Submission No 181

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: Deniliquin Mental Health Awareness Group (Deni MHAG)

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This is a submission on behalf of the Deniliquin Mental health Awareness Group in Deniliquin, NSW.

We are a volunteer group that have actively been working to raise awareness of mental health services in our region; how to access and work collaboratively with MLHD and MPHN to try and raise awareness of pathways and services.

We are a not -for -profit volunteer group, who has no access to state or federal funding and have to look for funding opportunities to achieve our goals. As a group we try and fill those gaps that are so huge, in particular to advertising, awareness campaigns and health services actually actively promoting their services.

Our website is one-of-a-kind and the type of localised information should be something that is available throughout all communities- but sadly does not exist. Our group works incredibly hard, all volunteer hours, to fill this massive gap that exist in the health service space.

www.denimentalhealth.org.au is our website and I urge you to look at this.

Health Outcomes for people living in rural, regional and remote NSW

We refer you to the following website https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/summary. Document attached.

On average, Australians living in rural and remote areas have shorter lives, higher levels of disease and injury and poorer access to and use of health services, compared with people living in metropolitan areas. Poorer health outcomes in rural and remote areas may be due to multiple factors including lifestyle differences and a level of disadvantage related to education and employment opportunities, **as well as access to health services.**

Our access to mental health services are limited, despite the fact that MLHD delivers a huge range of services. AS always, we believe they do what they can, however this is not good enough. There simply is not adequate funding to deliver care in a timely manner, with enough clinicians. **This is not a criticism of them. This is criticism of the levels of inadequate funding.**

We will address this in the following manner:

ACUTE SERVICES

When someone is in crisis or suicidal they have to either present at our ED department or call Accessline for a phone assessment and triage after which they will be referred and triaged appropriately. This means then to go to ED department; or depending on triage will be contacted by someone from the Specialist Mental health Team (Monday to Friday).

At presentation to ED they are triaged and will then be managed by an ED nurse (often they do not have any specialised mental health training) and stigma and discrimination can often experienced by clients presenting with complex issues.

Our usual number of nurses in ED is two nurses at any particular time, dealing with a whole loft of different and complex presentations across all of health. These complex presentations now increases an already full and overloaded system, having to be managed by non-mental health trained staff.

It is likely that the patient will now be offered a MHECS assessment (taken into a room with telehealth and connect to a mental health clinician who interviews and assesses). We know that for some people presenting with acute mental health, talking on a screen to someone can increase distress significantly and does not always have great outcomes.

The bottom line is – there is no option for a face-to-face assessment for mental health after hours or on weekends. We believe this is second best and certainly not what happens in metropolitan areas.

Even on weekdays, there might be an option to have a clinician from the Specialist mental health team attend the hospital to assist, but this is not consistent or standard practice and depends on availability and workload on any specific day.

Should HOSPITALISATION be needed, more than often (as we don not have "mental health beds") the patients will then be transferred out to Albury or Wagga- 2-3 hours away. This could be because the patient is suicidal and needs to be kept safe. This cannot happen in our local hospital, once again because we do not have adequate staff or even specialised mental health nursing staff, to be able to "watch' and keep this patient safe.

Should they remain in ED to wait for a "bed" or to be seen by a mental health clinician the next day, this places incredible strain on our 2 ED nurses (and clearly not enough staffing) to be able to manage this on top of every other presentation after hours. This has been known to sometimes stretch to 48 hours before a "Bed" is found or a decision has been made about care.

We have to understand the significant trauma for patients who are now put in an ambulance, transferred out to a strange place, with no family supports and to go to the "Dreaded mental health institution", unsure of what awaits them on the other side.

We are acutely aware that not every suicidal person has to be hospitalised and that this can be dealt with in the community. But to do this we need adequate funding, we need 24/7 service by specialised and trained nursing and mental health staff and we need a "safe space / ward / beds to be able to accommodate this.

We are acutely aware of all the reasons this is not happening (being lack of funding; lack of qualified staff and training; no psychiatrist to oversee treatment) but this is certainly not the same level of care that is delivered in metropolitan areas and we just have to accept that this "the way it is and make the best of it.

Reasons offered are we “simply just do not have the space or the staffing” to be able to keep patients in Deniliquin. We will address staffing later in the submission.

COUNSELLING BY MLHD/ MPHN COMMISSIONED SERVCIES

Short term non-acute interventions like Cognitive Behaviour Therapy, interpersonal counselling delivered by state funded services are totally inadequate for rural and remote and regional areas,

Currently access for residents is through the MY STEP program, a Murrumbidgee Primary health Network commissioned service delivered by MLHD (Murrumbidgee Local Health District)

This contract was “won” and taken away from an NGO Marathon health, who previously reached out and delivered this program. This contract has now been held by MLHD for 12 months and awareness of this campaign to GPs (referrers) and the public has been minimal.

These are shortcomings with this program:

- Long waiting periods (6-10 weeks at least)
- Not suitably qualified clinicians initially delivering who have adequate training in CBT and had to be “trained” after the program was awarded
- Insufficient awareness of the program in community and other professionals such as GP’s
- Too few clinicians within the service covering an immense wide and big areas of service
- This program sits within the “stepped care” model of MPHN (thus within MLHD who hold the contract people can be stepped Up or DOWN from acute to counselling without having to leave the service. This is a great concept, but unsure that this has led to better outcomes.

Once again, metropolitan areas have access to an immense array of counselling services because they have more access to Medicare services – In Deniliquin face to face options are absolutely minimal and people have large out of pocket expenses around co-payments and travel to access this privately within the Better Outcomes to Mental Health (Medicare funded / rebated services) .

We previously had NEW Access (beyond blue) delivered through an NGO (Intereach) commissioned by the MPHN. The same issues existed with poor advertising of the service; poor initial uptake due to lack of awareness and not suitably qualified staff delivering this program. This is supposedly now been taken into the Stepped Care model. We could argue that this is a loss of the program as intake happens in the same way as MY Step, and very different to what NEW Access was intended to achieve.

This is not a criticism of the service per se, but a criticism that contracts, programs and funding change frequently, leaving huge gaps for hand-over between agencies and simply just not enough services to need the meets of the community.

BETTER ACCESS TO MENTAL HEALTH – MEDICARE

The introduction of telehealth items during Covid has enabled people to be able to access a huge range of services, regardless of location of services.

Prior to this counselling had to be face to face and for the biggest part of the past 12 years there has only been ONE private practitioner meeting this need – being an Occupational therapist with a mental health practice. This offers no choice to patients, unless they travel 80 km further (at their cost) to see another practitioner for psychological interventions.

This whole initiative has certainly offered lots of people access to services since 2007, but is dependant on a Medicare Provider being in the region.

We urge the telehealth item numbers to remain past Covid and we urge for better payment of scheduled fees for Medicare, so disadvantaged rural communities can afford to access "private" practitioners. Our community members have to be able to afford an out of pocket expense (gap) to access counselling services (delivered outside of the state/ federal funded services) and just have NO other access to any face to face counselling services .

Practitioners would be prepared to bulk bill for reasonable remuneration by Medicare, but in the absence of that , patients are left without options. In metropolitan areas there are an array of counselling options (at no cost) for families.

YOUTH MENTAL HEALTH

We have no access to headspace for our youth under 25 years of age and have to travel 200km plus to access headspace facilities. This is a great initiative, but there is not enough of this available for rural communities. Our youth has to have a parent who can afford counselling and be socially economically sound, to be able to afford counselling for their children and to access this in a reasonable time frame. Youth are unable to seek counselling, without involvement of their parents (because of financial issues as discussed)

All of the above disregards to effectiveness of early intervention services and the validity of counselling services in maintaining mental health – and in rural areas, all too often, we are left with the idea that "you have to very unwell or suicidal" to get into a service in a timely manner.

Our youth has no mental health facilities in regional NSW to be admitted to and this is major issue. They have to go to Box Hill in Victoria or to Sydney. This is 4- 7 hours away and a as youth to be admitted to these facilities, without family or community support can be very detrimental.

We urgently need a youth inpatient facility within MLHD (Griffith, Wagga, Albury), however we are told that this will not be able to be staffed due to lack of psychiatric overview by psychiatrists (there are no psychiatrists as they do not prefer working in regional areas but in teaching positions) a) ; lack of specialised staff willing to work in the youth space and lack of other suitably qualified clinical staff.

Our youth should not have to leave the state to be able to receive service to be hospitalised for acute mental health issues.

DRUG AND ALCOHOL FACILITIES

There are very few options, with long waiting periods or at a huge cost to patients to access services with regards to rehab.

We have NO addiction services apart from one D and A worker in our specialised mental health team.

We have no groups or AA or access to group therapy.

MAJOR GAPS in psychosocial services and the NDIS

Many patients with severe mental health issues did not get onto the NDIS and this remains a problem. This happened as the NGO's who were supposed to assist them with this process failed miserably. The funding was withdrawn from some of the psycho-social programs that kept many people engaged and well.

Thus we have a large number of people with severe mental illness, completely or inadequately supported, increasing their risk of harm and homelessness.

However, for these clients some of them do not fit into the criteria of the current psychosocial programs delivered by Wellways in our community.

Who is to blame – not sure, but this is not good enough that people are left without supports, services or funding, who are extremely vulnerable and does not fit into the "funding streams" and current models. Many of these are people that actually require intensive support and of course could possibly get into the NDIA, but without support to do so, never gets approved or approved for a disability pension either.

Institutions ere abolished 20 years ago, and yet we are still waiting for adequate supports in regional and rural areas to support people with persistent and severe mental illness.

STAFFING ISSUES

We know our health service does what it can to recruit and maintain.

However, recruitment processes are slow and it is difficult to attract specialised nursing and mental health clinicians into services.

Before contracts and funding allocations are made, there needs to be a consideration of whether staff can be recruited.

There is not enough flexibility in allowing regional and rural loading to packages - this NEEDS to happen to make it attractive for people to consider leaving the coastal high-density main centres to come and work.

Incentives need to be added like reasonable interim accommodation packages - for eg 3 months free rent

Removalists costs.

This should not be for the local hospital to take out of their limited budget this needs to be a national incentive and worked into remuneration and recruitment packages and there needs to be enough money available for this. If need be this should be loaded into the relevant awards. With relevant retention bonusses and **loading for our rural areas.**

We always hear the same answer- we lack people with highly specialised skillsets to staff services, yet our underfunded, old facilities in regional areas compete with modern facilities in the cities. As a highly skilled person with qualifications and skillset, most people will choose facilities where it is safe to work, facilities are modern with safe equipment and they can work with a highly skilled team.

Our rural towns/ areas offer fantastic living advantages in terms of quality of life, but cannot recruit or retain staff if facilities are sub-standard and they have to work with perpetually insufficient staffing numbers.

We are dependent on locum nurses all the time. We need decent accommodation for them and to possibly retain, we have such and outdated, below standard nurse's accommodation units. There needs to be funding to keep facilities up to standard and make the facility inviting and attractive to work at - not only cosmetically but in terms of the facility capacity as well, If our health service relies on locums because of our regionality an rurality and the health service cannot adequately attract full time and permanent staff, they need to be supported with adequate funding structures and enough money to provide attractive packages to our locums and visiting practitioners.

FRAGMENTATION OF SERVICES

Commissioning and fracturing of previous health responsibilities placed into the hands of NOG"s and other agencies with duplication of buildings, car pools, infrastructure. The funding programs last 2-3 years and often just as it is established, the community knows about it and we actually get some service, they lose the contract to someone else the process starts again.

The middle layer of “commissioned “services by primary health networks makes it fragmented and confused not only service providers who have to refer, but also the public who is always in a position not knowing which door to knock on for a service. An example of this is the fragmentation of aged care services and mental health services in rural communities.

How did we get here and where to ?

The answer in our opinion, is through lack of responsibility by those who are tasked to deliver. NSW Health delivers on health in NSW. It should be all things health. Acute and primary care. Everyone knows where to go and which door to knock on. Adequate funding an employment across all levels of care and adequate infrastructure to deliver.

Rural and regional areas have not been considered in models of care that work for them, keeping in mind the limitations of access to services in smaller communities. We have no choice of providers. We are lucky to have services, let alone being able to make choices about best services or best practice that can work for us.

Deniliquin as a community and being the third largest hospital in MLHD would appreciate the Commission having consultations with our community.

As Deni MHAG plays a huge part in promoting services and raising awareness, consultation on what is happening in this space would be a fantastic outcome.