manages mental health and physical health separately and does not adequately acknowledge the connection between them. The Commonwealth's "Better Access Initiative" is a referral-based system that results in two main problems:

- Lack of holistic mind-body care - Mental illness is fundamentally a chronic disease which often appears alongside other chronic conditions and/or substance use disorders. 11% of the population have both a chronic physical condition and a mental health condition. People who experience comorbidities (two or more chronic diseases) experience higher levels of functional impairment, are more likely to have a disability, bodily pain, fair or poor health and high or very high psychological distress. This separation does not allow for holistic care which brings together psycho-social care, physical and mental healthcare.
- Inequitable access – for those that are unable to pay the high gap fees, wait for 3-6 months on a waiting list, and those who are ambivalent about receiving mental health care, they simply do not benefit from Better Access. Referred to as the "missing middle", they are not suitable for private mental health services and not suitable for the State-funded Community Mental Health Teams that only treat the most severe and acute patients. This cohort of people are dependent upon General Practice which has become a "de facto mental health system" for a wide range of patients across all levels of acuity and need, without the support to assist those most at need. This is an issue of health equity as those in the "missing middle" are over represented by First Nations, CALD, older persons and people living in rural and remote and low SES areas.

The existing Commonwealth Government initiatives which are delivered through Primary Health Networks also experience long waitlists, high demand and tight eligibility criteria. They are also poorly integrated with existing primary healthcare systems (e.g. General Practice). As such, they continue the separation between the treatment of mental health and other health conditions, failing to recognise the interaction between the two.

We need a system which better integrates mental healthcare with General Practice, allowing people with mental illness to receive the supports they require through their primary healthcare provider.

The paper developed by Dr Fung outlines several potential options including the Primary Care Behavioural Health model which directly integrates mental health, alcohol and other drugs care with general practice.

Case study

Uniting is piloting the PCBH model in Hornsby GP Unit, a general practice attached to

Hornsby and Ku Ring Gai Hospital.

The Behavioural Health Consultant (BHC), who has been given the title of "Wellbeing Clinician" is not merely co-located with the general practice, but is embedded within the general practice. The role of the BHC is to be an extension and support to the GP and practice team. They provide both structured support (through scheduled appointments) and responsive work, joining in appointments with GPs when invited and allowing patients to be seen immediately. This allows patients to be seen on the same day they attend their General Practice. In our preliminary evaluation, this enhanced access has resulted in a high percentage of First Nations, unemployed and older persons receiving mental health care. With the BHC sharing the same medical record system as the practice, care plans are developed together by the team of the GP, Practice Nurse and BHC therefore able to deliver comprehensive, holistic care. The BHC also collects and develops resources for the team to use with patients. This contrasts with private therapists that may be co-located with a general practice, but usually work autonomously.

We would be happy to brief the Inquiry on the work we are completing with the PCHB model in Hornsby GP Unit.

Recommendations

- That the NSW Government consider the recommendations provided by Dr Paul Fung in his report *More is not better, better is better: A blueprint for an integrated and connected primary care system that delivers better mental health and wellbeing for all*
- That the NSW Government fund a trial and evaluation of the Primary Care Behavioural Health model across a range of General Practice providers in both metropolitan, regional and remote areas

Alcohol and other drug supports

Uniting believes that drug policy should be evidence-based, fair, compassionate and treat all people with dignity and respect. We believe that using a health and welfare approach to drug use results in improved social and financial outcomes. Every $1 spent on treatment is returned as $7 in savings to the wider community.

Research shows that there are a range of positive outcomes from alcohol and other drug (AOD) treatment including:

- reduced use of alcohol and other drugs
- improved health and psychological wellbeing
- reduced instances of child abuse and neglect and removal of children
- reduced crime rates and imprisonment
- improved employment outcomes.[viii]

Every year more than 200,000 Australians are unable to access AOD treatment because there are not enough services available.[ix] Modelling conducted for the Network of Alcohol and Other Drug Agencies estimates that we need approximately double the existing number of residential rehabilitation and detoxification beds to meet the level of need in NSW.[x] There are similar gaps in availability of non-residential options such as community-based day treatment.

We note that access to services is particularly challenging for people living in regional and remote communities. As the 2018 *Parliamentary Inquiry into the Provision of Drug Rehabilitation Services in Rural, Regional and Remote NSW* found, there is a chronic shortage of detoxification and rehabilitation services in regional and rural areas.[xi]

Long travel distances to access treatment may also be a barrier to treatment – for example, the nearest rehabilitation service in Broken Hill is well over 300 kilometres.[xii]

Recommendations

- That the NSW Government commit to funding new AOD treatment services in high need rural and regional areas identified in previous inquiries; and
- That the NSW Government develop of a state-wide needs-based planning process, in line with the recommendation of the P*arliamentary Inquiry into the Provision of Drug Rehabilitation Services in Rural, Regional and Remote NSW*. The planning process should include both residential and non-residential services and address the needs of specific population groups such as women with children.

Conclusion

Thank you for the opportunity to contribute to the work of the Committee. We encourage the Committee to consider the recommendations we have provided and are willing to assist with any future consultation.

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[i] NDIS Review, 2023, 'What we have heard' https://www.ndisreview.gov.au/sites/default/files/resource/download/what-we-have-heard-report.pdf

[ii] National Disability Insurance Agency, Psychosocial disability summary, September 2022, https://data.ndis.gov.au/media/3567/download?attachment#:~:text=people%20has%20increased%20from%203%2C863,%2C%20an%20increase%20of%2017%25.&text=%E2%80%9C%20I%20love%20the%20fact%20I,while%20they%20are%20helping%20me.%E2%80%9D

[iii] Australian Bureau of Statistics, Disability, Ageing and Carers, Australia: Summary of Findings 2018, September 2020, https://www.abs.gov.au/articles/psychosocial-disability

[iv] Social Policy Research Centre, 2016, 'Partners in recovery evaluation', https://www.arts.unsw.edu.au/sites/default/files/documents/PIR_Evaluation_final_report.pdf

[v] NDIS Review, 2023, 'What we have heard' https://www.ndisreview.gov.au/sites/default/files/resource/download/what-we-have-heard-report.pdf

[vi] Social Policy Research Centre, 2022, 'Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative',

https://www.health.nsw.gov.au/mentalhealth/resources/Pages/cls-hasi-eval-rpt.aspx
[vii] Social Policy Research Centre, 2022, 'Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative', https://www.health.nsw.gov.au/mentalhealth/resources/Pages/cls-hasi-eval-rpt.aspx
[viii] Ettner, S., Denmead, G., Dilonardo, J., Cao, H., & Belanger, A., 2003, 'The impact of managed care on the substance abuse treatment patterns and outcomes of Medicaid beneficiaries: Maryland's HealthChoice program', *Journal of Behavioral Health Services and Research*, 30(1), 41-62.
[ix] Ritter, A. et al., 2014, *New Horizons: the review of alcohol and other drug treatment services in Australia, Drug Policy Modelling Program*, National Drug and Alcohol Research Centre, NSW.
[x] NADA, 2019, *Submission to the NSW Health Minister and NSW Ministry of Health for the provision of additional residential rehabilitation and withdrawal management beds in NSW*, https://www.nada.org.au/wp-content/uploads/2019/03/NADA-Submission_-NSW-AOD-Beds_120319.pdf
[xi] NSW Parliament, Legislative Council, 2018, *Provision of drug rehabilitation services in regional, rural and remote New South Wales*.
[xii] Ibid.