The NSW mental health care system on the brink: Evidence from the frontline

Report presented by:
NSW Branch of the Royal Australian New Zealand College of Psychiatrists

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Endorsed by:

the Australian College of Mental Health Nurses Inc

AMA NEW SOUTH WALES

APS Australian Psychological Society

Being Mental Health Consumers

Mental Health Carers NSW

mhcc mental health coordinating council

RACGP Royal Australian College of General Practitioners

Foreword

This report tells the story of frontline mental health workers across NSW.

The NSW Branch of RANZCP, in partnership with other peak health and mental health groups, surveyed frontline mental health workers across NSW to illuminate the mental health crisis facing NSW from the perspective of those charged with providing care.

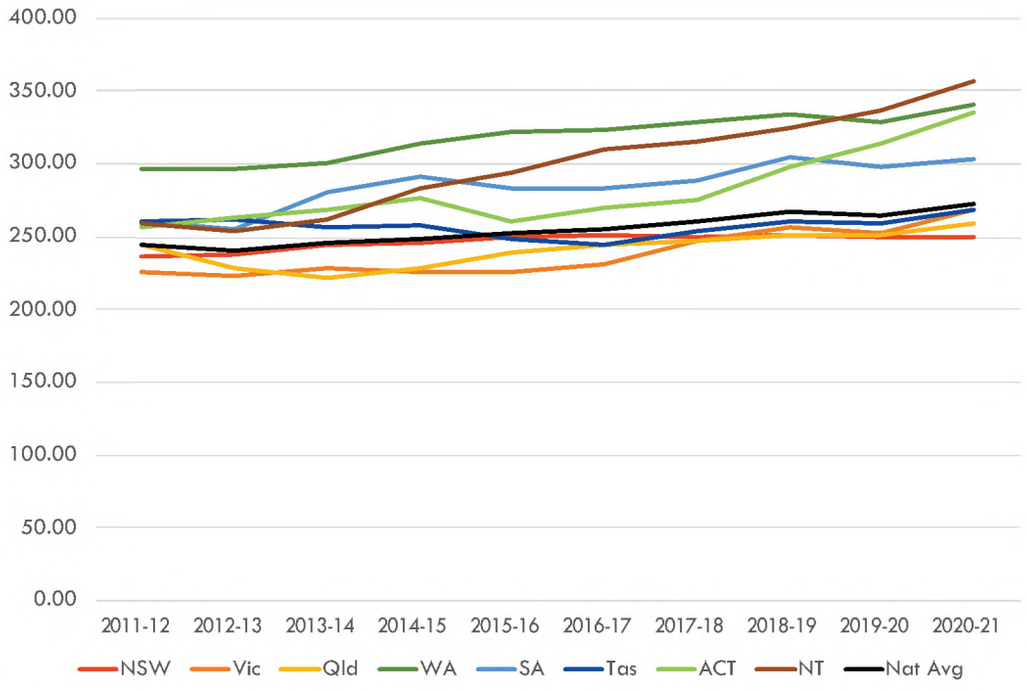
They describe a system that is too complex, inaccessible, sometimes ineffective, and with increasing inequality.

At the time of releasing this report, neither of the major political parties – LNP nor Labor – have made any substantial commitments to mental health system reform in NSW. The lack of policy priority is obvious.

In stark contrast, we've received over 1300 responses from frontline workers who, day-in and day-out, witness our most vulnerable - those living with a mental illness - denied access to timely and affordable mental health care because of the failures of successive governments over the last decades to plan, invest, and reform.

The stories of our respondents, while diverse in their profession, are unified. They show a system that is underfunded, fragmented, and unfit for purpose. There has been next to no movement in NSW's mental health spend for years, and in 2020-21, the State ranked lowest. With major spending commitments by the Queensland and Victorian governments, NSW will fall further behind.

State and Territory Mental Health Per Capita Spending 2011-2021



Prepared by The University of Sydney, using data from the Report on Government Services (RoGS)

In talking about reform, policy, systems and investment, we cannot forget that we're talking about people: the frontline health workers and the people they're there to help - the people of NSW.

This is not a report laden with statistics. In fact, the data that is collected in NSW tells very little about a person's journey, how long they wait for care, who misses out. While there are some moves to link up data from different settings, such as public mental health to primary care – no data sets exist that give us a comprehensive picture of the scale of the difficulties those living with mental health problems face when trying to access care in NSW.

But as those on the frontline know, many can't access care because it's too expensive, too far away, or just non-existent.

Where services do exist, they can be hard to access because of long wait times or absurdly restrictive entry criteria. People are falling through the cracks and left adrift in an already stretched public health system, presenting at Emergency Departments, a most incongruent setting for a mental health assessment for someone in distress.

The consequences are dire, and expensive. The risks include a sentence of chronic illness, intergenerational trauma, death, preventable incarceration and homelessness, which compound the pressure placed on other parts of the system. As evidenced by the Productivity Commission Report into Mental Health, bad mental health policy is bad for the economy.

Amongst the despair described by NSW mental health workers, we also saw the compassion and dedication of those in the sector. Despite exasperation, distress and burnout from overworking in an underfunded system, they declare a strong commitment to wanting the best outcome for those they are providing care and support to and gave many examples of how things could be better.

NSW health workers are united in wanting the system to be better resourced, better managed, more coherent, and better connected. These are complex problems requiring innovative solutions, and we stand ready, willing and able to work with the Government at every point. Other states are showing it can be done. It's NSW's turn.

Dr Angelo Virgona
Chair, NSW Branch of RANZCP

[1] Productivity Commission Inquiry Report No 95, Mental Health, 30 June 2020


COMPLEXITY
OVERWORKED
POOR FUNDING
FALLING THROUGH THE CRACKS
TRAUMA
SHORTAGES
NEGLECTED
LONG WAITLISTS
MORAL INJURY
RE-TRAUMATISATION
CRISIS-DRIVEN
ANXIETY
DISCONNECTED
UNDERFUNDED
TREATMENT
STAFF EXODUS
DIRE CONSEQUENCES
UNAFFORDABLE
LOW MORALE
TURNED AWAY
ACCESS
UNDERUTILISED
DENIED
FRACTURED

Executive summary

We asked the frontline mental health workers – the psychiatrists, psychologists, general practitioners, nurses, community mental health workers, peer workers and carers – to describe the system through their first-hand experience.

Respondents were asked to report on how the system met or didn't meet the needs of the people of NSW. Overwhelmingly, they painted a picture of a mental health system in crisis, and, by all accounts, deteriorating.

Across the state, mental health workers across various professions reported very similar stories: chaos, confusion, fiscal neglect, and fragmentation.

It's a system:

- That's poorly funded, operating in crisis;
- Where people are falling through the cracks, with dire consequences;
- That's ill-prepared to address community trauma, and in some cases, re-traumatising people;
- Where help is hard to access and often unaffordable;
- That's complex, fractured and disconnected;
- Where there are workforce shortages and under-utilisation;
- And where community mental health services are neglected, underfunded, and disparate.

We know there are effective services, and many things are done well. NSW has core sector strengths, and embarked on some great initiatives, particularly investing in novel services for younger populations. But these findings suggest not one part of the system is not under strain, and at risk of undermining our ability to help those most in need. There is no denying the system is universally underfunded, and communication between parts of the system is poor.

The survey forms part of an advocacy campaign undertaken by the NSW Branch of the RANZCP and an alliance of peak health and mental health groups to improve investment in mental health services and champion system reform and redesign, particularly in areas of governance and service integration. The alliance comprises:

- Royal Australian and New Zealand College of Psychiatrists
- Mental Health Coordinating Council
- Australian Psychological Society
- Australian College of Mental Health Nurses
- Royal Australian College of General Practitioners
- Australian Medical Association
- BEING – Mental Health Consumers
- Mental Health Carers NSW

The NSW mental health sector is united in calling for urgent reform and investment to address the myriad of issues affecting the sector.

There are solutions. This alliance calls on the Government and Opposition to seize the opportunity of working with a united sector, to make mental health a signature policy priority for the next Parliament. But NSW must move beyond the incremental to the ambitious.

How the survey was conducted

The aim of this survey was to gather a coalface snapshot of clinicians' and other mental health workers' experience in the mental health system in NSW.

The survey was a questionnaire with five close-ended questions and one open-ended question. We used a Likert scale of 1 to 5 (worst to best) for the close-ended questions to gauge perceptions of the NSW mental health system according to three performance measures: access, equity, and effectiveness. The open-ended question was an opportunity for respondents to add a description of their experiences, qualify their responses, and share ideas about how to make the system better. We also asked for their work location postcode to enable us to analyse rural/city differences.

We acknowledge the time and effort of every clinician and mental health care worker who completed the survey, and we thank them for providing such detailed accounts of their often distressing experiences.

The results at a glance

We received 1387 responses to the survey, including 878 open-ended comments. Of all responses, 43 per cent were from people working in rural or regional areas.[2]

- **Access:** Respondents said it was harder to access private psychiatrists, psychologists, and community mental health than it was to access general practitioners and services commissioned by Primary Health Networks (PHNs), such as headspaces.
- **Equity:** Similarly, respondents indicated that there were greater opportunities to receive help from general practitioners and community managed services than private psychiatry, psychology, and private hospitals. Public mental health services (e.g., in-patient and community mental health) were seen to be more equitable than accessible.
- **Effectiveness:** Respondents believed that, overall, when mental health services were able to be delivered, they were generally effective, and this response was consistent across the professional/working groups.

While the open-ended responses focused mostly on specific aspects of the NSW mental health system, many noted that the system is complex, difficult to navigate, and very much crisis-driven. In some areas services simply do not exist, or require significant travel, or have excessively long wait times. Eligibility for services is rigid, the cost often prohibitive, and even where services are subsidised, their scope is inadequate.

And there is the workforce story. Across all professional groups, the workforce is under duress and feeling unable to meet the needs of consumers. Many clinicians and mental health care workers experience high levels of stress and trauma. There is strong commitment to provide the best care possible, but the system is under pressure and unsustainable. There is escalating demand for specialist services, limited support for people in the community, and difficulties recruiting and retaining staff especially in rural areas and for people experiencing severe disadvantage (e.g., Aboriginal and Torres Strait Islander people).

[2] The full survey completion rate was 80 per cent.

Results and analysis

Data structure and presentation

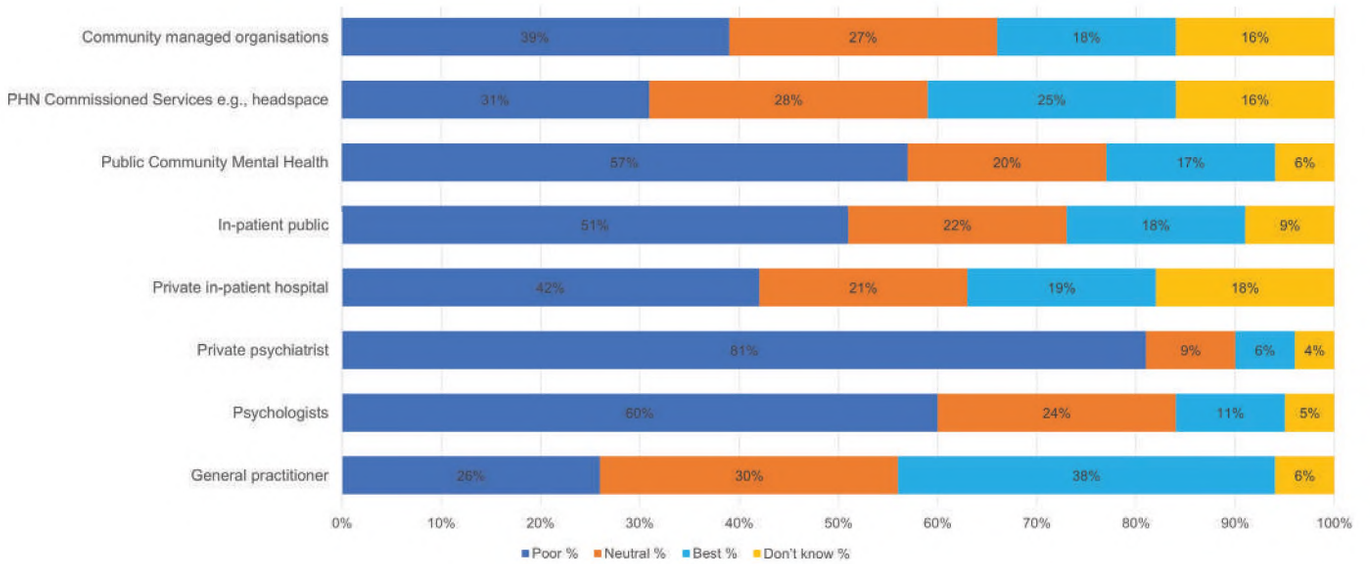
The answers to the close-ended questions are presented graphically. We present more detailed results in tablature form in the Appendix to this report, which also provide a breakdown of the percentages by rural or city location. The Likert scale of 1-5 was collapsed into three degrees: worst (1-2), neutral (3) and best (4-5).

The 878 open-ended responses were categorised and condensed into six major themes and 15 sub-themes. Identifying data has been omitted.

How respondents rate 'access'

Respondents were asked to rate performance of the mental health system according to ease with which people are able to access services. Accessibility varies considerably across service systems, with general practitioners and PHN commissioned services regarded as the most accessible, and psychiatry and psychology services the least accessible. The problem is more pronounced in rural and regional areas.

Performance of the mental health system according to accessability

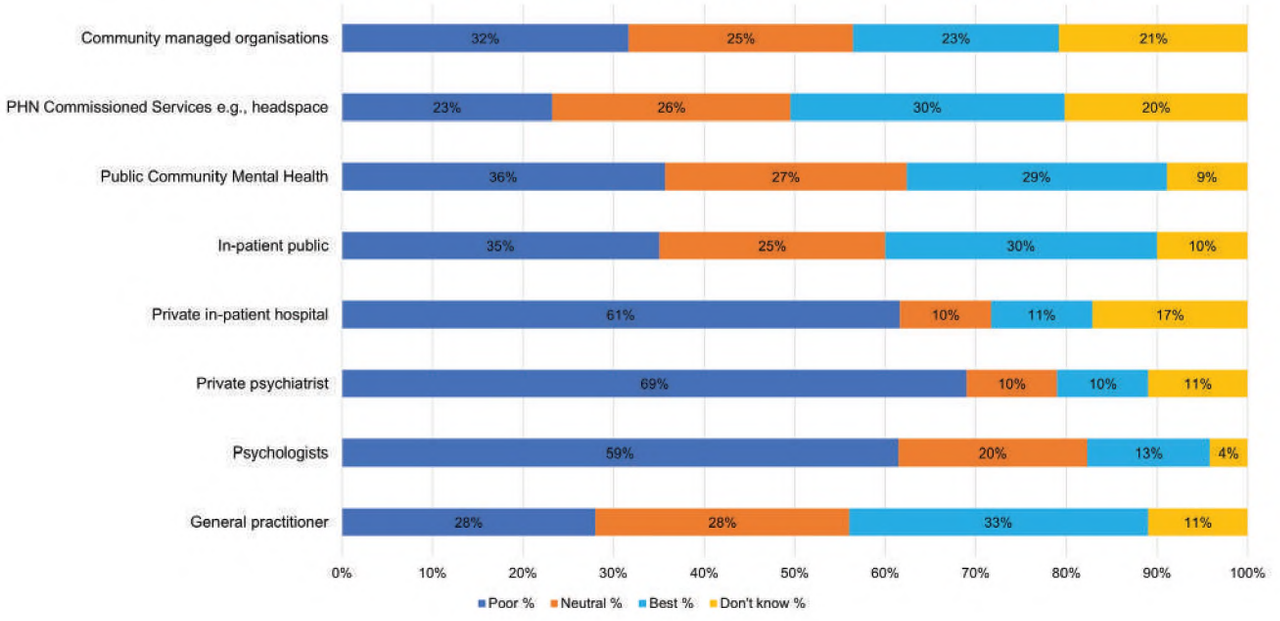


How respondents rate 'equity'

Respondents were asked to rate 'equity' of the system, defined as how fair the system is, recognising that each person has different circumstances and is allocated the resources and opportunities needed to reach an equal outcome.

Like access, equity varies substantially across the system. It is not surprising that private psychology and psychiatry services were considered the least equitable, given the costs and poor general access. Interestingly, access to private in-patient care was reported as markedly lower than was equity in that sector. However, the opposite was true for public community mental health centres, which respondents rated as being more equitable than accessible. General practitioners, public hospital and PHN commissioned services were seen to be most equitable.

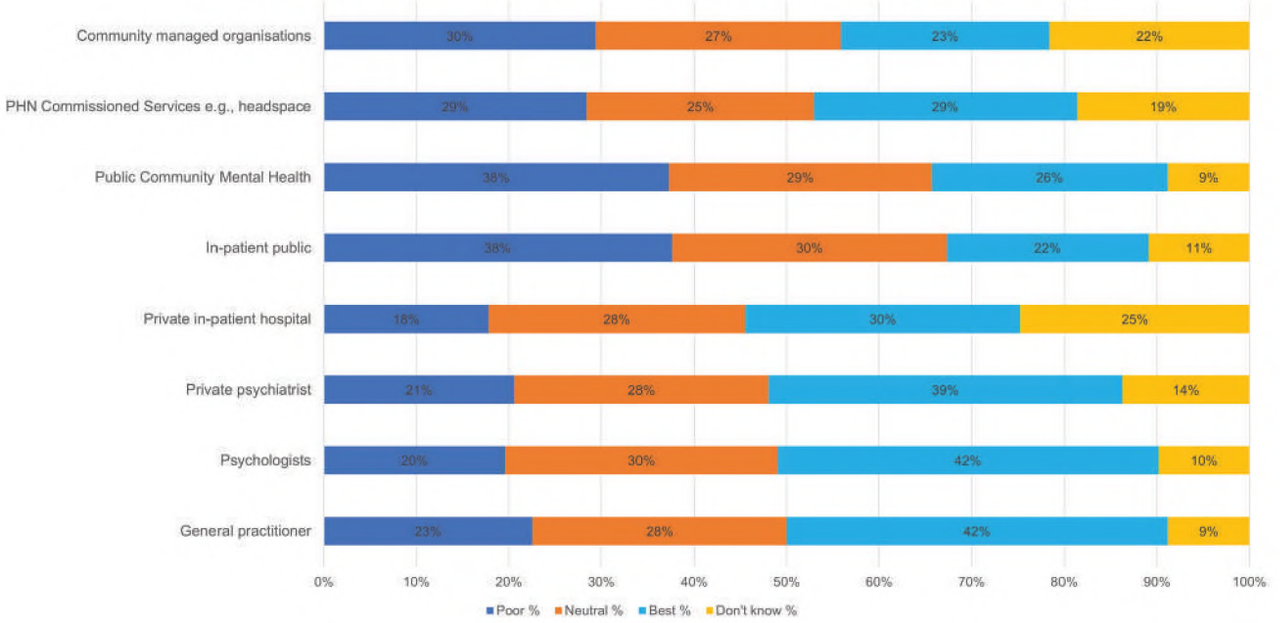
Performance of the mental health system according to equity



How respondents rate 'effectiveness'

Despite access and equity concerns, frontline workers believe the care they provide is being delivered effectively. Services that scored poorly on access and equity measures, particularly private psychiatry and psychology, scored significantly higher on effectiveness, suggesting that once patients/clients receive help, that help is considered to be effective.

Performance of the mental health system according to effectiveness



What respondents said

A crisis-driven system

Respondents noted that many people living with mental illness or experiencing psychological distress receive treatment, care and support only at times of crisis, because of a general lack of mental health services. People do not receive therapeutic supports, such as psychological therapies, and wellbeing supports, such as assistance connecting with the community, at the time when it would make the most difference.

There is no 'continuum of care' for MH clients anymore: no 'over-arching responsibility' taken for a client's care. Each issue requires negotiating complex access points, and each service provider operates in isolation of others (in a fragmentally funded environment that itself is not stable). This leads to crisis management, rather than planned care, to the detriment of clients' health and service providers' ability to provide good quality care.

– Mental health nurse (city)

I am frustrated that the system can feel set up for managing crises but not preventing them from happening, which is what I value as a GP. I called the Mental Health NSW line about a patient who planned to stop taking their depot medications for schizophrenia due to side effects. I was seeking a psychiatrist review to put him on another medication to prevent relapse. Unfortunately, the mental health clinician I talked to seemed dismissive as the patient was not actively in crisis. The Mental Health NSW team did contact the patient, but he did not respond. After being off his medication, he relapsed, and ended up with a police charge and hospitalised. When I call a service I want them to trust the judgement of us as general practitioners - that if we think it is important, then it is. That we know our patients, and we know preventive care.

– General practitioner (city)

Poor funding

Poor funding was a major concern, embedded in descriptions of specific areas of under-resourcing and in statements about the lack of services.

Several respondents made comments such as '[services are] stretched too thin',[3] 'not enough psychologists to meet demand',[4] 'difficulty in getting fast access to qualified, suitable psychologists and psychiatrists',[5] 'not enough beds, particularly sub-speciality areas, like eating disorders, rehabilitation'.[6]

Public frontline services are underfunded and overworked, funding goes to new initiatives instead. Huge issues with anyone accessing mental health and public services are so limited

– Psychiatrist (city)

The lack of services was blamed for much of the perceived ineffectiveness and inefficiency of the current system, resulting in an over-reliance on medication, under-availability of public psychological therapies and the difficulties of discharge planning.

Few people suffering from a mental disorder get evidence based psychological care - overreliance on medication and physical therapies e.g., woman with severe Obsessive Compulsive Disorder not able to get enough psychological services to reduce the disability she was experiencing despite psychological intervention being the goal standard. General-practitioner tried many medications and TMS but the current models of care did not enable her to receive optimal concurrent psychological interventions.

– Psychologist (city)

It's almost impossible to access community follow up for patients who are not on Community Treatment Orders unless they can pay for private providers and wait for months for an appointment and have a contact to advocate for a service. So many patients serious MH conditions e.g., with eating disorders, neuropsychiatric disorders, acquired brain injury, OCD cannot access mental health care once discharged from hospital

– Psychiatrist (city)

Respondents said that when basic services were available, they were poor and/or inefficient, leading to poor outcomes.

There is no multidisciplinary care available outside the public system and, even there, it is very poor. Clinicians work in isolation, become overloaded and inefficient. Triage and assessment services are piecemeal, so people often miss out on getting an accurate diagnosis early and, hence, the right management plan, leading to more inefficiency and suffering

– Psychiatrist (city)

[3] Community mental health worker (regional)
[4] Peer worker (city)
[5] Peer worker (city)
[6] Psychiatrist (city)

In particular, there were concerns about the challenges for people in rural or regional areas trying to access specialist services.

In a rural area such as ours, there is a shortage of GPs, psychiatrists, psychologists and huge waiting lines. there are very limited other supports stretched too thin geographically and people have to drive long distances to access services.

– Community mental health worker (regional)

Falling through the cracks

Many respondents used expressions such as 'falling through the cracks', and many said this was a consequence of a fragmented, under-resourced and crisis-driven mental health system.

It's virtually impossible for low-income patients to access private psychs. I have worked with many people over the years who cannot afford private psychologists. Community mental health are under resourced and cannot cope with the amount of people in need, leaving them to fend for themselves as far as obtaining adequate clinical mental health care. They end up falling through the cracks until they end up at emergency department or being referred to the Acute Care Team or taken into an inpatient unit. We need to be addressing the consumers' needs in the community, not waiting until they are in crisis

– Community mental health worker (regional)

Dire consequences

Tragically, in some cases, 'falling through the cracks' as a result of systemic failures has culminated in loss of life.

People are presenting to emergency with Mental Health issues and being turned back out onto the street/home. We need to have closer monitoring of these situations as 2 out of 3 cases I have had personal dealings with ended in suicide.

– Peer support worker (regional)

Our local public hospital is very underfunded and after minimal assessment of a very depressed man, discharged and he was found dead the next day by suicide and this was on the news, we are in a working-class area.

– General practitioner (city)

Or self-harm:

Client's family continually contacted community MH and hospital service to raise concerns for their loved one, following multiple hospital admissions over a period of 2.5yrs: with no change, no review, patient continual decline in mental health and concerns of erratic, concerning behaviour, concerns for patients' safety and safety for others. CMH services did very little to regarding concerns for services. Family escalated their concerns to director of mental health at the hospital who advised they would arrange a review of the patient's case. Within weeks of that call, patient set fire his Department of Housing property, burnt himself and while in hospital for burns was so unwell that the patient declined treatment for burns. Patient has, has spent 5 years in hospital.

– Community mental health worker (city)

Or people ending up in the criminal justice system:

People with lifetime complex cognitive and mental health impairments who demonstrate aggression, often without acute diagnoses, are channelled into the criminal justice system. There are not enough diversionary assessment, management, and treatment resources available to courts and standard health services through suitably trained forensic psychologists to service communities.

– Psychologist (regional)

Removal of bulk billing for private psychiatry limits access to a psychiatrist at all to most Australians. Inability of public system to provide psychiatrists to assess and manage ADHD in adulthood leads to dysfunction and slide into criminality resulting in ASPD diagnosis for many who have unrecognised and untreated ADHD. People with mental illness and history of interactions with CJS are stigmatised against by public mental health services and not provided with the treatment they need to both get well and to protect the community.

– Mental health nurse (regional)

Currently clinical psychologists who are seeing clients who are suicidal, disturbed from trauma, PTSD, did do not have back up by a mental health crisis team. Instead, they have to rely on calling police when situations arise

– Psychologist (city)

Trauma

Trauma-informed care

The need for trauma-informed mental health treatment, care and support emerged as another important theme. There is a need for more holistic approaches for consumers. Trauma-informed care can support recovery and prevent downstream impacts on other parts of the health system.

The people with the most complex mental health needs do not seem to have their needs met by the current system which emphasises the biomedical model. This leads to treatment pathways which favour pharmacotherapy and case management models. This does not seem to be effective in the long term for the majority of patients I see in general practice. What has helped many, is long term trauma-informed psychotherapy. This requires many more than the currently funded 10 sessions. As a specific example, one patient I see with a history of complex developmental trauma but diagnosed with borderline personality disorder and schizoaffective disorder spent several years being treated involuntarily both as an inpatient and outpatient. Eventually, the relationship between the treating team and patient became unworkable so she was abruptly discharged to my care with no further psychiatric or community mental health involvement. After 3 years of trauma-informed psychotherapy with myself (bulk-billed, so actual cost of the therapy was not covered by this) she has not required further admissions and has shown much improvement. I wonder how much suffering for both the patient and staff could have been avoided during those distressing, combative involuntary treatment periods if an adequate number of appropriate trauma-informed psychotherapy sessions was publicly funded. I also wonder how much money would have been saved - adequate psychotherapy vs repeated ED presentations and hospital admissions and enforcement of CTOs.

– General practitioner (city)

Re-traumatisation

Poor acknowledgement of the role of trauma in mental health disorders and presentations, poor access to trauma therapies, and traumatogenic aspects of the public mental health system featured in many responses. It was also noted that a system that is not working properly can itself also cause trauma or re-traumatisation. Comments linked this to a system in crisis and over-stretched services.

Public Hospitals are doing very little for mental health patients, other than keep them alive. Patients are fearful and resist admission as they feel hospitalisations are unhelpful, if not damaging (traumatising).

– Community mental health worker (city)

In public health often people are more traumatised when they leave then when they entered. There are rarely sufficient psychologists, psychiatrists rarely make it known when they will be seen which is disrespectful, and allied health services are usually short staffed, with little funding put into wholistic therapies like diet and exercise. There is also little to no follow up for any allied health services they can access unless paying privately. Only people able to fund their treatment privately really have hope of recovery, the others get stuck in the never ending revolving door of illness due to a utter lack of appropriate services.

– Allied health worker (city)

Moral injury

Another theme is that of moral injury, occurring when people work in systems that do not allow optimal, evidence-based care; where the quality of care provided is determined by factors other than the best interest of the patient. Examples listed early discharge due to a lack of beds, not enough places in specific treatment programs, like Dialectical Behaviour Therapy; and people being unable to afford care that works, having instead to settle for cheaper, accessible alternatives like medications, to treat symptoms but not cause.

Working as a psychiatrist in this system is like being a cardiothoracic surgeon whose patient needs a triple coronary artery bypass, but tells them 'we can only do one bypass, there's not enough resources in the system; we'll manage the blocks in the other arteries with medications'. We are the only profession that ends up having to prescribe or recommend treatments that are outside best guidelines, because we have to use whatever we can muster.

– Psychiatrist (regional)

Access – it's hard to get help

Unaffordable

Respondents identified treatment as out of reach for many, particularly for those on fixed incomes.

Psychological treatments are very expensive and not affordable for the majority of patients with mental health problems.

– General practitioner (regional)

Each time I have tried to refer to a psychiatrist they are booked out, or when they eventually get their appointment, the charge is extortionate for how little time they spend with their clients.

– Psychologist (regional)

People from low socio-economic backgrounds cannot afford to access private psychologists, private psychologists, or private inpatient admissions. Headspace and Community Health services often have prohibitively long wait lists and even though they are more accessible financially, are not practical for people who need timely support.

– Psychologist (regional)

Many commented that service providers often do not or no longer 'bulk bill' because rebates are too low.[7] This means many miss out on specialist or generalist care when evidence shows such care would make a big difference.

[There is a] Significant divide between public and private psychiatric services. Most people need what private services offer (subacute services, treatment for high prevalence conditions, preventative treatment), as they can't access this within the public sector. However, most struggle to access private services due to cost or scarcity.

– Psychiatrist (city)

Private psychology is inaccessible for low-income consumers. Very few psychologists bulk-bill and their fees are very high.

– Psychiatrist (city)

Unaffordability also results in people living with mental health conditions trying to access help from an already over-stretched and under-resourced public health system, particularly emergency departments.

The only way most patients in my Local Health District can get psychiatric assessment and treatment is to come through emergency department. There is minimal psychotherapy through the public system. Private psychiatry waiting time is long and only accessible to the well-funded, socially advantaged part of the population. Availability and cost prevent most of Western suburbs patients accessing same, and public system outpatient/community-based access to psychiatrist assessment and treatment is minimal to zero in my area.

– Psychiatrist (city)

There is a patchwork of multiple avenues of mental health care in Australia, which are all funded by multiple different models and accessed in multiple ways, causing confusion to the client and the health practitioner. Access for low-income people is difficult particularly for chronic mental health conditions. Public funded community mental health is vastly underfunded and understaffed for the large numbers of patients who need it, and who often need social support/multidisciplinary support as well. The gap for private psychiatry/psychology is out of reach for many. PSS has restricted access to limited psychologists so some of my patients have lost the therapist they were responding well to. Mental health problems are mostly chronic and cyclical, and 10 sessions of partly funded psychological sessions per calendar year is inadequate for good health outcomes. And why aren't excellent social workers and other counsellors not funded through Better Access?

– General practitioner (city)

Chronic shortages in staff, lack of beds, incompetent and bullying management, constant pressure to discharge before ready, terrible staff morale and exhaustion, revolving door and poor patient outcomes all leads to a totally dysfunctional and dying public system.

The only way most patients in my LHD can get psychiatric assessment and treatment is to come through emergency department, and then still most just get a mental health nurse assessment who discusses with a psychiatrist. Most mental health nurses have only basic assessment and

[7] Bulk billed healthcare services are those that are covered by Medicare and provided at no out-of-pocket cost to patients.

poor diagnostic skills. We can't get and retain trained, competent nursing staff. There is minimal psychotherapy through the public system. Private psychiatry waiting time is long and only accessible to the well-funded, socially advantaged part of the population. Availability and cost prevent most of Western suburbs patients accessing same, and public system outpatient/community-based access to psychiatrist assessment and treatment is minimal to zero in my area.

– Psychiatrist (city)

Long waitlists

Long waitlists was another theme, particularly in comments on the private/primary health sector, and, as noted, the public sector keeps no waitlist data. There are lengthy wait times to see a psychiatrist, psychologist or general practitioner. The wait times are getting longer, because of workforce shortages, lack of services and funding, coupled with growing demand. The situation is worse in rural areas. Long wait times are a major barrier to people getting timely help and a contributing factor to people using over-stretched services in the public system.

The situation in this area is so bad now, that many people cannot access a GP AT ALL. Many surgeries have closed their books. People requiring mental health services cannot wait 6 weeks for an appointment.

– Allied health worker (regional)

Waiting lists all blown out to 3 + months for urgent needs. The system only has capacity to Band-Aid up the crises which then perpetuate because access to long term community care does not exist.

– Psychiatrist (city)

Medicare rebates are extremely inadequate for all mental health services - GPs, Psychologists and Psychiatrists. This creates huge out of pocket costs for patients. There are enormous workforce shortages in all these professions, creating great accessibility problems.

– Psychiatrist (city)

Long waits mean people with mental health conditions miss out on timely treatment and supports, as well as other essential services, like housing and NDIS, because they are unable to obtain the necessary assessments to qualify for these services.

GPs have significant amount of wait times, this is impacting mental health treatment plans which in turn delays the time before people can access support services.

– Allied health worker (regional)

Most consumers have no access to private psychologists or psychiatrists. The public system has few resources to help these consumers and the NDIS is too hard to access without an expensive paid functional assessment. GPs have limited time and assess clients for referral using a K10 which has limited information.

– Allied health worker (city)

Patients are driving from Newcastle to Sydney to get a private psychiatrist appointment after trying to get it locally for more than 6 months.

– Psychiatrist (city)

Services denied

Many respondents are concerned about service entry requirements being 'too inflexible' and 'too rigid'. People in desperate need are denied access to services not only because of lack of resources but also because they do not meet the criteria for help from existing services.

The public mental health system has too many criteria for acceptance of patients … The public system cannot cope with the influx. Clients therefore have nowhere to go. This is a serious issue of accessibility for this group and undermines the whole mental health system with this revolving door, ineffective and risky service.

– Psychologist (regional)

In most community mental health services and inpatient units in children and adolescents, eating disorders and Autism Spectrum Disorder are exclusion criteria.

– Psychiatrist (city)

There are so many regulations and criteria people need to meet to access services especially those people who do not have NDIS funding.

– Community mental health worker (city)

Two-tiered system

Many described a mental health care system that is fast becoming 'two-tiered'. Those with financial means can access help quickly in a private hospital, while those less well off have to wait to access help from the public system or simply go without. People living with a mental illness often have low incomes, cannot afford private health insurance, and, increasingly, with reduction in bulk-billing rates, cannot afford a general practitioner. The impact of the two-tiered system is worse for those who live in rural and regional areas.

Most people are priced out of private services and there's poor access to those than can afford. I'm an emergency psychiatrist and there is inequitable distribution in the public services.

– Psychiatrist (city)

There is almost zero access for people on Centrelink or low incomes to see a psychiatrist for assessment or medication review. Community mental health generally no longer provide access to a psychiatrist. Clients can't afford to pay the gap fee. Even though there are Medicare items such as Item 291 for referral to a psychiatrist, the gap fee can still be more than $200 for this appointment. This has a significant impact on the treatment of complex mental health clients, as they are often in need of comprehensive assessment and appropriate medication support for acute symptoms. There is significant inequity for clients in this area. Similarly, clients who cannot afford to pay the gap fee (or ongoing full fee after 10 sessions) for a psychologist are often left without any treatment options for complex mental health issues. These clients are often not acute enough (i.e., suicidal) for community mental health support and often bounce between crisis services (homelessness, unemployment, lack of food and basic needs) without any appropriate mental health care.

– Psychologist (regional)

Fractured

Complexity

Many commented that access to the mental health system is complex, confusing, and difficult for consumers to navigate because of a lack of information, language barriers, and lack of financial resources. Complexity hinders effective operation of services and provision of quality care. Variable performance of helplines, including Mental Health Access Lines, contributes to confusion about where and how to enter services.

Very difficult for clients to negotiate health care system, need to speak English, be persistent, navigate slow telephone line responses, this leads to Emergency department presentations.

– Psychiatrist (city)

Difficult to navigate non-government organisations and community supports leads to further fragmentation of care.

– Psychiatrist (city)

NDIS is too complicated for those who need it most. More affluent families will be able to navigate the system and get funding more easily. It is very difficult to access private psychiatry services, so people saturate GPs/public services in crisis.

– General practitioner (city)

Disconnection

Many reported a lack of integration and coordination across service sectors, with consumers bouncing between services, and being subjected to multiple assessments and rejections because of strict eligibility criteria.

There is also a disconnect between mental health services and other crisis and community services, with detrimental impact on people who need multiple services, such as housing, and follow-up primary care services from general practitioners. Communication and liaison is not built into funding packages and arrangements under programs like the NDIS, resulting in unclear responsibilities and a poorly coordinated service system.

Patients don't receive the length of care or comprehensiveness of care needed because funding is fragmented among too many competing players often vying for the same pot of money and headed by careerist non clinicians who don't understand (or care about) the larger challenges of the mental health system so 'parts' of peoples' treatment are managed by different parts of the system and there is no coordination or integration, and patients miss out. [There] needs [to be] a more integrated shared care system so different parts can share resources and responsibility and/or need a disbanding of certain sectors of the system and consolidation into core treatment providers.

– Psychiatrist (city)

Consumers with accessing both MH services within the health system as well as NDIS funded services. There is or seems to be a lack of coordination around this.

– Allied health worker (city)

Workforce

Shortages

Staff shortages across the board was a key theme, with related issues of low morale and staff exodus, particularly from public health. Despite their commitment, many say they struggle to do their best by consumers because of a lack of staff in so many parts of the mental health system. They feel overworked, under-resourced, and on the brink of burnout. Staff morale is low and many are leaving the sector, citing bullying and abuse.

I have been working in public mental health services for over 10 years in NSW. I feel the morale now in the frontline is the lowest I have ever seen or experienced. The main concern I have is that of workforce shortage, particularly of consultants. We have a brand new hospital but not enough staff to open the units.

– Psychiatrist (regional)

High staff turnover at [NAME OMITTED] Centre for Mental Health and [NAME OMITTED] Community Health Centre which means inconsistency with recovery of the consumer and no rapport or relationship formed to assist them on their recovery journey. High staff turnover also shows lack of communication with others in that organisation which then creates a breakdown of communication to carers and consumers which impacts on their recovery. High stress in those two services and very limited workers compared to where it needs to be therefore also creating stress on the workers which effects how they work with consumers and carers. There needs to be more staff at public mental health services as not everyone can access private health systems due to financial hardship.

– Community mental health worker (city)

Though I live in an area that finds recruitment difficult, it's the poor retention that crippled us. "The good ones always leave". There are reasons for that but so much is left unsaid, particularly in a small community. Management is often less experienced than the staff they employ. Bullying is rife. Pressure to meet unrealistic targets. Verbal and physical abuse that is never challenged and lots of other contributing factors. With a strong, skilled, and fair management system in place, a focus on staff retention could make a huge difference.

– Mental health nurse (regional)

Underutilised

Many nurses, allied health and peer workers commented that they are well placed to fill the capacity gap caused by growing demand for services, but their skills and those of other professions are being underutilised.

The system fails to recognise the role and capacity that mental health social workers and social workers play in providing interventions. They have been left out of the conversation and yet there is a huge workforce supporting clients day in day out who are largely hidden and ignored in these essential discussions.

– Allied health worker (city)

There seems to be a perception that psychologists are the primary providers of mental health services there is a huge mental health nursing workforce that is being under-utilised.

– Mental health nurse (regional)

System requires many more providers across different areas to service current demand. Wait lists are too long. Consideration should be given to harnessing already trained professionals (counsellors, art therapists, music therapists, play therapists, etc) and incorporating them into Medicare and other government funded supports to ensure mental health services are available and provide choice to those who require help

– Allied health worker (regional)

Community Mental Health Services

Neglected, underfunded, disconnected

Community mental health services are considered to be under-resourced, and narrow in scope with extraordinarily restrictive eligibility criteria. As a result, they mainly serve patients on community treatment orders or provide short term crisis intervention follow-up, mostly by phone, of those presenting in parasuicide crisis. Communication between teams and referring services was noted as poor and when people were seen, other than those on community treatment orders, the length of engagement with the service is too brief to be clinically useful.

CMHT over stretched and provide very little care or treatment. Ever widening remit of what is mental health with decreasing funding - huge disparity between community expectations and this.

– Psychiatrist (city)

Community mental health services stripped down to being just CTO land, sucking life and vitality out for both patients and health workers.

– Psychiatrist (city)

Highly complex patients with multiple impairments and/or diagnoses are extremely poorly catered for in private and public. I heard recently of a young adult in my organisation (not my patient) who has an intellectual disability, Autism Spectrum Disorder, and pathological anxiety and significant self-injurious behaviour. The local public hospital neuropsychiatrist upbraided the man's management team essentially claiming they should stop wasting his time and find a private clinician to provide care. He then refused to see the patient again. There are NO private adult psychiatrists in our area with books open, let alone one who will manage a patient with intellectual disability as well as mental illness, and travelling for two hours to Sydney with this young man is simply not possible unless he was heavily sedated.

– Psychiatrist (regional)

Conclusion

Those working in the mental health sector were asked to describe the system as they saw it. Their experiences.

They painted a picture of services across the sector that were hard to access, not equitable, but somewhat effective.

Some of their experiences were distressing to read. They spoke of people not knowing where to go to get help, **to being turned away from community mental health services** because they do not meet the eligibility criteria or **because there's just not enough of anything.**

They spoke of private care those living with mental health issues would **access if they could afford it;** but even when they can afford it, **the waiting lists are getting longer and longer.** People are getting the **revolving door treatment,** and **can't navigate the services** because it's all confusing and fragmented.

The system is fractured. Nothing is linked up properly, and this can have **dire consequences…** from suicide or self-harm to ending up in the criminal justice system.

And underlying much of it is a **workforce shortage**, and good people leaving the system because they're worn out. Our system is a **two-tiered** one that's **crisis driven**. Too many Australians are **falling through the cracks**, and **their trauma isn't dealt with.** In fact, they're often **re-traumatised by the system.** There was a handful of positive stories about parts of the system, but mostly, respondents described a mental health system in crisis, and, by all accounts, deteriorating.

The real sense is that, unless there is urgent investment in, and attention to, the myriad of issues affecting the sector, particularly given the workforce issues, it will evolve into an irreversible downward spiral.

Appendix

Table 1 - Performance of the mental health system according to accessibility

Service	Worst			Neutral			Best			Don't know			Total		
	City	Rural	Total	City	Rural	Total	City	Rural	Total	City	Rural	Total	City	Rural	Total
General practitioner	17%	35%	26%	28%	31%	30%	47%	30%	39%	8%	3%	6%	574	506	1080
Psychologist	53%	70%	60%	29%	18%	24%	13%	9%	11%	5%	3%	5%	575	505	1080
Private psychiatrist	77%	86%	81%	11%	6%	9%	8%	4%	6%	4%	4%	4%	581	508	1089
Private in-patient hospital	38%	47%	42%	23%	18%	21%	21%	16%	19%	18%	19%	18%	577	507	1084
In-patient public	50%	52%	51%	22%	22%	22%	18%	19%	18%	10%	17%	9%	577	508	1085
Public Community Mental Health	56%	58%	57%	20%	20%	20%	16%	18%	17%	8%	4%	6%	582	507	1089
PHN Commissioned Services e.g., headspace	29%	34%	31%	25%	34%	29%	27%	22%	25%	19%	10%	16%	582	509	1091
Community managed organisations	27%	26%	39%	25%	29%	27%	17%	18%	17%	17%	14%	16%	580	507	1087

Table 2 - Performance of the mental health system according to equity

Service	Worst			Neutral			Best			Don't know			Total		
	City	Rural	Total	City	Rural	Total	City	Rural	Total	City	Rural	Total	City	Rural	Total
General practitioner	23%	35%	28%	24%	31%	28%	39%	30%	33%	14%	8%	11%	596	506	1102
Psychologist	56%	62%	59%	21%	17%	20%	13%	12%	13%	5%	3%	4%	597	509	1116
Private psychiatrist	68%	71%	69%	10%	9%	10%	11%	9%	10%	11%	10%	11%	600	509	1109
Private in-patient hospital	62%	61%	61%	10%	9%	10%	11%	12%	11%	17%	19%	17%	596	508	1116
In-patient public	35%	36%	35%	23%	27%	25%	32%	29%	30%	11%	8%	10%	597	508	1115
Public Community Mental Health	34%	38%	36%	26%	27%	27%	28%	29%	29%	12%	6%	9%	601	510	1111
PHN Commissioned Services e.g., headspace	22%	26%	23%	25%	28%	26%	29%	32%	30%	24%	15%	20%	596	509	1115
Community managed organisations	30%	34%	32%	22%	27%	25%	24%	22%	23%	24%	17%	21%	594	507	1111

Table 3 - Performance of the mental health system according to effectiveness

Service	Worst			Neutral			Best			Don't know			Total		
	City	Rural	Total	City	Rural	Total	City	Rural	Total	City	Rural	Total	City	Rural	Total
General practitioner	21%	25%	23%	26%	29%	28%	42%	40%	42%	11%	6%	9%	586	512	1098
Psychologist	20%	20%	20%	31%	28%	30%	39%	45%	42%	11%	8%	10%	588	512	1100
Private psychiatrist	21%	20%	21%	26%	29%	28%	40%	37%	39%	13%	13%	14%	588	512	1100
Private in-patient hospital	19%	17%	18%	31%	25%	28%	29%	30%	30%	21%	28%	25	583	509	1092
In-patient public	34%	41%	38%	31%	28%	30%	23%	20%	22%	12%	10%	11%	587	511	1098
Public Community Mental Health	36%	39%	38%	29%	28%	29%	25%	26%	26%	11%	7%	9%	589	511	1100
PHN Commissioned Services e.g., headspace	30%	27%	29%	22%	27%	25%	26%	31%	29%	22%	15%	19%	585	511	1096
Community managed organisations	30%	29%	30%	25%	29%	27%	22%	23%	23%	24%	19%	22%	585	510	1095

Contact

Julia Thoener
Policy and Advocacy Advisor

The Royal Australian and New Zealand
College of Psychiatrists
RANZCP NSW Branch

PO Box 280
Rozelle NSW 2039
Australia

Tel: +61 2 9352 3606
Email: julia.thoener@ranzcp.org
Web: www.ranzcp.org