Mental Health, Royal Commission

REGIONAL AND RURAL AREA MENTAL HEALTH

Joint Submission

July 2019

Albury Wodonga Health

Ballarat Health Services

Bendigo Health

Goulburn Valley Health

Latrobe Regional Hospital

Contents

Executive Summary

It is widely acknowledged, and welcomed, that a broad review and service reform is required across the Victorian Mental Health System. Each of the Designated Mental Health Services (DDMHS's) that make up that system will have unique challenges and areas for consideration in relation to service provision for their catchment area. In addition to this, there are four core, overarching themes in respect to mental health service provision in rural and remote communities that the five regional DMHS's participating in this particular submission felt needed to be collectively emphasised in addition to local submissions. These relate to:

- funding models that acknowledge and adequately reflect the increased cost of service provision to rural communities;
- the development of workforce strategies targeted at maximising recruitment and retention of specialised mental health staff in regional areas;
- considered planning in relation to infrastructure that promotes evidence based service provision across all service settings; and
- minimisation of additional patient and family/carer burden by ensuring equitable access to specialist mental health services, which are currently located in metropolitan areas

It is anticipated that in reshaping mental health care provision across Victoria, service provision to remote and rural communities does not continue to be overlooked and underestimated, but is rather overtly acknowledged and strengthened in the recommendations of the Royal Commission.

Funding Reform

Requirement: funding reform that is equitable across DMHSDMHS's and accounts for the unique requirements of each in providing effective and timely mental health services across a range of geographical and remote regions

An examination of the barriers to accessing mental health services experienced by Victorians was recently explored through an audit conducted through the Victorian Auditor-Generals Office (VAGO), *Access to Mental Health Services, March 2019*. The report, inclusive of outcomes and recommendations, speaks to the ongoing and systemic factors impeding timely access to services when and where communities need them, including an examination of current funding inequities and deficiencies across Victorian Designated Mental Health Services (DMHS's). This is of particular concern for regional DMHS's who experience higher operating costs that further increase the gap between funded and actual cost of service provision within their catchment area.

DMHS's receive block funding comprising a set price per bed day rate for inpatient and residential programs. Community based services are calculated on a per service hour basis, measured against the service hour target determined by DHHS for each DMHS. These rates are applied without consideration to the specific needs of the DMHS's and the communities within their catchment area. Such considerations disregarded in the calculation of service funding, but pivotal in providing effective and efficient mental health services, include:

- Population; including growth, ageing and index for relative socioeconomic advantage and disadvantage (IRSAD)

- Special populations; including Aboriginal and Torres Strait Islander peoples and people of refugee backgrounds

- Unmet demand; allowing for recognition of shortfalls in current service provision

- Distance and access to transport between communities and services; accounting for the travel required for individuals and family/carers to access the services they require as well as the travel for services to provide outreach treatment and support. For individuals relying on public transport to access services, consideration to both the presence of transport between their community and the location of services, as well as the timing of this access is required; i.e. for individuals relying on transportation via train, the availability of a train that travels between the two points is just as important as how often that route is available, once a day versus every hour

- Availability / presence of other service providers within the catchment area; a lack of GP's or private psychiatry and psychology services increases reliance and demand on DMHS's to fill the gap. In addition, the presence of sub-regional, small rural hospitals which, despite the absence of dedicated mental health funding and support (bed and clinicians), are experiencing mental health presentations to their Urgent Care Centres (or equivalent). In these circumstances support from DMHS's in relation to both practice in the form of consultations, assessment and patient transfers, as well as education to build capacity within

these workforces is significant and unaccounted for in the funding model. Limited market forces in relation to NDIS providers also increases unaccounted for demand on DMHS's to meet the unseen gap in the support needs of individuals within their region

- Increased likelihood of dual relationships and the effects of traditional rural stoicism; both a strength evidencing itself within strong community relationships, these can also result in added barriers to early and timely engagement with mental health services for some. There is an increased likelihood of a person having a social or familial relationship with the local mental health practitioner in rural and remote communities which may impact a person's willingness to seek local mental health care. Strategies to address this will need to allow for individual choice in relation to where they seek mental health support. This will require both equity in the location of services to increase access without the burden of significant travel as well as flexibility within access 'zoning'

A funding reform is urgently required to allow DMHS's to meet current unmet demand within their region before being in a position to be able to effectively expand services in line with community need and future growth. This cannot be achieved without a funding model that is reflective of the unique requirements of each DMHS in supporting patients and delivering mental health services that meet the changing needs of the communities they service across a range of geographical locations.

In addition, funding must support innovative approaches to service provision in which distance and cultural differences are a significant challenge. This necessitates particular investment in relation to ensuring culturally appropriate services (e.g. increasing access to interpreters in remote areas) as well as in infrastructure to address geographical distance; i.e. cars, mobile devices (phones and computers for access to digital clinical information at the point of care) and telehealth. Support for alternative approaches to service provision and models of care, including incentives to increase and standardise integration and collaboration across service sectors, should also be reflected with the aim of early identification of individual need and ensuring the appropriate and timely service response despite the barriers that currently impede access and engagement in remote and rural regions.

Workforce Development

Requirement: strategy development specific to the rural mental health workforce in relation to all disciplines fundamental to effective mental health service provision (medical, nursing and allied health) and inclusive of the lived experience workforce

Re-instatement of endorsement as a mental health nurse on AHPRA registration, accompanied by reforms in undergraduate education to acknowledge and re-establish the speciality of mental health nursing

Specialised mental health clinicians are a dwindling commodity, with the national and international shortage being experienced projected to considerably worsen over the coming decade. Without urgent focus and the development of long term strategies to address and reverse the shortage, further direct impact on the capacity and quality of mental health service provision across all DMHS's will continue and will impede future growth in step with population changes in size and need. A 'one-size fits all' approach with metro-centric workforce strategies to date has not worked and strategies to effect change in relation to attraction and recruitment, mental health undergraduate education for all disciplines, as well as workforce retention is needed.

Workforce training should be localised to allow for individuals to train and stay within their region. Evaluation of workplace employment for graduates who trained at regionally located universities showed that 80 per cent of rural graduates who grew up in regional/rural Australia and undertook training at a regional university, went on to employment within regional and rural communities (Brown et al. 2017, p. 46; Simpson & Wilkinson 2002, p. 1.). Development/re-instatement of pre-qualification mental health specific courses for nurses and allied health disciplines that prepare graduates for roles within the speciality of mental health, as well as for remote and rural practice, will serve to support workforce growth, capability and retention in these areas. Currently, many undergraduate nursing courses only include 40 hours of mental health content in addition to a three week practical placement.

In addressing the workforce needs specific to regional DMHS's, alternative and additional workforce models and disciplines (i.e. a strengthened and supported lived experience workforce to compliment the qualified clinical workforce, advanced allied health models, Nurse Practitioner and advanced practice nursing led models etc.) should also be explored. While focus on increasing support for a lived experience workforce is required, it is crucial that this is not undertaken in lieu of or at the expense of developing and increasing the clinical mental health workforce. In addition, consideration to overcoming current barriers to training, particularly in relation to local Psychiatrist Training Programs, in rural areas due to the criteria for supervision, through incentivised central support using video conferencing, should also be reflected in the development of a workforce strategy specific to regional DMHS's.

Focused strategies to address the typically unfavourable lens applied to mental health professionals within the media, public and at times the healthcare system, need to be prioritised to optimise attraction and uptake of a career in mental health. This should include transparent recognition and discussion at a community level distinguishing antisocial behaviour from incidents resulting from

mental illness, as well as occupational violence. Government support to address occupational aggression, particularly in the context of increased alcohol and drug related presentations, in a manner that doesn't further demonise individuals with a mental illness, is critical. Everyone accessing and providing mental health support needs to feel safe; patients, visitors and staff. This requires access to the right service without delays, within the right environment and provided by an appropriately skilled workforce.

Infrastructure development to ensure therapeutic environments

Requirement: planned, purpose-built, consistent and comprehensive infrastructure development for the provision of enhanced and comprehensive service provision with clear commitment to funding and consideration for:

- **bed-based mental health service provision in a therapeutic and recovery focused environment with consideration of integrating inpatient units in general hospitals**
- **community based service provision within purpose built mental health hubs that consider and promote colocation with key service providers across service sectors**

The majority of mental health facilities were built or re-purposed over 20 years ago as a result of de-institutionalisation and, despite efforts to maintain these environments, many no longer appropriately accommodate the cohort of patients they service. DMHS's are left to make the best of outdated and impractical facilities in order to safely treat and support patients with increasingly complex needs, often at significant cost. All while trying to create an environment that is welcoming, therapeutic and supportive of risk mitigation and patient recovery across all age demographics and service settings.

All DMHS's require purpose built, bed-based facilities across a broad and consistent range of care and population needs. This includes inpatient psychiatry facilities with adequate numbers of age and gender-specific beds and dedicated intensive care areas; adult and youth Prevention and Recovery Care (PARC) facilitates; Continuing Care Units (CCU); Secure Extended Care Units (SECU's) and; aged psychiatric residential care beds. The latter will be particularly important with increasing population longevity, including for people with severe mental illness. Ensuring a broad and consistent range of services is available within the catchment area of every DMHS is crucial in ensuring timely access to services, while minimising patient, family and carer burden due to increased cost and time from travel requirements.

Thought to how services will accommodate the currently required as well as future growth, in terms of infrastructure and location, also needs to be planned for in a considered manner. For example, when future growth requires additional inpatient beds across DMHS's, how these beds are incorporated at a service level will be crucial in maximising the impact of these beds on service provision for the community accessing them as well as the services governing them; i.e. should they be integrated within existing units or added as an additional unit within the same service.

Facilities, especially bed based, need to reflect a recovery-based model of mental health care, enabling patients to participate in everyday living and leisure activities. Occupational engagement should be promoted at all points of a person's care, including supporting people to actively participate in or independently complete activities of daily living and leisure. It has been estimated that up to 70 per cent of a person's day during an inpatient admission is 'down time' or not purposefully occupied by the development or practice of everyday living skills (King, McCluskey & Schurr 2011, p. 654). Environments and workforce levels need to promote and support everyday functioning.

In addition, statewide planning in relation to infrastructure needs to be informed by evidence-based exploration of models for co-location with broader health and other key service providers required to meet the complex needs of individuals within the catchment area of the DMHS. This would include purpose built facilities that would allow and promote the co-location of inpatient and community based mental health services with other key agencies including, Housing and Employment, Drug and Alcohol, Dual Disability, Justice, as well as Child Protection and Family Violence services.

Metropolitan based Specialist Mental Health Services

Requirement: serious consideration to ensuring regional DMHS's are funded and supported with the required infrastructure to deliver core mental health streams and reduce reliance on metropolitan based specialist services, particularly in relation to CDMHS inpatient and community based services

Whilst there is a reasonable range of statewide specialist services within the Victorian mental health system, the vast majority of these are Melbourne based. As a result, these services, including Eating Disorder, Forensic, Personality Disorder, Neuropsychiatry and CDMHS inpatient beds, are often in high demand resulting in delayed access and a limited ability to provide early intervention. In addition, geographical distance further compounds access issues for patients and their family/carers living in rural and remote areas of Victoria.

Access to specialist services, particularly in relation to CDMHS, is critically important to regional areas, which need both CDMHS inpatient beds as well as much greater CDMHS and perinatal mental health capacity to address the effects of adverse childhood experiences. While it is acknowledged that these are higher in populations with greater socioeconomic disadvantage (IRSAD), which in turn is more likely to occur in rural Victoria, services remain underfunded and, particularly in relation to CDMHS inpatient beds, unavailable in these regions. Without early and appropriate intervention for these high risk and complex patient cohorts, delayed treatment and pressures faced by DMHS's and generalist health services, to support these patients in the absence of optimal expertise or an ideal environment will continue.

For patients and their family/carers living in rural and remote areas, access to Melbourne-based services incurs significant family dislocation, costs associated with travel, accommodation and lost income, as well as removing the sufferer from the social and service supports within their local community. For example, a patient living in Barham (located within the catchment area of Albury Wodonga DMHS) who requires an inpatient admission to a Melbourne based specialist service will require travel of up to four hours one way. If the admission occurs via Albury Wodonga Health services, travel increases to seven hours to facilitate admission to an appropriate specialist facility. Travel time of this length is not limited to this particular rural community. For example, facilitation of a CDMHS admission for a patient living in Horsham (located within the catchment area of Ballarat Health DMHS) requires travel of up to three hours one way.

A review of the location of Victoria's specialist statewide services, as well as the capacity of these services to meet demand, is required to ensure timely and equitable access across all catchment areas minimising additional burden to patients and the family/carers. Without review and change in this respect, regional DMHS's will continue to experiences avoidable challenges in relation to providing effective, holistic care that promotes recovery and aims to support individuals to remain within their own community.

References

Brown, L.; Smith, T.; Wakely, L.; Wolfgang, R.; Little, A.; Burrows, J. Longitudinal tracking of Workplace Outcomes for Undergraduate Allied Health Students Undertaking Placements in Rural Australia. *Journal of Allied Health* 2017, Summer, 46

King. A., McCluskey, A. & Schurr, K.: The time use and activity levels of inpatients in a co-located acute and rehabilitation stroke unit: An observational study. *Topics in Stroke Rehabilitation*, 2011, 18:sup1, 654-665, DOI: 10.1310/tsr18s01-654

Simpson, M.D., Wilkinson, J.M.: The first graduate cohort at Charles Sturt University: What impact on the rural pharmacist shortage? *Pharmacy Practice and Research* 2002, 32, 1.

2019 Submission - Royal Commission into Victoria's Mental Health System

Group Submission

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Please find attached joint submission document in respect to regional and rural mental health service provision considerations and requirements across four key themes: -Funding reform - Workforce development -Infrastructure development to ensure therapeutic environments - Metropolitan based Specialist Mental Health Services Submission prepared and endorsed by the following Regional DMHS's: - Albury Wodonga Health - Ballarat Health Services - Bendigo Health - Goulburn Valley Health - Latrobe Regional Hospital "

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
N/A

What is already working well and what can be done better to prevent suicide?
N/A

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
N/A

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
N/A

What are the needs of family members and carers and what can be done better to support them?
N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
N/A

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
N/A