Special Commission of Inquiry into Healthcare Funding

Statement of Dr Nicola Holmes

Name: Dr Nicola Holmes

Occupation: General Practitioner

1. This statement sets out the evidence that I am prepared to give to the Special Commission of Inquiry into Healthcare Funding as a witness.
2. The statement is true to the best of my knowledge and belief.

A. My role

3. I am a General Practitioner (**GP**) at Coffs Medical Centre three and a half days each week. I am also a GP at 'Pete's Place', a homeless clinic in Coffs Harbour, for one half day each fortnight until the end of August 2024.
4. I have been a GP in Coffs Harbour since 2000. I have a particular interest in mental health and education. I worked as a GP at Headspace Coffs Harbour from 2008 - 2020 and as a Medical Educator for the North Coast GP Training from 2006-2020. Prior to working in Coffs Harbour, I worked as an intern and RMO1 at Gosford Hospital and in the United Kingdom for 18 months in Paediatrics and completed my GP training in Newcastle and Coffs Harbour.
5. I am currently working with Black Dog Institute (involved in research into mental health across the lifespan with goal of reducing deaths by suicide) to develop and deliver content for mental health programs. I am also currently working with Orygen (Internationally renowned youth mental health research centre based in Melbourne) to develop educational resources for GPs about youth mental health.

6. I also offer educational resources and workshops to the community about mental health, including free parenting workshops for parents of primary school children and teaching programs for GPs and psychologists.

B. Access to mental health services

7. In Coffs Harbour, there are federally funded mental health services, such as Headspace (for 12-25 year olds), and the new Medicare mental health drop in centre for over 18 year olds directed at early intervention. There are also state funded public mental health services, such as Coffs Harbour Health Campus (**CHHC**), available for patients with acute mental health conditions.

8. However, there is a lack of available public services in Coffs Harbour for patients with complex mental health conditions, such as chronic eating disorders, borderline personality disorder, comorbid autism spectrum disorder (**ASD**) and attention-deficit/hyperactivity disorder (**ADHD**), schitzoaffective comorbid with drug addictions and severe anxiety. Nationally these patients are called the 'missing middle'. Patients in the missing middle have conditions that impact on their functioning in a way that warrants more intensive clinical intervention, but they are not supported by existing health services:

   (a) GPs are not willing or do not feel confident managing such patients for the reasons I explain in [9] below.

   (b) Headspace Coffs Harbour (**headspace**) previously provided for the missing middle but is no longer able to provide services to patients with these conditions for the reasons I explain in [10] below.

(c) These patients do not present as acutely suicidal or psychotic or so cannot access various public services provided by the Mid North Coast Local Health District (**MNCLHD**) including CHHC.

(d) Patients with complex mental health conditions have the greatest clinical need and usually cannot afford private consultant fees, and there is a lack of private providers locally.

9. Based on my discussions with other GPs, I am aware that GPs often do not feel able to provide services to missing middle patients because they often require more intensive care than a GP can provide (eg weekly to fortnightly appointments and longer consultations). Further, there is a of lack support from the local health district enable GPs to provide care to such patients in a safe and effective manner as these patients often need stepped up care to inpatient services at times of high risk. Although the National Disability Insurance Scheme (**NDIS**) can support a GP in providing care, the NDIS process is difficult to navigate and almost impossible for complex mental health patients to gain access. As such, GPs feel burdened by a risk that is not manageable at a GP level but that is not high enough to warrant intervention by the CHHC. There is lack of funding incentives for GPs to take on more complex mental health patients.

10. From its inception in 2008 until 2020 headspace provided public mental health services for people with complex mental health conditions (this evolved as a unique set of circumstances including lack of available services from the LHD and a small passionate group of clinicians that actively recruited and grew the service. At this time, headspace had five GPs, two mental health nurses, three youth workers, community engagement officers and approximately five highly skilled psychologists.)

11. Federal funding through local Primary Health Networks (**PHNs**) tightened to focus on early intervention and the local service was not supported to continue seeing complex missing middle. For example in approximately 2020, headspace requested $16,000 from

the PHN to establish a Borderline Personality Disorder Clinic; however, the PHN declined and indicated that Headspace should not be providing early intervention to such patients Following this, all five GPs resigned in the one week, followed later by a key community engagement officer present from 2008, one mental health nurse and most of the psychologists, and services were impacted.

12. Headspace has continued to provide early intervention services but have been unable to fill the GP position which means patients are lacking wrap-around care such as sexual health and drug and alcohol support as well as timely access to mental health care plans and prescribing of selective serotonin reuptake inhibitors etc.
13. I understand that the PHN has implemented a Mental Health Nurse Initiative Program whereby they employ 1.4 full-time equivalent **(FTE)** mental health nurses to cover complex mental health patients of any age in the Coffs Harbour area. However, in my view, 1.4 FTE mental health nurses do not meet the current needs of the Coffs Harbour population, and each GP practice with greater than six doctors could support having a mental health nurse employed in their surgeries.
14. I am aware that the MNCLHD manages acute mental health conditions, such as acute psychosis, through the CHHC. However, I am unaware of the MNCLHD providing any public mental health services specifically for patients with complex mental health conditions or providing any support for GPs to effectively manage such patients in the Coffs Harbour area. They will not provide support letters for patients with complex mental health needs to access NDIS funding and those with ASD and ADHD are generally excluded from accessing services. There are no gender affirming clinicians in the public sector locally. No scripts for adult ADHD medications are provided.
15. The inaccessibility of access to services for patients in the 'missing middle' means they may not receive appropriate care for their condition. This in turn means they often enter disability services, homeless services or the justice system. For example, on 6 February

2019, I wrote a letter to Sara Shaugnessy, Clinical Director of Mental Health at CHHC, detailing an example whereby a patient approached me requesting if I could organise for him to go back into jail. The patient informed me that he felt unsafe in the community, had tried a mental health rehabilitation admission but that he felt a lot safer and calmer in jail. Annexed hereto and marked **"A" (SCI.0011.0425.0001)** is a copy of that letter.

16. In my view, to increase access to public mental health services and support GPs in this regard, the MNCLHD could run more groups, such as borderline personality groups for adolescents, managing severe anxiety groups, anger management groups and Dialectical Behaviour Therapy groups for adults through the CHHC. The MNCLHD could also run public outpatient psychiatric clinics, including specific clinics for patients with autism and ADHD, which could include remote telepsychiatry input with local support from the MNCLHD members. Further, the MNCLHD could increase intensive outreach mental health teams who visit patients in distress and assess them in a space separate from the emergency department **(ED).**

17. In my view, GPs may be more confident and willing to services to missing middle patients if they were able to refer patients to public psychiatrists for diagnostic options and medication advice. I believe it would also assist GPs if they had assistance from mental health nurses. In my experience, the feeling of a lack of support in a team is a major block for GPs. Having mental health nurses with block funding (rather than fee for service) gives them the ability to do check in phone calls, support family members, and follow up medication reviews, among other tasks, with patients. They have also been some of the best therapists I have worked with in the complex group.

C. Local health district culture in Coffs Harbour Health Campus and engagement with patients

18. For those patients who do gain access to LHD services at the CHHC there is also an issue of engagement, where the patient's experience is so traumatic that they refuse to

engage with services offered and refuse to return to hospital-based treatments in the future. This leaves GPs in the difficult position of holding high risk patients in the community to avoid further traumatizing them by referring into more appropriate services.

19. I have discussed with Stewart Dowrick (CE of the MNCLHD) and Penny Jones (Director, Integrated Mental Health, Alcohol and other Drugs, MNCLHD) the importance of adverse childhood events (**ACE)** scores and these being the best predictor of poor mental health outcomes (as well as physical outcomes including non-insulin-dependent diabetes mellitus, cancer, Chronic Obstructive Pulmonary Disease, premature death etc) and are really needed if the department is to consider itself "trauma informed". Training all staff from receptionists to consultants in trauma informed care and collecting ACE scores on patients and tailoring interactions and therapies and communications appropriately would be a change that would improve patient engagement with services.
20. From a GP's point of view, and from many discussions with patients and current and past staff there is a significant problem with the culture within the CHHC generally and CHHC mental health particularly. The rapid turnover of staff and reliance on locums who are not invested in community is a testament to this problem. It does not appear that exit interviews are conducted with leaving specialists and registrars which would be a start to trying to address this problem.

D. Integration of services

21. In Coffs Harbour, there is a lack of integrated services including between mental health, drug and alcohol, dental, and sexual health services. This can lead to duplication of services as well as missed opportunities to provide effective care to patients.
22. In my experience, it is important that patients with complex mental health conditions receive wrap-around services as other factors can impact on their mental health. As such, in addition to mental health support, it is important for patients with complex

mental health conditions to have access to housing services, as mental health can decline when a person does not have safe and secure housing, dental services, and drug and alcohol services. Services available should also include contraception services, which can be incorporated by establishing public Mirena Intrauterine device (**IUD**) clinics, as well as social work supported services which can assist patients to navigate the process to obtain housing support, Centrelink or NDIS services. A public gynaecology clinic was advocated for by our indigenous obstetrician and gynaecologist, but the District has only made a gynaecology clinic available for public patients at high risk of cancer, for example those with high risk cervical screening results for colposcopy or those with complex ovarian masses.

23. In my view, one way to effectively provide wrap-around services could be for psychiatry departments to run multidisciplinary teams **(MDTs)** whereby staff from different disciplines, such as psychiatrists, psychologists, GPs and social workers, can meet in person or virtually, to create a wrap-around treatment plan for patients. This would be run similar to MDTs run for cancer patients currently.
24. To assist MDTs in creating such a plan, prior to the MDT meeting, an initial 'tick-a-box' form could be completed for the patient indicating what additional services are needed eg dental, STI screening, hep C screening, housing support, financial counselling, gambling support, AOD support, help finding a bulk billing GP, NDIS application support, work and development order support for current fines etc. This could be completed by the patient prior to the MDT meeting. This would assist the MDT's understanding of what services the patient requires as, for example, the form may indicate that in addition to mental health services, the patient requires dental services.
25. Any patient admitted to the mental health department should have such services provided while an inpatient. The same patient form could be used for inpatient admissions identifying other concerns that need addressing as above. For example, the

patient could be taken to a dentist appointment, a drug and alcohol appointment to commence opioid replacement therapy, or an IUD procedure could be undertaken under sedation for those with history of sexual trauma or high anxiety, during their mental health inpatient admission which is often prolonged. Upon discharge, the plan could also indicate, for example, that a GP, dental or housing appointment has been booked for the patient as many patients without strong family advocates struggle to organize their own follow up after a mental health admission.

26. Safety plans (including which medication can be used and staged supplied scripts provided) could be created during inpatient stays or during MDT meetings. These safety plans need to be shared with the patient, their family and GP in written form to help prevent escalation and further hospital admissions.
27. Whilst these solutions may require greater resources from the MNCLHD or the CHHC at this initial stage, ensuring wrap-around services are provided to patients may prevent further issues and expenditure of resources in the future.

E. Funding issues

28. There is a lack of funding for mental health services in the MNCLHD as well as a lack of transparency regarding allocation of funding. For example, in 2021, I was informed by a staff member in the Acute Care team at CHHC that, for one day, there were 142 patients listed on the high-risk suicidal board with only two staff members to contact and assess those high-risk patients. It seems to me that it would be more efficient and would produce better health outcomes in the long run if some of the funding currently spent on locums was reallocated to supporting services such as these.
29. In my view, there needs to be greater funding and resources allocated to mental health services, and greater transparency regarding funding allocation to ensure better health outcomes for patients as well as to reduce burnout in staff members.

F. How issues were raised with decision-makers

30. From 2013, I have raised the above issues with various levels, including the PHN, Gurmesh Singh MP, Member for Coffs Harbour, Pat Conaghan MP, Member for Cowper, various Directors of Mental Health at CHHC, and the MHCLHD Board and CEO, Stewart Dowrick.
31. For example, on 9 September 2022, I wrote an email to the Chief Executive of the MNCLHD, Stewart Dowrick's, secretary. Annexed hereto and marked **"B" (SCI.0011.0426.0001)** is a copy of that email. This email refers to a meeting between Mr Dowrick and Ms Penny Jones, Director of Mental Health Services at CHHC. In my view, this meeting was not helpful in understanding the vision for mental health services within the MNCLHD. I was told verbally that adverse childhood events scores were being collected on patients presenting to the mental health unit and that they could be communicated to GPs. However, after the meeting it was confirmed this data was not being collected. I felt that Mr Dowrick was dismissive of my concerns.
32. On 10 September 2023, I wrote a letter to the MNCLHD Board. Annexed hereto and marked **"C" (SCI.0011.0424.0001)** is a copy of that letter. This letter identifies recent suicides of young persons in the Coffs Harbour area. This letter also poses six questions to the MNCLHD regarding how the MNCLHD is addressing such issues and delivering adequate mental health services in the MNCLHD.
33. On 29 September 2023, the MNCLHD responded to my above letter. Annexed hereto and marked **"D" (SCI.0011.0427.0001)** is a copy of that letter. This letter responded to each of my six questions. However, this letter indicated that engagement and responses to me at the current level was resulting in an "unreasonable redeployment of resources" that the MNCLHD could not sustain. As such, the MNCLHD requested that "further advocacy regarding primary care providers and the continuity of care between the District and primary care mental health services be directed through the Primary Health Network."

34. On 23 March 2024, I wrote a letter to the MNCLHD Board. Annexed hereto and marked **"E" (SCI.0011.0428.0001)** is a copy of that letter. This letter identifies several issues with mental health services in Coffs Harbour as well as indicates that I wished to continue my advocacy for improvement in tertiary mental health services for the local community and improve communication with GPs regarding mental health patients.
35. I received a response to this letter on 11 April 2024 from Delwyn Kruk, Manager Governance and Executive Services at MNCLHD. Annexed hereto and marked **"F" (SCI.0011.0429.0001)** is a copy of that letter. The letter purported to attach the MNCLHD Early Psychosis Procedure, however, this document was mistakenly omitted. When I reviewed the guidelines after later being provided a copy, I was not satisfied that they were followed with my patient. Annexed hereto and marked "**G" (SCI.0011.0432.0001)** is a copy of the guidelines. If there are MDTs being conducted as part of first presentation psychosis patients, these are not documented and communicated with GPs as the ones done in cancer services are.

G. Other possible solutions

36. The use of Artificial Intelligence **(AI)** software, such as Heidi, could increase efficiency of mental health services. For example, when I use AI during a consultation, I firstly obtain the patient's consent. The AI then listens to and records the consultation and summarises it into a medical style note in an organised structure. This enables me to be more present and engaged with the patient. This also reduces the amount of time I spend on documenting consultations as well as increasing accuracy of the notes. Further, this could enable clinicians to review a greater number of patients within a shorter period and could reduce wait times for patients to access a GP who provides care for patients with complex mental health conditions.
37. Standardised questionnaires could also be used to increase efficiency in mental health services. For example, patients could fill out a 'tick-a-box' form about their background,

various other questionnaires such as WEISS II or timelines with 10 best and 10 worst events chronologically or genograms with characters of people on them and mental health and alcohol and other drug issues in family members etc prior to an appointment. This would allow clinicians to focus on psychoeducation and collaborative management plans during the consultation rather completing a questionnaire for the patient.

Signature:

Name: Dr Nicola Holmes

Date: 16/9/2024