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About the Royal Australian New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care.

The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a binational college, has strong ties with associations in the Asia and Pacific region. The RANZCP has more than 5500 members including more than 4000 qualified psychiatrists and around 1400 members who are training to qualify as psychiatrists.

The RANZCP NSW Branch represents over 1600 members including over 1200 qualified psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery.

How this pre-budget submission was developed

Our pre-budget submission was developed in consultation with members of the NSW Faculty and Section Subcommittees and members of the NSW Branch Committee.

It draws on their knowledge and expertise of the mental health-care system, in identifying issues affecting people living with mental health conditions and evidence-based solutions to improve their lives and the mental health-care system. For the most part, it relies on the views and concerns of the individual psychiatrists consulted for this pre-budget submission, and where appropriate, quantitative data to validate key issues raised by them.
Message from the Chair –
Dr Angelo Virgona

It gives me great pleasure to present our 2020 Pre Budget Submission (‘Submission’), “Let’s Fix Something” to the NSW Government on behalf of NSW members of the Royal Australian and New Zealand College of Psychiatrists.

The development of our Submission comes at a time when mental healthcare in this country is under close scrutiny to see whether current investment is delivering the best outcomes (and value for money) for people with mental health conditions and their families. Our Submission also comes at a time when our mental healthcare system is being put to the test by persistent drought and ravaging bushfires that are devastating communities across this State.

We are not taking a scatter gun approach. Everyone knows there is not enough of anything in this sector, but the Branch supports an approach where critically disadvantaged areas are brought into focus.

The submission we made to the Productivity Commission (‘Commission’) inquiry into mental health in April last year highlighted the need for critical evaluation and bold reform. The Commission heard this message from every corner of the mental health sector, heeded it and is calling for a rebuild of the sector. Making these once in a generation changes to funding and governance arrangements will take great commitment from all levels of government, and we urge the State government to rise to the challenge.

This budget must see a strong focus on rural issues, and deliver programs that will turn the tide against maldistribution of medical and specialist resources. We have recommended the reinvigoration of the Rural Psychiatry Project, with the aim of getting more trainees to live and work in rural areas, as well as supporting those trainees and psychiatrists already there. It worked before. It’ll work again.

We’ve recommended better scoping and planning of child and adolescent mental health services to ensure children and their families get the best possible wrap-around responses available. Focussed investment in early life services, across the State, is critical if we’re serious about prevention.

We’ve also recommended an overhaul of the Mental Health Access Line (MHAL). Our research found significant shortcomings in most Local Health Districts’ access lines, creating confusion for consumers, carers, GPs, psychiatrists and other mental health clinicians and workers. This confusion around access and not getting timely responses and assessments, puts lives at risk. NOW is the time to fix this service. These are times of more frequent and challenging crises, and the effective access points that properly functioning MHALs deliver, are a critical component of responsive mental health systems.

We need to have an honest conversation about what’s going on in our prisons. They have been de facto psychiatric wards for years, but wards where you don’t get treatment. Too many are being denied basic mental health care. It’s simply not good enough to have people languishing in their cells, plagued by untreated symptoms. Resources need to be increased and turf wars, between Justice Health and Corrections need to be sorted.
More generally, and its exploration is beyond the scope of this submission, is the need for dramatic reinvigoration of the community mental health sector. At NSW Health’s Mental Health and Emergency Department forum in December 2019, the focus was how to deal with the ever-increasing mental health demand in emergency departments (EDs). The consensus view was that, in the absence of significant community mental health investment, the demand on EDs will grow, and that any innovations in that space will not have significant impacts on demand. All inquiries into the mental health sector since the 80’s have bemoaned the lack of a robust and responsive community mental health sector. Hospital-based services will continue to suck the life out of mental health budgets unless there is clear commitment to, and quarantined funding of, the community sector.

Our Submission reflects the priorities our Branch Committee and Faculty/Section Subcommittees have identified over the course of the year in their deliberations on mental health policy issues. Accordingly, I would like to thank those who contributed to the development of this important policy document.

Dr Angelo Virgona
Chair - RANZCP NSW Branch Committee
Workforce

Grow and support the psychiatric workforce in rural communities

Invest $2.5 million over five years to establish a Rural Psychiatry Project to support rural psychiatric registrars.

Psychiatrists are an integral part of our mental health system. They provide clinical services to people with mental health conditions as well as clinical leadership and governance to mental health services. They also teach and supervise doctors training to become psychiatrists, other doctors working in mental health and other health practitioners.

When we talk to members about mental health care in NSW, they tell us things need to improve drastically if they are to meet growing demand for mental health care, especially in rural communities where access to essential and specialised mental health services are limited or non-existent.

QUICK FACTS

- 2.8 million (or 36.5%) of NSW’s population lives in regional, rural and remote areas¹
- 287 towns in NSW have populations of less than 1000
- Suicide rates are two to three times higher in regional/rural LHDs than Sydney based districts. Hunter New England LHD has the highest number of suicides in NSW (154).
- People living in rural and remote areas have two to six times less access to a psychiatrist than people living in cities (see Table 2).²
- 54% of Aboriginal people live in regional, rural and remote areas.³ Aboriginal people have significantly higher rates of mental illness than non-Aboriginal people in New South Wales.⁴

We hear there is a severe and worsening shortage of psychiatrists in rural and remote parts of NSW, and a lack of incentives to support recruitment and retention of health professionals in areas of high need. For many people in rural and remote NSW, mental health services are simply out of reach because of cost, distance, and a shortage of health professionals. Higher rates of suicide in these communities are an unacceptable reflection of gaps in the state’s health system.

Rural communities also experience greater mental health mortality and morbidity, being more vulnerable to mental health problems related to natural disasters, financial hardship, lack of or inaccessibility to health services, and geographical and social isolation. In addition, across rural and remote NSW, there is an acute shortfall in treatment and recovery services (for example, for people who have experienced trauma and people who misuse alcohol and other drugs) as well as subspecialty care for vulnerable groups, such as children and adolescents, Aboriginal and Torres Strait Islander Peoples, and older people.

It is well-established that the geographic distribution of psychiatrists tends to be more concentrated in major population centres than in rural and regional areas. This is attributed to:

- Professional isolation in more remote areas because there are fewer peers and support networks from whom to learn from and seek advice on clinical practice
- Workloads being higher and less flexible because there are fewer health professionals patients can go to. This limits opportunities to take time off to attend professional development activities or holidays.
- There being fewer job opportunities for partners
- The bulk of training opportunities taking place in cities. As a result, people establish their lives within their local community and find it hard to leave when qualified.


We know from various data sources that populations in regional and rural areas will continue to grow, some in the order of 20% (e.g. Central Coast, Nepean Blue Mountains) and will require a commensurate level of service planning and investment in new mental health services. Only the Far West will see a decline in population (see Table 1). And to improve health outcomes for people with mental illness, regional and rural areas of NSW need greater access to the diversity of care that is available to people in urban areas.

We hear reports from our members and in the media that health agencies are increasingly needing to turn to alternate models of service delivery such as locums, visiting medical officers (VMOs) and fly-in fly-out (FIFO) doctors to address the lack of mental health services and professionals available in rural and remote communities. The extent of this situation is made evident in Table 1 where we see, for example, LHDs like Western NSW, Southern NSW and Murrumbidgee delivering psychiatry services almost entirely through the use of VMOs. The case for more psychiatrists in rural areas is also made evident in the data presented in Table 2. As shown, rate of growth for MBS subsidised mental health services is highest in in regional, rural and remote areas, in some cases, six times higher.

FIFO and outreach services offer an alternative where specialist services are otherwise unavailable, [however] they ‘should not be seen as permanent solutions’ or replacements for a workforce based on the location.5

While visiting specialists provide an adequate short-term solution to the problems noted above, they do not address the psychiatry workforce pressures within the mental health system overall, nor do they address the problem that many people with mental conditions living in these communities face which is a lack of continuity of care and access to a broader range of mental health care services. In the large regional hospital I work in, all the senior management are FIFO, and almost all the VMOs. They have no committed connection to the region, or to VMO succession planning. Also, the defunding of outpatient services and consequent outsourcing to NGOs and deskilling of outpatient services is very disheartening. This is a false economy which will have long-term effects on whether clinicians can bear to work in the public system.

Workforce Survey Respondent – Psychiatrist, Rural LHD

The trend to fly-in services, while no doubt well-intentioned, has probably had an adverse effect on attracting more psychiatrists to live in regional areas. In other specialties, locally, I have observed, that if a specialist wants to move here, they have little difficulty in getting a VMO position at the base hospital. This provides a firm foundation for their practice, and most of them stay, set up a local practice, become very invested in the local community and spend their money locally. In psychiatry it has been inordinately difficult to attract people, and when they do come, they are not welcomed by the public mental health service, are often only employed as locums and inevitably they never get attached to the community and usually fairly quickly move back to the city.

Workforce Survey Respondent – Psychiatrist, Rural LHD

10 Assumes a population of 100,000 people.
11 8 were not stated
### TABLE 1 - Current and projected population, number of public sector psychiatrists per 100,000 by LHD

<table>
<thead>
<tr>
<th>LHD</th>
<th>2019</th>
<th>2036</th>
<th>Change</th>
<th>% + or -</th>
<th>Admissions mental disorders 2017-18</th>
<th># Suicide (rate per 100,000)</th>
<th># of public sector psychiatrists (headcount) as July 2019</th>
<th>Psychiatrist/population size</th>
<th>Per 100,000 population 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Staff specialists</td>
<td>VMOs</td>
</tr>
<tr>
<td><strong>City/metropolitan areas</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sydney</td>
<td>686,694</td>
<td>895,790</td>
<td>209,096</td>
<td>30%</td>
<td>16,000</td>
<td>54 (7.7)</td>
<td>71</td>
<td>5</td>
<td>76</td>
</tr>
<tr>
<td>Northern Sydney</td>
<td>945,497</td>
<td>1,121,810</td>
<td>176,313</td>
<td>19%</td>
<td>21,103</td>
<td>49 (7.3)</td>
<td>71</td>
<td>17</td>
<td>88</td>
</tr>
<tr>
<td>South Eastern Sydney</td>
<td>947,829</td>
<td>1,124,960</td>
<td>177,131</td>
<td>19%</td>
<td>17,058</td>
<td>97 (9.8)</td>
<td>60</td>
<td>8</td>
<td>68</td>
</tr>
<tr>
<td>South Western Sydney</td>
<td>1,019,985</td>
<td>1,402,810</td>
<td>382,825</td>
<td>38%</td>
<td>13,701</td>
<td>84 (8.6)</td>
<td>29</td>
<td>34</td>
<td>63</td>
</tr>
<tr>
<td>Western Sydney</td>
<td>1,027,226</td>
<td>1,482,480</td>
<td>455,254</td>
<td>44%</td>
<td>17,585</td>
<td>56 (5.8)</td>
<td>59</td>
<td>5</td>
<td>64</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,627,231</td>
<td>6,027,850</td>
<td>1,400,619</td>
<td>30%</td>
<td>85,447</td>
<td>340</td>
<td>290</td>
<td>69</td>
<td>359</td>
</tr>
<tr>
<td><strong>Regional and rural areas</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Staff specialists</td>
<td>VMOs</td>
</tr>
<tr>
<td>Far West</td>
<td>30,060</td>
<td>27,780</td>
<td>-2,280</td>
<td>-8%</td>
<td>500</td>
<td>NA</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Southern NSW</td>
<td>214,124</td>
<td>250,170</td>
<td>36,046</td>
<td>17%</td>
<td>2,330</td>
<td>35 (16.1)</td>
<td>0</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Mid North Coast</td>
<td>223,355</td>
<td>251,910</td>
<td>28,555</td>
<td>13%</td>
<td>4,513</td>
<td>35 (15.1)</td>
<td>5</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Murrumbidgee</td>
<td>243,309</td>
<td>244,740</td>
<td>1,431</td>
<td>1%</td>
<td>2,872</td>
<td>48 (21.5)</td>
<td>0</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Western NSW</td>
<td>283,615</td>
<td>301,690</td>
<td>18,075</td>
<td>6%</td>
<td>3,577</td>
<td>38 (13.8)</td>
<td>4</td>
<td>41</td>
<td>45</td>
</tr>
<tr>
<td>Northern NSW</td>
<td>306,903</td>
<td>344,060</td>
<td>37,157</td>
<td>12%</td>
<td>3,167</td>
<td>49 (17.6)</td>
<td>8</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>Central Coast</td>
<td>348,472</td>
<td>415,060</td>
<td>66,588</td>
<td>19%</td>
<td>8,498</td>
<td>41 (11.9)</td>
<td>14</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Nepean Blue Mountains</td>
<td>385,180</td>
<td>466,660</td>
<td>81,480</td>
<td>21%</td>
<td>8,959</td>
<td>50 (13.6)</td>
<td>17</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>Illawarra Shoalhaven</td>
<td>416,091</td>
<td>471,700</td>
<td>55,609</td>
<td>13%</td>
<td>7,139</td>
<td>51 (13.1)</td>
<td>18</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>Hunter New England</td>
<td>942,374</td>
<td>1,063,870</td>
<td>121,496</td>
<td>13%</td>
<td>18,717</td>
<td>154 (16.5)</td>
<td>46</td>
<td>20</td>
<td>66</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,393,483</td>
<td>3,837,640</td>
<td>444,157</td>
<td>13%</td>
<td>60,272</td>
<td>501</td>
<td>112</td>
<td>184</td>
<td>296</td>
</tr>
<tr>
<td>Justice</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>43</td>
<td>19</td>
</tr>
<tr>
<td>Sydney Children’s Network</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td>8,022,733</td>
<td>9,867,526</td>
<td>1,844,793</td>
<td>23%</td>
<td>145,719</td>
<td>868 (10.1)</td>
<td>460</td>
<td>277</td>
<td>737</td>
</tr>
</tbody>
</table>

Notes:
- LHD: Local Health District
- # Suicide (rate per 100,000): Suicide rate per 100,000 population
- # of public sector psychiatrists (headcount) as July 2019: Number of public sector psychiatrists as of July 2019
- Psychiatrist/population size: Psychiatrist per 100,000 population
- Per 100,000 population 2019: Psychiatrist per 100,000 population in 2019

* Figures may not add up due to rounding.
### Actions required

People living in regional and rural communities deserve the same level of access to mental health care as people living in city and urban areas. This means providing greater access to psychiatrists including those who work privately and those who specialise in certain fields, for example, addiction, trauma, old age and young people who make up a large and growing number of people who commit suicide.

We need to find ways to build and retain a ‘critical mass’ of psychiatrists so that it is attractive for them to want to work and live in the community and overcome the professional and organisational disadvantages of remoteness from urban centres.

To that end, we call on the government to invest $2.5 million over five years to establish the Rural Psychiatry Project to build a sustainable psychiatry workforce in rural NSW and improve rural mental health service capacity through provision of peer support and continued professional development. Funds will be used to employ one full-time project officer, a 0.4 staff specialist to oversee implementation of the Project and trainees’ educational expenses (e.g. attending Congress, books, internet, research project, travel etc.). This particular initiative should be overseen by the NSW Branch of RANZCP in partnership with NSW Ministry of Health.
Improve access to the mental health system

Properly fund the Mental Health Access Line (MHAL) to ensure people with mental health conditions, their carers and health care professionals access the right mental health service at the right time and place.

QUICK FACTS

MHAL was established more than a decade ago to provide triage and assessment of people with mental health conditions. Depending on the help needed, the service links the person up with a local mental health service for ongoing support. The line is staffed by mental health experts and operates 24/7 all over NSW.

Psychiatrists use the service to follow-up on patients discharged from hospital or refer them to a service in the community, often a crisis team.

For many people with mental health conditions, MHAL is the first entry point into the mental health system.
In 2019, the NSW Branch surveyed members about their experiences of MHAL. The survey found significant shortcomings in the operations of the service to the extent that these were putting lives at risk and causing users of the service to feel frustrated, helpless and stressed.

The evidence received from our Fellows regarding MHAL paints a worrying picture about the quality and standard of the service. We heard that approaches to referral, triage and advice are not consistent and that some MHALs refuse referrals because patients are considered high risk (e.g. not age appropriate e.g. a child) or not having the right primary diagnosis (e.g. dementia).

We heard members who responded to the survey say they have given up using MHAL because it wastes their time, many of their calls are not returned, they are put on hold for lengthy periods of time (sometimes up to two hours) and referrals getting bogged down in bureaucratic processes. Many also said they would stop using the service altogether if not for the fact they are forced to use it.

Of grave concern to us were reports of the service turning consumers away because their needs were too complex or were at risk of suiciding.

**Actions required**

The NSW Premier has made suicide prevention a top priority during its next term of government. Any approach to suicide prevention must include a commitment to the provision to timely and accessible mental health services. An effective, clinician-staffed MHAL is an important component in the suite of services needed to address the suicide epidemic in this country. We noted in our 2019/20 PBS that approximately $30 million per year (based on tender responses over a decade ago) was needed to make MHAL a fully operational and comprehensive service, but with improvements in technologies since, it is likely to be a less expensive.

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Children and young people

Coordinate to intervene early

Invest $500,000 undertaking consultations across all NSW Local Health Districts and Networks to identify service co-ordination gaps in mental health services for children and young people.

Invest $750,000 annually creating 10 Child and Adolescent Psychiatry Trainee Fellowships to build capacity and capability in specialist child and adolescent psychiatry in high need areas.

QUICK FACTS

- Since 2007, the rate of suicide among 17-24 year olds has almost doubled from 55 to 103 in 2017. Hospitalisation rates have increased by 50% for this cohort over this same period (see graph).  
14

- As at 30 June 2018, there were nearly 14,000 children and young people in statutory out of home care. Of these, 40% were Aboriginal.  
15

- 75% of mental health problems first appear before the age of 25.  
16

- 1 in 4 young people aged 16–24 experience a mental illness.  
17

17 Ibid.
The mental health system works well when consumers receive the mental health support they need, when and where they need it. It also works well when various parts of the system work together to deliver the best care. However, as reported by our Fellows, many children and young people have difficulty successfully navigating different service systems relating to mental healthcare. Some of these include early childhood services, housing, employment, and income support, and services that help with legal and alcohol and drug issues.

We heard the current fragmentation of services in mental health is not maximising the best outcomes for children, young people and their families. Poor planning can lead to a service environment that is difficult to navigate. This is further impacted by a lack of capacity in localised service delivery required to respond to complex need.

When we consulted our Fellows about the needs of children, adolescents and young people with mental health conditions, they told us coordination works well in some areas and with some services, but there is still a long way to go to achieve effective service coordination and integration for this vulnerable group.

Our Fellows told us that childhood and adolescence offers a crucial window of opportunity to intervene early to prevent children and young people developing serious mental illness and self-harming. Funding to implement prevention and early intervention services starting from pregnancy to start of school aligned with the “First 2000 days’ policy could be the investment that would make a difference to our children’s long term future. They tell us they need core psychosocial issues tackled by wraparound services. This is particularly important in preventing young people entering the criminal justice system.

We also heard that some health districts are unable to provide a full-range of experiences for child and adolescent psychiatry trainees (e.g. preschool services, juvenile justice, developmental disability etc.) to meet advanced training requirements and build capability and capacity in this area of specialist care. Our Fellows are advocating for fully funded fellowships to guarantee future supply of and patient access to child and adolescent subspecialists care.
Our visits ... reminded us of the importance of service coordination to ensure that our children and vulnerable members of our community have the chance to reach their full potential and contribute to the prosperity of our state.

The Hon Bronnie Taylor MLC
Committee Chair

Actions required

Our Fellows who specialise in child and adolescent psychiatry told us governments need to continue funding a fully integrated child and adolescent mental health services that coordinates care from prevention to early intervention through to clinical and specialist care. However, this needs to happen in a planned and considered way that takes into account of existing services and needs of the local community. To that end, the Branch calls on the government to invest $500,000 holding consultations with key stakeholder groups across all LHDs to map and benchmark existing services, highlight what is working and what is not, and commit to fund identified gaps.

In our consultations, our Fellows highlighted the need to invest in child and adolescent opportunities to build capacity and capability in child and adolescent psychiatry to ensure children and young people get the care and mental health support they need over the longer term. For this reason, we are calling on the government to invest $750,000 annually creating 10 (five full-time and five part-time) Child and Adolescent Psychiatry Trainee Fellowships to be located in high need areas.

SPOTLIGHT

Outreach Support for Children and Adolescents (OSCA) provides a specialist mental health service within Child Youth Mental Health Service (CYMHS) that provides short-term (up to 4 months) intensive and outreach interventions. Referrals for OSCA are through the local CYMHS community teams.

OSCA offers a family focused multidisciplinary approach aimed to provide more intensive work for young people (under 18 years) and their families who are experiencing moderate to severe mental health issues.


19 Based on estimation that each Fellowship costs around $100,000.
Personality disorder is a term used to describe personality traits when they have become extreme, inflexible and maladaptive. This tends to create a pattern of problems that cause the person and those around them significant distress over a period of time.

It is thought that around 7-11% of the Australian population suffers from this pattern of problems at any given point in time. In relation to the NSW population, this percentage equates to 525,000 and 750,000 people having condition. It is also thought trauma (and related conditions such as PTSD) plays a causal role in borderline personality disorder (BPD).

**People with complex traumatic and personality disorders**

**Invest to build capability of the mental health workforce**

Invest $2 million annually to develop the capability of the mental health workforce in delivering therapeutic interventions and supports for consumers with complex trauma and personality disorders.

**QUICK FACTS**

The condition is estimated to account for 40% of psychiatric inpatient hospitalisations.

People with personality disorders are more likely to self-harm or commit suicide.

They are also more likely to experience stigma, depression, and anxiety disorders and to misuse alcohol and other drugs.

It is estimated that 60-70% of the prison population has BPD.

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20 NSW population is around 7,500,000.
When our members talk about people who have complex trauma and personality disorders they voice concern about the mental health workforce not being adequately trained to identify, treat and manage people with this mental health condition. They say people with this condition and their families face significant stigma and discrimination and are frequently excluded when they attempt to access services from emergency departments and mental health services. They also say many do not receive evidence-based help because many front-line health workers do not know how to recognise the condition, its underlying causes (i.e. trauma), and administer evidence-based treatments. They also talk about the way complex trauma affects both physical and mental health and contributes to co-morbidity.

Our Fellows tell us current services and programs such as the Westmead Psychotherapy Program and Project Air are inadequately resourced to carry out the level and kind of training needed to equip front-line staff with the right skills. They tell us these organisations need to be funded and established in the same way as those operating in Victoria which last year invested $10 million over four years for the Personality Disorder Initiative.

**Actions required**

Given the population prevalence, the high hospital admissions, the high rate of suicide and self-harm characteristics of BPD, and the state government’s intent to decrease the suicide rate, attention must be given to responding more positively to people with BPD and complex trauma. Most patients with complex trauma and personality disorder will be best treated in the community before they reach crisis. To that end, we are calling on the government to invest $2.5 million annually in building awareness and skills in the wider workforces related to identifying BPD like symptoms (often in the context of trauma) adopting supportive behaviours, developing appropriate diagnostic and treatment pathways and delivering definitive treatment. Consideration should be given the establishment of an equivalent to Spectrum or upscaling services such as the Westmead Psychotherapy Program to have a state-wide remit.

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Forensic

Ensure equivalency of care for people with mental illness in custody

• Invest $3 million annually to increase bed capacity (by up to 15 beds) for prisoners with severe mental illness

• Establish an appropriate number of Assertive Multidisciplinary Case Management Teams (with clinical leadership by a psychiatrist) to provide assertive treatment, follow up and release planning for those in prison with serious mental illness. 25

Premier’s priority 10. Reducing recidivism in the prison population. Reduce adult reoffending following release from prison by 5 per cent by 2023.

QUICK FACTS

• Prisoners are 2 to 3 times as likely as those in the general community to have a mental illness and are 10 to 15 times more likely to have a psychotic disorder. 26

• 40.1 per cent of adults released from prison in 2017 had re-offended within a year of their release. For Aboriginal people, the rate is 70%.

25 This would ideally reflect one case manager per 15 to 20 prisoners with serious mental illness if equivalent to the community.

In custody, if a person is found to be acutely unwell and is assessed as a mentally ill person requiring inpatient involuntary care they are placed on a waitlist for a bed at a declared facility. It can take several weeks to be transferred to a declared facility for treatment, and during that time the person may remain acutely unwell and untreated. If they are at risk of harm to themselves they are placed in a safe cell which is generally regarded by inmates as harsh and extremely distressing.  

Under Rule 24 of the UN Standard Minimum Rules for the Treatment of Prisoners, prisoners and detainees have the same rights to availability, access and quality of mental health care as the general population. However, when we talk to our Fellows who work with mentally ill people in custody, they tell us many of these individuals are denied this right. They tell us inmates with severe mental illness receive nowhere near the same level of access to care and treatment as people with the same condition living in the community do. They also tell us it is not uncommon for people (sometimes up to 15) to have to wait weeks, even months, to be transferred to a prison hospital or declared facility to get the treatment they need. And if they are at risk of harm, it’s also not uncommon for them to be put in seclusion for long periods of time. We hear this happens a lot even though the law provides for inmates in this situation to have equal access to treatment.

We also hear prisons are increasingly being used as treatment centres when clearly they are inappropriate environments to be providing healthcare; it compromises clinical care and proper management of prisoners, and breaches human rights. We hear this happens because there aren’t enough beds in the corrections hospital system to transfer patients into, or because there aren’t enough resources to enable patients to be transferred to a (declared) facility in the community. Either way, more needs to be done to ensure severely mentally ill people in custody receive treatment in an equivalent timeframe to patients in the community. This view is consistent with recommendation 16.2 of the Productivity Commission’s Draft Report on mental health.

**Actions required**

If government is serious about reducing re-offending rates and giving people released from prison the best chance of staying out of prison and re-integrating successfully back into the community, then more resources need to be put in to adequate treatment programs, secure hospital beds and post-release support, which includes case-management and housing.

To this end, we are calling on the government to:

- Invest $3 million annually to increase bed capacity (by up to 15 beds) for prisoners with severe mental illness
- Establish an appropriate number of Assertive Multidisciplinary Case Management Teams (with clinical leadership by a psychiatrist) to provide assertive treatment, follow up and release planning for those in prison with serious mental illness.

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28 Section 55 of the Mental Health (Forensic Provisions) Act 1990 allows for transfer of a correctional patient to any declared mental health facility. 29 Thus: “National mental health service standards should apply to mental healthcare service provision in correctional facilities to the same level as that upheld in the community.”
30 NSW Faculty of Forensic Psychiatry Subcommittee, Treatment of Mentally Ill in Custody, Issues Paper, 15 November 2019
Older people

More support is needed for older people with mental illness

Invest $28 million over four years to employ 45 clinical nurse specialists (in old age psychiatry) across NSW to enable increased access to mental health services for older people with a mental illness who are at risk of social isolation and suicide.

Invest $26 million over four years establishing 16 Assertive Outreach Teams to provide multidisciplinary care, comprehensive assessment, proper care planning, and follow-up monitoring and care of older people with severe mental health conditions.

Premier’s priority 10. Towards zero suicides. Reduce the rate of suicide deaths in NSW by 20 per cent by 2023.

QUICK FACTS

- Hospitalisation rates of people 65+ with mental health disorders have doubled in the past 10 years (see graph). \(^{31}\)
- The number of suicides among this age group has increased from 92 per year to 146 (or 59%) over this same period. \(^{32}\)
- The number of older people with mental health problems is projected to grow by 34% over the next ten years, in line with the total 65+ population growth rate. \(^{33}\)
- By 2026, there will be an estimated 260,000 people aged 65 years and over with a mental health problem in NSW, and approximately 56,000 (3.3% of the 65+ population) with a severe mental illness requiring care from specialist mental health services. \(^{34}\)

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33 NSW Health. NSW Older People’s Mental Health Services Service Plan 2017-2027 [cited 17 December 2019]
34 Ibid
NSW’s population is ageing. The number of people aged over 65 is expected to increase to 2.1 million people by 2036, growing at nearly three times the rate of the general NSW population. It is expected people aged 85 years and over will double over this period (see Table 1).

These population projections suggest that people with long standing mental illness will be joined by those with mental illness that develops in later life. Such illnesses include depression, anxiety disorders, schizophrenia and other psychotic illnesses, bipolar disorder, alcohol and substance misuse disorders and dementia.

Our Fellows who specialise in psychiatric care of older people tell us the causes and management of mental disorders in older people are complex and not easily addressed, for instance antipsychotic medication. They also tell us that timely and easy access to services for older people with these conditions are often lacking, and their complex needs are not being met by the healthcare, disability or aged-care sectors.

**Population projections by age cohort 65 and 85+**

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<th>Year</th>
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<th>2021</th>
<th>2026</th>
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</table>

**Hospitalisations by cause: Mental disorders, persons aged 65+ years. NSW 2007-8 to 2017-18**

**Number of suicides 65+ in NSW from 2007-2017**

**Actions required**

Our Fellows who specialise in old age psychiatry tell us access to timely assessment and treatment for old people with mental health conditions is essential if they are to be cared for and supported properly in the community and avoid hospitalisation or institutional care. For this reason, they are calling on the government to invest $54 million over four years to:

- Employ 45 Clinical Nurse Specialists (in Old Age Psychiatry) in Older People Mental Health Community Services to work with mentally ill old people undertaking assessments (within 48 hours of referral), commencing treatment/recovery plans, and monitoring patient outcomes.
- Establish 16 (15 LHDs and one Justice Health) Assertive Outreach Teams within existing Older People Mental Teams services to provide home-visits to patients requiring regular monitoring, support and assistance with medication. The team would operate on an extended-hours basis (e.g. 7am to 8pm) seven days a week and comprise one 0.4 psychiatrist, one full-time nurse and one occupational therapist.

35 In particular long acting injectable medications, and mood stabilisers, may not be well tolerated and need regular review to carefully titrate treatment response against adverse effects.


37 Clinical Nurse Consultant costs approximately $153,000 per year to employ. 45 CNCs (x $153,000) over four years equates to $28 million (amounts include on-costs).

38 One staff specialist (psychiatry) costs $353,000 to employ per year. 16 at 0.4 FTE equates to $2,296,000. 16 (full-time) CNCs costs $2,460,000 and 16 (full-time) Occupational Therapists costs $1,840,000. Total investment over four years is $26,384,000.
Case Study

Mrs Genny K is a 78-year-old woman with a long history of schizophrenia. In her younger years, her psychotic episodes would occur every ten years or so, she managed to work as a secretary and was a keen gardener. Over the past ten years, her illness has become increasingly chronic and severe, she has been left with chronic symptoms such as poor motivation and auditory hallucinations and requires regular antipsychotic medications to prevent a relapse of severe psychosis that would require hospital admission at least annually. She moved home several times due to her paranoia and is now living in department of housing accommodation. She lives alone, is suspicious of other people and has very only limited contact with her two adult children. Genny currently attends the community health centre for olanzapine injectable medication monthly and is required to stay for at least two hours on each occasion due to physical monitoring requirements, which she finds both inconvenient and distressing. She does not like injections and reports pain at the injection site each month. She has very poor insight into her mental illness and multiple previous trials of oral medication have led to relapse of psychosis as she does not take her medications at home. With an assertive /outreach home treatment team in place we could offer oral medications and regular monitoring at home, with the aim of encouraging improved mental health, stable accommodation and enhanced community engagement and activities that will help to maintain her mental health.
Contact

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