Suicide Prevention Australia

SEPTEMBER 2023

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

Submission

Introduction

Suicide Prevention Australia welcomes the opportunity to provide input to the Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.

Suicide Prevention Australia is the national peak body for the suicide prevention sector. We have over 400 members representing more than 140,000 employees, workers, and volunteers across Australia. We provide a collective voice for service providers, practitioners, researchers, local collaboratives, and people with lived experience.

Over 3,000 people tragically die by suicide and an estimated 65,000 people attempt suicide each year. Over 7.5 million Australians have been close to someone who has taken or attempt suicide. Our shared vision is a world without suicide and with our members, we work to inform through data and evidence; influence systemic changes that drive down suicide rates and build capability and capacity for suicide prevention.

In 2021, 880 Australians living in NSW lost their life to suicide (10.6 per 100,000 population). [1] The suicide rate in NSW has not fallen below the current rate in a decade. [2] Of the total NSW population, 16.7% live with high or very high psychological distress, and 7% experience a severe mental health condition. [3] It is estimated that the number of people living with a mental health condition in NSW will increase to 1.96 million by 2041. [4]

While NSW Government invested $2.9 billion into mental health in the 2022-23 Budget, the state has one of the lowest per capita spends in Australia to support people with mental health conditions. [5] Government investment has targeted acute psychiatric facilities and hospital settings and overlooked investment into community-managed mental health services which could alleviate distress and prevent people from reaching crisis. [6]

We consulted with people with lived experience and our members to inform our submission. Our submission will respond to the following Terms of Reference:

(a) equity of access to outpatient mental health services

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

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

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

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

(g) benefits and risks of online and telehealth services

(h) accessibility and cultural safety of mental health services for First Nations people, culturally and linguistically diverse (CALD), LGBTQIA+ people, young people, and people with disability

(i) alternatives to police for emergency responses to people experiencing acute mental distress, psychosis, delirium, dementia or intoxication in the community, including but not limited to Police, Ambulance, Clinical, Early, Response (PACER)

Summary of Recommendations

1. NSW Government to increase investment into outpatient community mental health services to better support affordability of mental ill-health treatment in the community, better resource existing services to respond to demand, and increase out-of-hours support services to address accessibility barriers.

2. NSW Department of Health to 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.

3. NSW Government to designate 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.

4. NSW Government to invest in a state-wide dedicated Community Mental Health Navigation Support Service staffed with allied health and peer workers who are equipped to help people navigate mental health and/or suicidality support services, and other relevant systems including social services, child protection and family court services, housing services, and unemployment services in the community.

5. NSW Department of Health to invest in promotion of pathways to community mental health care in publicly accessible spaces, including spaces where diverse population groups are likely to visit, and engage community leaders in diverse population groups to lead communications.

6. NSW Department of Health to develop CMHS navigation support resources available by scanning QR codes to address stigma and shame experienced by people in need of support and encourage help-seeking behaviour. QR codes with key messaging should be available in common public spaces such as shopping centres, libraries, and sporting clubs. Two types of messaging should be provided beside QR codes for consumers and carers with tailored information.

7. NSW Government to invest in outreach capacity of general practitioners to follow up community mental health treatment when discharge summaries are received from hospitals. Responsibility of follow up initiated by nominated GPs within seven days of discharge should be reflected in NSW discharge protocols.

8. NSW Government to invest in suicide prevention and intervention training tailored to carers, that is delivered free of charge, and available via multiple modes of delivery to address the accessibility barriers carers face.

9. NSW Government to enhance investment into Carer Gateway and promote the service to enhance accessibility and awareness among carers.

10. NSW Government to invest in CMHS to provide assertive outreach to ensure people in distress are supported in the community.

11. NSW Government to target mentorship programs and fund community champion positions to regional, rural, and remote communities to enhance capacity of communities to support people in the absence of specialist services.

12. NSW Government to mandate funding contracts for mental health and suicide prevention services to 5-year funding cycles to increase recruitment, retention, evaluation of service, and provide continuity of care for patients.

13. NSW Government to undertake a needs assessment of CMHS in regional, rural, and remote areas to identify key stakeholders delivering suicide prevention (including local community leaders and organisations) and identify where funding should be invested to support capacity and growth.

14. NSW Government to invest in wellbeing support for CMHS workers, including through the provision of vicarious trauma education, trauma-informed care, and tailored wellbeing support programs for workers.

15. NSW Government to invest in creating salary supported dedicated positions for lived experience in CMHS to guide best practice service delivery.

16. NSW Government to invest in workforce development to address current and future shortages and foster career pathways.

17. NSW Government to provide support and resources for the Lived Experience (Peer) workforce and create employment pathways, workforce readiness and industrial protections.

18. NSW Department of Health to recognise ‘Peer Worker’ position titles in salary awards to employ lived experience peer workers and address inconsistency in use of position titles across LHDs.

19. NSW Department of Health to provide all mental health professionals (including psychiatrists and mental health nurses) with education and training to better understand human rights of people living with mental health conditions, their obligations under the United Nations Convention on the Rights of Persons with Disabilities, as well as about how alternatives to CTOs could be supported through integrated community wrap-around services and care planning.

Summary of Recommendations

20. NSW Health to ensure telehealth and online service providers are delivering high quality and safe treatment to communities by embedding accreditation standards in commissioning processes.

21. NSW Health to increase number of available language interpreters (including Auslan) in CMHS and ensure they are provided with training in culturally sensitive and trauma-informed care.

22. CMHS to engage First Nations, culturally and linguistically diverse, and LGBTQIA+ community leaders to lead knowledge sharing and navigation support of CMHS in their own communities.

23. NSW Health to invest in compulsory training in cultural competence and skills for safe practice across the mental health, suicide prevention, and disability service systems (including NDIS). Training should be available for public and community-based workers, including the CMO sector, and nurses. Ideally training should be delivered for workers across different service settings, be peer-led by people with lived experience of diverse population groups, so that they can learn from each other.

24. NSW Government to expand and appropriately resource specialist mental health clinicians in both police districts and within ambulance call out teams across all LHDs in NSW to ensure equity and build prevention capability.

25. NSW Health to ensure standard and consistent mental health and suicide training is provided to all emergency first responders in NSW.

26. NSW Government to ensure establishment of Safe Havens in every LHD in NSW to provide safe spaces for people experiencing suicidal distress.

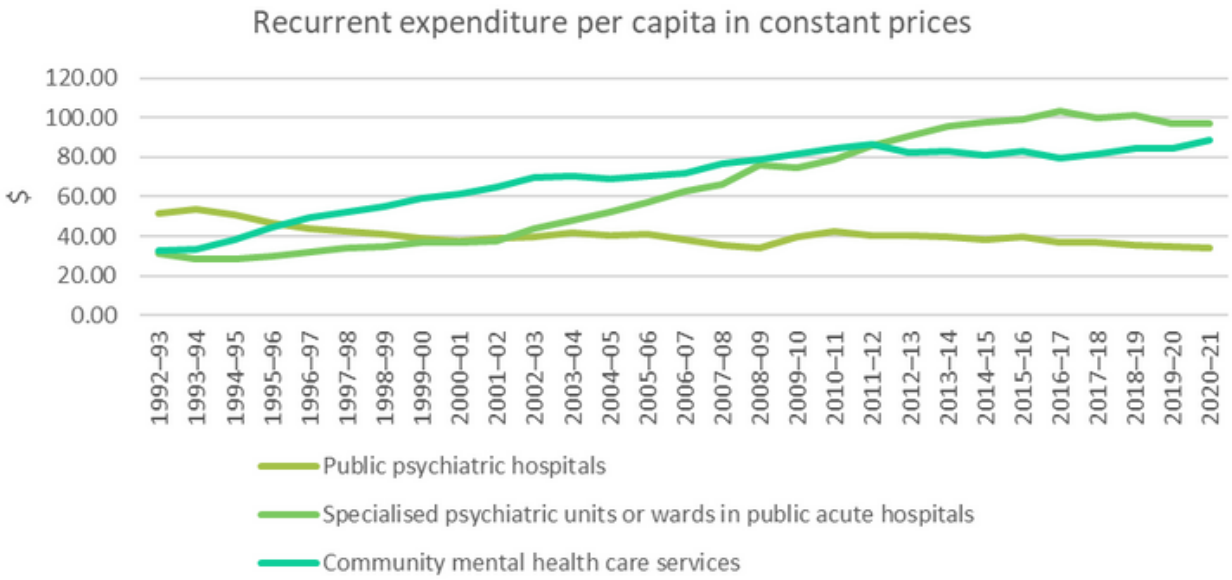
(a) Equity of access

There are over 8 million people living in NSW, and almost 17% are experiencing high or very high psychological distress. [7] In 2020-21, there were 17.9 (per 100,000 population) community mental health service patients in NSW, averaging 23.2 service contacts per patient. [8] NSW reported the highest number of treatment days in community mental health services across all jurisdictions for the period 2020-21 with almost 2.5 million treatment days. [9]

Hospitalisation for specialised psychiatric care in 2020-21 experienced 34,645 overnight stays in NSW public acute hospitals. [10] There were 105 (per 10,000) presentations for mental health to emergency over 2021-22 in NSW, and the highest primary mental health diagnosis nationally was neurotic, stress-related and somatoform disorders. [11]

Over time, NSW investment into mental health has steadily increased its focus on specialised psychiatric care in hospitals without similar investment into community mental health services. In 2019-20, NSW spent more on specialised psychiatric units in acute public facilities than the national average per capita and had the lowest per capita expenditure on community mental health services. [12]

Investment in hospital-based mental health care responds to a person's needs at the crisis point, instead of preventing the person from reaching crisis.



Data Source: Australian Institute of Health and Welfare, Expenditure on mental health-related services 2023

The rate of people who have readmitted to hospital after a period of mental health treatment within 28 days of discharge from a psychiatric hospital or psychiatric unit in a hospital has continued to increase in recent years in NSW from 14.7 (2018-19) to 15.3 (2020-21). [13] Readmission of First Nations people remains the highest rate (18.6%) compared to non-Indigenous people (14.8%) in 2020-21. [14] The Mental Health Commission of NSW attributes high readmission rates to a lack of follow-up support, inadequate community care or ineffective treatment during hospital admission. [15]

Continuity of care has been evidenced to reduce hospital readmission. NSW Health's Lumos program found those who visited a GP in the first few days post discharge from hospital were less likely to need to return to hospital. [16] Program data demonstrated patients at high-connectivity practices were 10% less likely to present to an emergency department and a 12% less chance of experiencing an unplanned hospitalisation. [17] Results from a study into hospital discharge and the relationship with GPs in Central and Eastern Sydney region found seeing a GP within 2 weeks of discharge was associated with lower rates of rehospitalisation for infrequent GP users. [18]

In consultation with our NSW members and people with lived experience, the following key barriers to accessing outpatient mental health services were identified:

Lack of affordability

The costs of services are a significant barrier to access indicating access to community mental health services is not equitable. Recent evaluation into the Better Access Scheme found overall, affordability was a key barrier to access, with poorer access to treatment associated with exacerbated increases in out-of-pocket costs. [19] When a person has complex or coexisting conditions, multiple specialists are required in treatment care plans which require high financial costs that either add additional distress to the person or prevent them from accessing support altogether.

Limited availability

There are long wait times to access psychological support and specialists, and limited practitioners are available or taking new clients. According to latest data released by the Australian Psychological Society, 1 in 3 psychologists in Australia are unable to take new clients, and 65% reported worsening wait times averaging 55 days. [20] Support services are typically only available during regular working hours (i.e., Monday to Friday between 9am and 5pm), this presents a significant barrier for people wishing to access support but who also work during regular working hours. Limited after-hours support is available for people with mental ill-health or suicidality. NSW data has found that accessing out-of-hours care was more challenging for NSW adults with a mental health issue than those without. [21]

Lack of compassionate care

Not all community mental health services adopt a trauma-informed approach to care delivery which can result in additional distress and/or trauma preventing help-seeking behaviour. Often people with mental ill-health or coexisting conditions need to visit multiple practitioners which requires them to retell their experiences which can result in re-traumatisation, this can also occur if a person has had a previous negative experience with a service. A holistic approach to treatment is required that values people with mental ill-health beyond their symptoms and addresses the social determinants of health that can increase distress.

Recommendations

1. NSW Government to increase investment into outpatient community mental health services to better support affordability of mental ill-health treatment in the community, better resource existing services to respond to demand, and increase out-of-hours support services to address accessibility barriers.

2. NSW Department of Health to 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.

3. NSW Government to designate 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.

b) Service Navigation

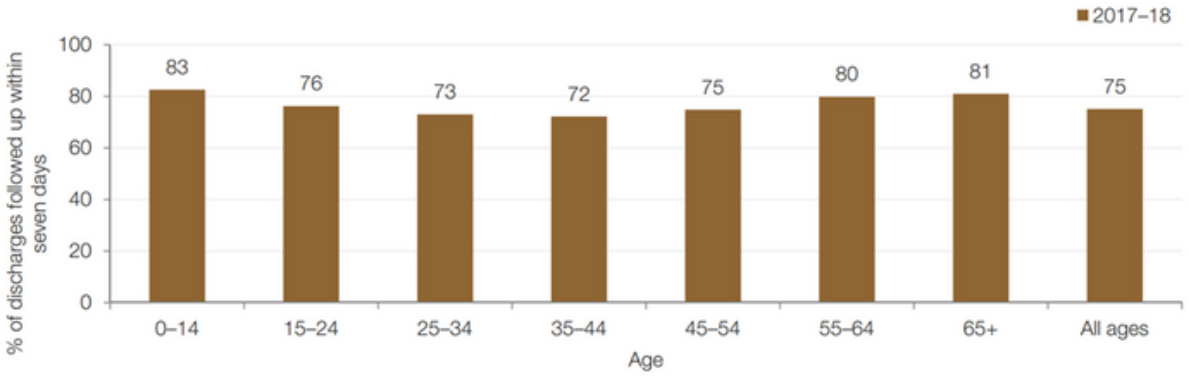
"When you're in crisis yourself and caring for someone in crisis, you don't know what the options are or what support looks like. You just know that you and your family are drowning." – Carer at MHCN Consultation

Navigating community mental health services can be challenging, retraumatising, and particularly difficult if you are already experiencing distress, have a disability or a chronic enduring mental illness. Our members identified the following concerns in attempting to navigate community mental health care services:

- Often complex and coexisting conditions require multiple specialists which can be difficult to navigate.
- People are not always provided with a clear treatment path in the community, including when discharged from hospital, and families or carers are not always provided with the information needed to help the person coordinate their care in the community.
- People are required to re-tell their experiences which can be traumatising or trigger distress.
- Previous histories of negative experiences with service providers or accessing mental health care can prevent help-seeking behaviour.
- Lack of continuity of care can negatively impact help-seeking behaviour.
- There are challenges in finding the right service provider to meet needs, often people have to go through multiple referral pathways to locate the right support.

Contact by a community mental health service following hospital discharge for mental ill-health concerns in NSW is not consistent across the state. Data shows 72% of people aged 35-44 years are contacted within seven days following discharge from an acute mental health inpatient unit, and 73% of people aged 25-34 years for the period 2017-18. [22] This means that more than a quarter of people are discharged from an acute mental health inpatient unit without clear treatment pathway information in the community for both age groups, and just under a quarter of young people aged 15-24 years.

Figure 18 **Percentage of discharges from a specialised acute mental health inpatient unit contacted by community mental health services within seven days of discharge, by age, NSW, 2017–18**



Notes: This performance measure was calculated by the NSW Ministry of Health.
Source: NSW Ministry of Health, System Information and Analytics Branch, InforMH.

Data Source: Bureau of Health Information, Healthcare in Focus 2019

Failing to provide discharge summaries to people and/or families in NSW means clinicians are not meeting their responsibilities outlined in the NSW Health Patient Discharge Documentation Guideline (GL2022_005). [23] According to this policy directive, all nominated general practitioners are to be provided with copies of discharge summaries. GPs are well-placed to follow up continuing treatment in the community, and GP connectivity has demonstrated effectiveness in preventing readmission. [24]

When a person is in distress, this adds an additional layer of difficulty in trying to navigate the mental health system. A previous suicide attempt is the strongest risk factor for a subsequent suicide death and the risk for suicide after an attempt is significantly elevated comparted to the general population. [25] Between 15% and 25% of people who make a suicide attempt will make an additional suicide attempt, with the risk highest in the three-month period following a suicide attempt. [26] Transition from hospital to community treatment is a critical time for support to continue.

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 the closest support to people who have attempted suicide and who are in immediate risk of suicide, and as such it is critical suicide prevention to ensure carers are supported in their caring roles to not only continue to support their relatives and friends, but to help manage the impact of caring for someone experiencing suicidal behaviours has 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 and help them know when to get help for the person they care for or themselves. 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. [27]

Recommendations

4. NSW Government to invest in a state-wide dedicated Community Mental Health Navigation Support Service staffed with allied health and peer workers who are equipped to help people navigate mental health and/or suicidality support services, and other relevant systems including social services, child protection and family court services, housing services, and unemployment services in the community.

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9. NSW Government to enhance investment into Carer Gateway and promote the service to enhance accessibility and awareness among carers.

c) Capacity of CMHS in regional, rural, and remote areas

Approximately 28% of the Australian population live in rural and remote areas. Capacity of community mental health services in regional, rural and remote areas is limited, and at times non-existent. Our members reported community mental health services in regional, rural and remote areas frequently cover extreme distances e.g. up to 200-300kms which makes it severely challenging to ensure people in crisis or distress receive timely support in the community.

The Bureau of Health Information surveyed almost 22,000 people in NSW on their experiences of care in NSW emergency departments for the period 2021-22. Just over half of survey respondents (n=11,039) who attended emergency departments in one of 41 large rural public hospitals were less likely to be provided with a discharge summary (43%) when compared to patients from urban public hospitals (74%). [28] Only one in four patients received a discharge summary in rural hospitals at Young, Deniliquin or Murwillumbah. [29]

Suicide Prevention Australia's annual survey capturing the state of the country's suicide prevention sector found 88% of respondents reported increased demand for services in the past 12 months, and 76% reported they require increased funding to meet the increased demand. [30]

Often 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 patient 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.

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 5 year contracts. This 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. [31]

Our members identified the following concerns experienced by CMHS in regional, rural and remote areas:

- ·The time to reach a person in distress in a regional, rural, or remote area can be significantly long, with some sector workers reporting it could take up to 3-8 hours.
- ·There is limited availability of peer workers, CMHS, and alternatives to emergency departments in regional, rural, and remote areas resulting in a lack of choice of service. Of the services that are available, complex eligibility criteria can make them hard to access and can vary in their definition of moderate or medium support needs which adds confusion for people attempting to access mental health support in the community.
- ·CMHS face recruitment and retention challenges for skilled staff due to limited funding, short contracts, and lack of incentives to live in regional, rural and remote areas. One member reported a challenge faced by schools in regional, rural and remote schools in recruiting school psychologists or wellbeing officers. While the positions exist, they can't fill them.

- ·Tenders are typically awarded to large scale organisations who may have better capacity to complete tenders, but who aren't necessarily connected to the community or have previously been undertaking suicide prevention in the community.
- ·Locals in regional, rural, and remote areas understand the community best, and have access to people in the community experiencing distress. Community champions or leaders should be empowered and supported by paid roles to continue providing suicide prevention to their communities.
- ·Assertive outreach by CMHS is needed to ensure people at-risk of suicide are followed up in the community with treatment care plans. Additional investment in resourcing is required to equip CMHS to be able to deliver assertive outreach services.

Our members further reported under-investment and under-resourcing of CMHS may play a significant role in compassion fatigue and high-turn over of staff in CMHS which impacts the quality of service delivery. Burn out experienced by workers can have unintended consequences such as labelling patients as 'too hard to engage', lack of trauma informed care provided, and lack of culturally appropriate practice.

CMHS workers need to be supported both by increased investment to meet demand and increase capacity, and through investment in the wellbeing of CMHS workers. Types of support provided to CMHS workers should include providing vicarious trauma education, regular debriefing and supervision, and connection to wellbeing supports. A wellbeing approach to culture change in CMHS should be led by people in leadership positions, and include training delivered by people with lived experience from diverse population groups of how to work with populations at-risk of suicide. Integration of people with lived experience in leadership positions in CMHS is needed to guide service delivery and ensure safe, culturally appropriate, and trauma-informed care of patients.

Recommendations

10. NSW Government to invest in CMHS to provide assertive outreach to ensure people in distress are supported in the community.

11. NSW Government to target mentorship programs and fund community champion positions to regional, rural, and remote communities to enhance capacity of communities to support people in the absence of specialist services.

12. NSW Government to mandate funding contracts for mental health and suicide prevention services to 5-year funding cycles to increase recruitment, retention, evaluation of service, and provide continuity of care for patients.

13. NSW Government to undertake a needs assessment of CMHS in regional, rural, and remote areas to identify key stakeholders delivering suicide prevention (including local community leaders and organisations) and identify where funding should be invested to support capacity and growth.

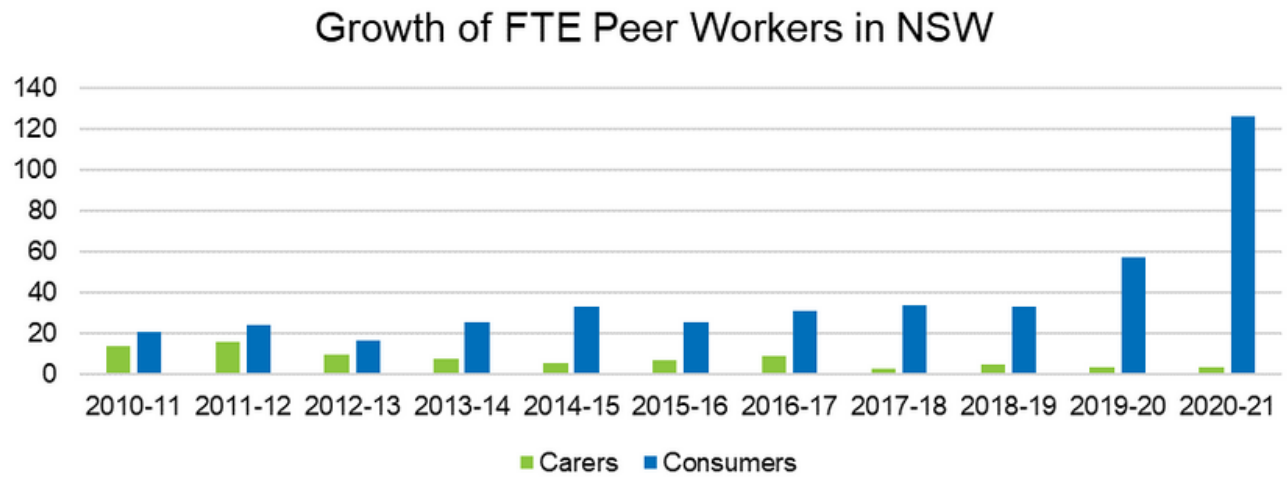
14. NSW Government to invest in wellbeing support for CMHS workers, including through the provision of vicarious trauma education, trauma-informed care, and tailored wellbeing support programs for workers.

15. NSW Government to invest in creating salary supported dedicated positions for lived experience in CMHS to guide best practice service delivery.

(e) Resourcing the mental health and suicide prevention workforce

The suicide prevention workforce includes the clinical workforce who interact with those at risk of suicide (e.g. medical professionals), the formal suicide prevention and mental health workforce (e.g. working in suicide prevention, crisis support and postvention) and the informal suicide prevention workforce (e.g. those working with individuals who might be vulnerable to suicide).

In 2021, peer workers were reported to make up 14% of the community mental health sector. [32] While the number of consumer peer workers in NSW has continued to grow over the past decade, the number of carer peer workers has declined. [33]



Data Source: Australian Institute of Health and Welfare, Mental Health Workforce

Our members reported experiences of being employed by NSW Health in peer worker positions that required them to change their position title to 'Health Education Officer' to receive payment against the salary award. Erasing peer worker titles devalues the lived experience workforce, and lived experience leadership. The sector reports 'Peer Worker' position titles vary across LHDs and should be standardised to value lived experience peer workers.

To fully embed lived experience leadership, knowledge and insights across suicide prevention, further planning and investment in workforce development will be required. This will ensure we can both grow the lived experience and peer workforce and put in place supporting structures to sustain and support that workforce. This could include sustained investment in peer networks, workforce development, professional development bursaries, and suicide-prevention specific lived experienced resources.

NSW holds the largest population in Australia. However, in 2020-21 there were 43.1 full-time-equivalent (FTE) health care providers per 100,000 population working in CMHS in NSW, which is lower than the national average of 50.8 per 100,000 population. [34] NSW FTE health care providers working in hospital admitted patient services however, were higher than the national average with 62.3 per 100,000 in NSW, and 58.0 per 100,000 nationally. [35]

Research undertaken by the Mental Health Coordinating Council reported one quarter (26.7%) of the entire mental health workforce in NSW works at a community managed organisation (CMO), and just under half (48%) of all CMO workers are employed on a temporary contract or casual (hourly rate of pay) basis. [36] More than half of the mental health CMO workforce is employed on a part-time basis (54%) compared to the total Australian workforce (32%). [37]

Recommendations

16. NSW Government to invest in workforce development to address current and future shortages and foster career pathways.

17. NSW Government to provide support and resources for the Lived Experience (Peer) workforce and create employment pathways, workforce readiness and industrial protections.

18. NSW Department of Health to recognise 'Peer Worker' position titles in salary awards to employ lived experience peer workers and address inconsistency in use of position titles across LHDs.

f) Community Treatment Orders in NSW

The use of Community Treatment Orders (CTOs) are a form of restrictive practice and can be violation of human rights where the focus is on control rather than rehabilitation or recovery. Research found NSW to have one of the highest rates of CTOs worldwide, and 6,767 instances of CTOs were issued in a single year in 2022. [38] Rates of use of Forensic CTOs (use of CTOs in prison) in NSW have reported an annual increase of 4% since 2017-18. [39] Use of CTOs in prisons can be used as a form of coercive control to forcibly medicate prisoners as a form of punishment, effectively violating their human rights. [40]

CTOs perpetuate mental ill-health stigma and restrict autonomy of treatment on the individual. There is a lack of evidence on the effectiveness of CTOs and a lack of clear understanding of their purpose. [41] It is currently unclear whether involuntary medication management provided through CTOs produce better outcomes as opposed to if supports were provided on a voluntary basis.

Consultation with people with lived experience identified the following concerns:

- CTOs assume medication is the only solution to treatment and a lack of education, therapy and holistic supports (e.g. physiotherapy, dieticians) are provided in involuntary treatment plans.
- CTOs do not seek to address the severe side effects that some medication can cause the individual in treatment plans.
- There is a lack of planning or focus for the person to eventually come off the CTO, meaning some people experience traumatic withdrawal symptoms when medication stops at the end of the CTO which can impact their ability to maintain employment and increase likelihood of reoffending.
- Legal teams aren't appropriate to discuss medication and treatment plans but are often involved.
- There is a lack of information on how to end a CTO, what alternative treatment options are available, the rights of consumers and carers involved in CTOs, and how to access CMHS when under a CTO.
- Clinicians are too quick to apply CTOs, and CTOs are overused.

Alternatives to CTOs can include:

- Peer workers: Integrate employed peer workers in multidisciplinary treating teams to provide support to the person experiencing mental ill-health.
- Advance Care Directives: Utilise Advance Care Directives to respect treatment instructions made by the patient when in sound capacity to adhere to consent when the person is not of sound capacity to make decisions. Jurisdictions which consider Advance Care Directives as a legally binding document are Queensland, South Australia and the Northern Territory. [42]

Recommendations

19. NSW Department of Health to provide all mental health professionals (including psychiatrists and mental health nurses) with education and training to better understand human rights of people living with mental health conditions, their obligations under the UNCRPD, as well as about how alternatives to CTOs could be supported through integrated community wrap-around services and care planning.

(g) Benefits and risks of online and telehealth services

Our members reported minimal risks are involved with online and telehealth services, as long as the type of care provided is trauma-informed and holistic in nature. People with lived experience reported varied quality of care using online and telehealth services.

There is growing recognition of the need to ensure suicide prevention programs and services are delivered to minimum quality standards and have sustainability factored into their design. Communities need to have the assurance that Australia's suicide prevention programs provide a consistent, high quality and safe standard of care.

Embedding accreditation and standards into commissioning of programs and services in suicide prevention supports safe, high-quality and effective programs and services. Investments in suicide prevention will not be effective unless directed to programs that deliver outcomes. For this reason Suicide Prevention Australia partnered with people with lived experience of suicide, consumers, clinicians, service providers and accreditation experts to develop the Suicide Prevention Australia Standards for Quality Improvement, which were released in June 2020.

As outcome-oriented standards, the Standards are designed to support the suicide prevention sector and provide assurance to consumers that the suicide prevention programs developed by an organisation are safe, high-quality and effective. The Standards offer an opportunity for organisations to participate in an accreditation program that will provide consistency in delivery and quality improvement. These are bespoke, fit-for-purpose standards reflecting the unique aspects of suicide prevention.

Over 70 programs and services have achieved accreditation, including major organisations including Beyond Blue, Lifeline, Roses in the Ocean, Standby – Support After Suicide and LivingWorks, and over 160 are currently working towards accreditation.

More information about the standards can be found here: https://www.suicidepreventionaust.org/suicide-prevention-quality-improvement-program/. Accreditation standards should be embedded in commissioning processes for suicide prevention services in particular services commissioned by all levels of Government.

Digital technologies which encourage service access should be encouraged. There is however concern that online and telehealth services will become a replacement to face-to-face service delivery, and we believe that providing choice of service delivery is key to effective suicide prevention.

Recommendations

20. NSW Health to ensure telehealth and online service providers are delivering high quality and safe treatment to communities by embedding accreditation standards in commissioning processes.

(h) Accessibility and cultural safety of mental health services for population groups

People experiencing mental ill-health are a diverse population with intersecting identities such as First Nations, LGBTQIA+, people with disabilities, veterans, older people, young people, children, and culturally and linguistically diverse. In addition to being vulnerable to experiencing stigma related to mental ill-health, people also experience additional levels of stigma and discrimination due to their intersecting identities.

Intergenerational trauma, social marginalisation, dispossession, loss of cultural identity, community breakdown and the artefacts of colonialism have had a profound impact on the mental health, wellbeing and lives of First Nations peoples. Our members reported inclusive and culturally appropriate care as critical to continuity of care in the community. People from culturally and linguistically diverse backgrounds including people who are deaf and/or hard of hearing face additional challenges in accessing CMHS due to a lack of available interpreters, and language barriers in understanding health information and navigating service systems.

People with lived experience identified:

- Culturally and linguistically diverse communities are more likely to seek support from a community leader than a mental health service due to language access barriers, lack of awareness of how to navigate the system, and the stigma surrounding diverse cultural identities understanding of mental ill-health.
- Lack of understanding of LGBTQIA+ identities and prejudice attitudes by health care practitioners are harmful to treatment.
- Peer workers should be utilised in CMHS for diverse populations to assist in language translation, navigation, and support.
- Diverse population groups such as First Nations, LGBTQIA+ and culturally and linguistically diverse groups experience distrust with mental health care based on perceived or experienced stigma and discrimination.
- NDIS assessors are not appropriately trained in inclusive, culturally appropriate, and trauma-informed care.

Recommendations

21. NSW Health to increase number of available language interpreters (including Auslan) in CMHS and ensure they are provided with training in culturally sensitive and trauma-informed care.

22. CMHS to engage First Nations, culturally and linguistically diverse, and LGBTQIA+ community leaders to lead knowledge sharing and navigation support of CMHS in their own communities.

23. NSW Health to invest in compulsory training in cultural competence and skills for safe practice across the mental health, suicide prevention, and disability service systems (including NDIS). Training should be available for public and community-based workers, including the CMO sector, and nurses. Ideally training should be delivered for workers across different service settings, be peer-led by people with lived experience of diverse population groups, so that they can learn from each other.

(i) Alternatives to emergency departments

In August 2020, NSW provided $6.1M to employ 36 specialist mental health clinicians across 10 Police Area Commands and Districts to expand the Police Ambulance and Clinical Early Response (PACER) pilot program. [43]

The trial outcomes included avoidance of ED presentations, early links to community and welfare services, provision of alternative pathways to care, significant reduction in demand on agencies including Police time on scene, and reductions in ED presentations via Police and Ambulance. [44]

The Mental Health, Ambulance and Police Project (MHAPP) is another example in NSW where specialist mental health clinicians are provided during peak periods to work with ambulance and police services to support people experiencing a mental health crisis. [45] Program benefits include early access to specialist mental health assessment in the community, reduced exposure to EDs, and more timely access to services and support.

We support alternatives to emergency departments which focus on de-escalation and avoid unnecessary hospital admissions for people experiencing suicidality or mental ill-health. NSW data reported patients with mental health-related presentations are more likely to spend more than 4 hours in emergency departments than people presenting without a mental health presentation. [46] People with enduring mental health conditions are more likely to make multiple visits to emergency departments and have fewer positive experiences. [47]

Safe Spaces are emerging as an important suicide prevention alternative to Emergency Departments. Many individuals experiencing suicidal thinking currently present to Emergency Departments, yet these complex clinical environments are not the most appropriate point of care for people experience emotional distress and people with lived experience report distress can be exacerbated by this setting. [48]

Safe Spaces aim to provide an alternative and are an umbrella term referring to non-clinical, peer-led supports for people in suicidal distress and/or crisis. They are also known in some areas as safe havens or safe haven ‘cafes’. Safe spaces are ‘drop in’ style spaces that offer a non-clinical alternative to acute, clinical services for people experiencing emotional distress or suicidal crisis.

The NSW Suicide Prevention Strategic Framework 2022-2027 identifies Safe Havens as an initiative committed to within the Towards Zero Initiatives. [49] We welcome NSW Government investment for four new Safe Havens as part of the $25 million mental health and wellbeing flood recovery package announced in 2022 and encourage NSW Government to ensure Safe Havens are established in every LHD in NSW. [50]

Recommendations

24. NSW Government to expand and appropriately resource specialist mental health clinicians in both police districts and within ambulance call out teams across all LHDs in NSW to ensure equity and build prevention capability.

25. NSW Health to ensure standard and consistent mental health and suicide training is provided to all emergency first responders in NSW.

26. NSW Government to ensure establishment of Safe Havens in every LHD in NSW to provide safe spaces for people experiencing suicidal distress.

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Contact

Caitlin Bambridge
Policy & Government Relations Manager
Suicide Prevention Australia
caitlinb@suicidepreventionaust.org

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