Submission No 447

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

Organisation: Karitane

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Karitane submission the Upper House Committee Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

Ms Grainne O'Loughlin
CEO

Karitane would like to thank the Hon Greg Donnelly MLC and the Portfolio Committee No.2 for the opportunity to respond to the inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales.

Karitane is an affiliated health organisation under the joint governance of the Karitane Board and the South West Sydney Local Health District (SWSLHD), and is a registered charity and not-for profit entity. Established in 1923, Karitane receives a combination of NSW government (Health & Dept. of Communities & Justice), federal government and own source revenue streams to support comprehensive child and family and perinatal infant mental health services for some of the most vulnerable families across NSW including metropolitan, rural and regionally based families. Karitane delivers high quality, comprehensive, evidence-based parenting services for families with children aged 0-8 years of age using face to face, place-based and a range of virtual care services which has increased accessibility of support for regional and rural families over the past 3 years. In 2019-2020, we received referrals from 1,025 different postcodes in NSW, delivering 30,480 occasions of service with 99% client satisfaction.

Karitane is recognised as a respected and trusted service leader in child and family health, perinatal infant mental health, parenting and targeted early intervention services. We are well placed to respond to peak inquiries and have a wide stakeholder engagement circle across Australasia. We have particular expertise in the issues impacting families accessing parent support services, families with multiples risk factors and vulnerabilities, as well as issues facing service providers, workforce and parenting support services. Karitane would welcome the opportunity to discuss these issues in more depth with the Committee.

As a leading provider of tertiary child and family health services across NSW, Karitane has a unique perspective on access to healthcare for regional, rural and remote families, compared to their metro counterparts. The issues faced by these families in accessing services are wide-ranging and systemic, arising from a challenging funding system and policy environment that results in a lack of coordinated services and often opportunistic rather than strategic distribution and allocation of resources.

Karitane has a range of ideas that we believe could ameliorate some of the challenges in secondary and tertiary health service access and outcomes for rural, regional and remote families across NSW. We would also welcome the opportunity to discuss these ideas further with the Committee.

Karitane is committed to the principles of value-based healthcare and delivers evidence-based programs. We are outcomes-focussed and collect empirical data to demonstrate the efficacy of programs. We have a rigorous academic portfolio and strong affiliation with University partners such as Western Sydney University, UNSW, and relationships with Local Health Districts, PHNs and NGOs across NSW.

Karitane is also recognised as a lead provider of comprehensive education and training in child & family and perinatal mental health in NSW through Western Sydney University and provides training to healthcare professionals, non-government organisations and corporate partners across Australia.

Grainne O'Loughlin
CEO
Karitane

Executive Summary

Karitane supports the principle that rural, regional and remote families should have equitable access to physical place-based care as their metro counterparts supported by clinically appropriate virtual care services. This could be achieved through a strategic expansion of services to regional hubs based on rigorous examination of need and vulnerability, underpinned by a major shift in the way services are funded and with a focus on redistribution and realignment of resource allocation.

Key enablers would be a clear and effective workforce strategy, strategic use of telehealth/virtual care and "blended" services in both metro and regional areas (so that rural families are not required to rely on **only** telehealth); and better integration of health and social services across the continuum of care. Regional, rural and remote areas already show much higher levels of vulnerability compared to metro regions; access to in-person tertiary health services must be improved to ensure that we reduce disparities and maximise lifetime health outcomes between metro and rural/regional areas.

Responding to the Terms of Reference of the Inquiry

This submission responds to the following items identified in the Terms of Reference:

(a) health outcomes for people living in rural, regional and remote NSW
(b) a comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW
(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services
(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW
(e) the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW
(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them
(l) other related matters.

Summary of Recommendations

Equity of Access

1. Secondary and tertiary child and family health services should be distributed according to need and vulnerability and not an overconcentration in metro locations
2. The government can utilise existing data that maps need, vulnerability, demographics, population projections, and existing service availability to identify regional locations for new secondary and tertiary child & family health and perinatal infant mental health services
3. New services could be established in line with meaningful, collaborative consultation & co-design with the local community and existing health services to ensure new services complement rather than replace or replicate existing community-led initiatives
4. Wherever possible, place–based care should be provided in the community and as close to home as possible in order to minimise the separation of families and communities, minimise risk and improve family outcomes.
5. Referral pathways need to support less vulnerable families to access primary and secondary supports before issues escalate/deteriorate, ensuring highly vulnerable families with complex concerns can access intensive tertiary services in a timely manner.

6. Referral pathways should be streamlined & coordinated across PHNs, LHDS, DCJ districts and take into account families who enter the system through health, social services & NGO pathways.

Funding Mechanisms

7. The funding mechanism for state-wide, tertiary parenting services needs to be reviewed to ensure there is no geographic disparity in service access/delivery.
8. Funding for services that can be accessed from anywhere, such as virtual services, should not be allocated on a purely geographical basis – rather, these services should be able to be accessed by families all across NSW if/when clinically appropriate.
9. Funding rounds should be long-term/recurrent to offer greater job security to the workforce, offering permanent work rather than temporary or short-term, uncertain contracts which ultimately affects attracts and retention of staff and continuity of care
10. A whole of government approach to funding should be developed for Child and Family Health & Perinatal Infant Mental Health services, with clear delineation between the Department of Health & relevant branches, the Department of Communities and Justice and DSS overlay, ensuring service providers are not "bounced" between agencies when seeking or negotiating government support
11. Regulatory requirements on funding should be rigorous but not onerous, and better streamlined across funding sources where possible.

Policy Frameworks

12. Policy must be more integrated across health, social services and education to prevent families falling through the gaps. The Brighter Beginnings – First 2000 Days Framework is an excellent example of cross sectoral collaboration and shows promise if true collaboration on the implementation component ensues.
13. Overarching health policies and frameworks must consider the unique needs and barriers for rural, regional and remote families in NSW – we understand that strategies developed for metro regions will not necessarily be transferable to rural regions.

Workforce

14. NSW must develop a coordinated workforce plan for the Child and Family Health and Perinatal Infant Mental Health workforce that considers need in both metro and regional/rural regions and focuses on key enablers
15. Models of remote clinical supervision for staff should be adopted to enable service delivery in areas of lower population density
16. Education, capacity building, and networking opportunities should be funded to enable skill-share between metro and regional locations
17. Metro practitioners who work with rural families via telehealth should undertake rural and regional competency training and collaborate with local place-based service delivery teams.

Integrated Care Services/Hubs

18. The government to develop a strategic method to expand integrated care hubs across NSW in partnership with providers and local healthcare services, and fund this expansion. These hubs should extend beyond vertical integration of health providers and include NGO and cross government services.
19. All care delivered through integrated care hubs must be high-quality and evidence-based, delivered by appropriately trained professionals. Academic research support for trialling such models of care also requires funding support.

Virtual Care & Telehealth

20. The government must support providers to unlock the unrealised potential of telehealth – but also recognise that it cannot be the sum total of service delivery to rural, regional and remote families
21. There should be support for blended models of telehealth and in-person service delivery that achieve optimal outcomes for families
22. More support and funding should be provided to evidence based & emerging models of care, such as I-PCIT, Virtual Breastfeeding Support, , Virtual Home Visits and Virtual Residential Care Units to meet demand for these services and reduce long waiting times.
23. More clinically appropriate metro families should access telehealth services, to ensure tertiary support beds and services are more freely available for more vulnerable and complex rural and regional families to access in-person services
24. The government must act to improve vital communications infrastructure as a key driver of better health, education and social outcomes in rural, regional and remote NSW.
25. Government must support better access to data (internet broadband) for rural & regional families who are required to use videoconferencing for virtual care services.

The importance of early parenting support services for regional and rural NSW families

The transition to parenting can be difficult, and can be made more complex by a range of risk factors and vulnerabilities that families can be exposed to. Parental support is one of the critical challenges of our time, with one in seven women and one in ten men suffering from postnatal depression or anxiety. There is evidence to suggest that living in a rural area can increase the risk of perinatal mental health concerns. People in advantaged geographical areas are generally less distressed and have lower rates of mental and behavioural conditions. Mental health concerns in parents, including depression and anxiety, have been shown to negatively impact the formation of strong attachment relationships between babies and their parents, and impact the achievement of key developmental milestones.

Infants and toddlers who display persistent behaviour problems are at greater risk of pervasive behaviour problems later in life. Left untreated, early onset conduct problems typically persist, placing the child at greater risk of developing more severe and chronic behaviour and conduct disorders. Evidence demonstrates that by the age 28, the health, education and criminal costs associated with individuals with pervasive behavioural problems are 10 times higher than individuals with no such problems.

Australian research shows that the single strongest variable risk factor for mental health problems in young children is negative parenting practices. Support for parenting, particularly early intervention and universal supports, is strongly associated with positive change and is widely recognised as the most cost-effective way to improve mental health outcomes in young children and prevent difficulties in later life.

While evidence-based child and family support programs demonstrate clear success for treating early childhood disruptive behaviour disorders, most affected children do not have access to such services in their communities. Across all metro and regional locations, it is estimated that only 25% of families of children with a clinical diagnosis (and 12% with sub-clinical problems) seek professional assistance, and only 20% of pre-schoolers with disruptive behaviour disorders ever actually receive treatment. Those who do receive services do not always receive evidence-based care. It is reasonable to assume that the majority who do access treatment are based in metro areas. There are major access barriers, which are particularly apparent for children and families living in regional, rural and remote areas with fewer specialised clinicians available.

Access Economics determined in 2010 that the value of benefits from intervening in childhood and early adolescence is around $5.4 billion. Numerous studies around the world have demonstrated clear monetary return on investment (ROI) for a range of parenting support programs, such as Parent Child Interaction Therapy (PCIT) which is estimated to generate AU $12.99 in cost savings to government for every $1 invested.

Karitane considers that there is major unmet need amongst new parents in rural and regional areas who require support services to adjust to parenting and provide a safe, nurturing environment for their babies. While current services and structures do provide supports that greatly benefit the parents who access them, the system is fragmented and difficult to access for regional, rural and remote families. Significant waitlists mean families are not always able to access services in a timely fashion, and the need to travel to metro areas to access tertiary services can be a major barrier.

The need for services to support families will continue to grow in NSW as the population expands in coming decades and this is increasingly true for rural, regional and remote families. There is emerging evidence that more families are now also moving from metro to regional areas as a result of the COVID Pandemic, increasing the health service demands in these areas.

Karitane Service Overview

Karitane is a provider of secondary and tertiary level parenting support and child and family health services. Services are delivered along a continuum of care across prevention, early intervention and intensive support, including virtual services. Karitane's services are strongly aligned with the NSW Brighter Beginnings First 2000 Days framework.

Our services are delivered primarily from Carramar in South Western Sydney, with parenting centres and integrated care hubs located at Camden, Randwick, Bondi Junction, Oran Park, Shellharbour, Taree and Shortland. Our tertiary intensive support services are all delivered from South Western Sydney, with referrals accepted from across NSW.

A general overview of services provided by Karitane is outlined in the table below. We launched the Karitane Digital Health Hub in 2018, delivering evidence-based clinical telehealth interventions across our continuum of care. This meant that in April 2020, Karitane was well-positioned to pivot to a digital-first model of care for the duration of COVID-19 NSW lockdown, including delivery of a new virtual residential unit service. As restrictions have eased, we have returned to in-person service availability, but are seeking to maintain some of our new digital services developed during the height of the pandemic in order to increase availability and access for a range of vulnerable families. These are currently being evaluated to establish impact, effectiveness and efficiency as we move to a post-COVID environment.

Image 1: Karitane Continuum of Care

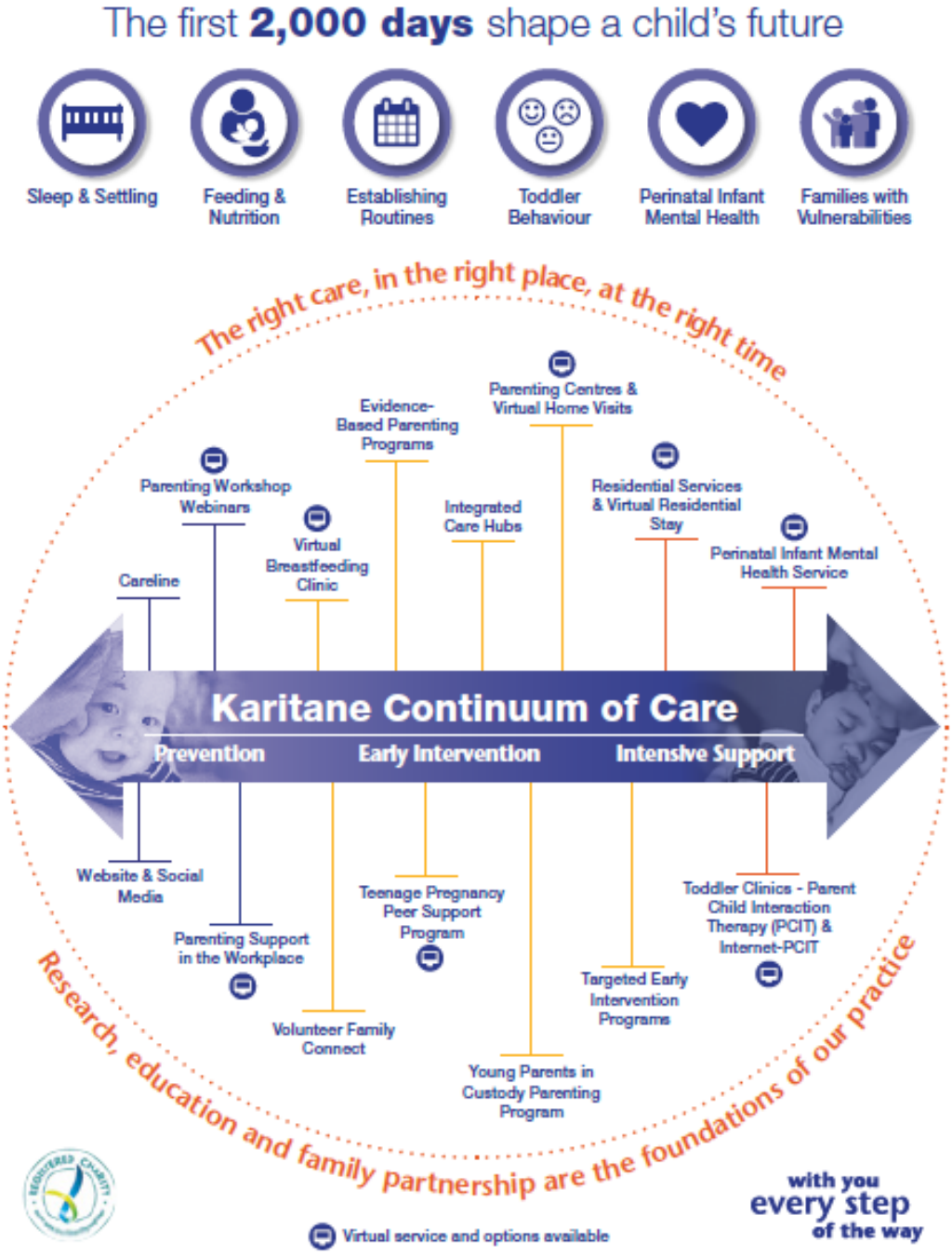


Table 1: Karitane services

Service type	Service	Geographic intake
Tertiary services (require specific referral by health professional)	**Residential Parenting Service**	South West Sydney location; referrals accepted across NSW (in person service)
	Virtual Residential Parenting Service	NSW statewide (virtual service)
Secondary services (require referral by health professional)	**Perinatal Infant Mental Health Services**	South West Sydney (in person)
	Toddler Clinic – Parent Child Interaction Therapy (PCIT)	Sydney Metro South West Sydney (in person). Referrals accepted from across Sydney
	Internet-Parent Child Interaction Therapy (I-PCIT)	Rural and remote NSW (virtual service)
	Young Parents Program supporting teenage parents	South West Sydney (in person)
	Virtual Home Visiting with Child and Family Health Nurses	NSW statewide (virtual service)
	Juvenile Justice – Young Parents in Custody program	South West Sydney (in person)
	Psycho-education groups	South West Sydney; Eastern Suburbs (in person service)
	Virtual Breastfeeding Clinic	NSW statewide (virtual service)
	Parenting Centres	South West Sydney; Eastern Suburbs (in person service)
	Integrated Care Hubs and Shopping Centre drop-in locations	Sydney, Shellharbour and Newcastle, with a view to additional locations (in person)
	Volunteer Family Connect – in-person, phone and virtual connection for marginalised families	South West Sydney (in person and virtual service) HNELHD, Taree
	Early Intervention & Placement Prevention Program (EIPP) **Supported playgroups** for marginalised families – able to be delivered virtually	South West Sydney (in person) South West Sydney (in person and virtual service)
Universal Services	**Parents in the workplace** – webinar and resources in corporate environments	National (virtual service)
	Parent Education – in-person and web-based sessions on a range of topics	South West Sydney (in person) and national (virtual service)
	Social media – strong networks, resources and live webinars and Q&A sessions with Child and Family Health Nurses	National (virtual service)
	Careline – phone support staffed by Child and Family Health Nurses	National (phone service)
	Website – range of evidence-based resources	National (virtual service)

Better access for rural and regional communities: the right services in the right places

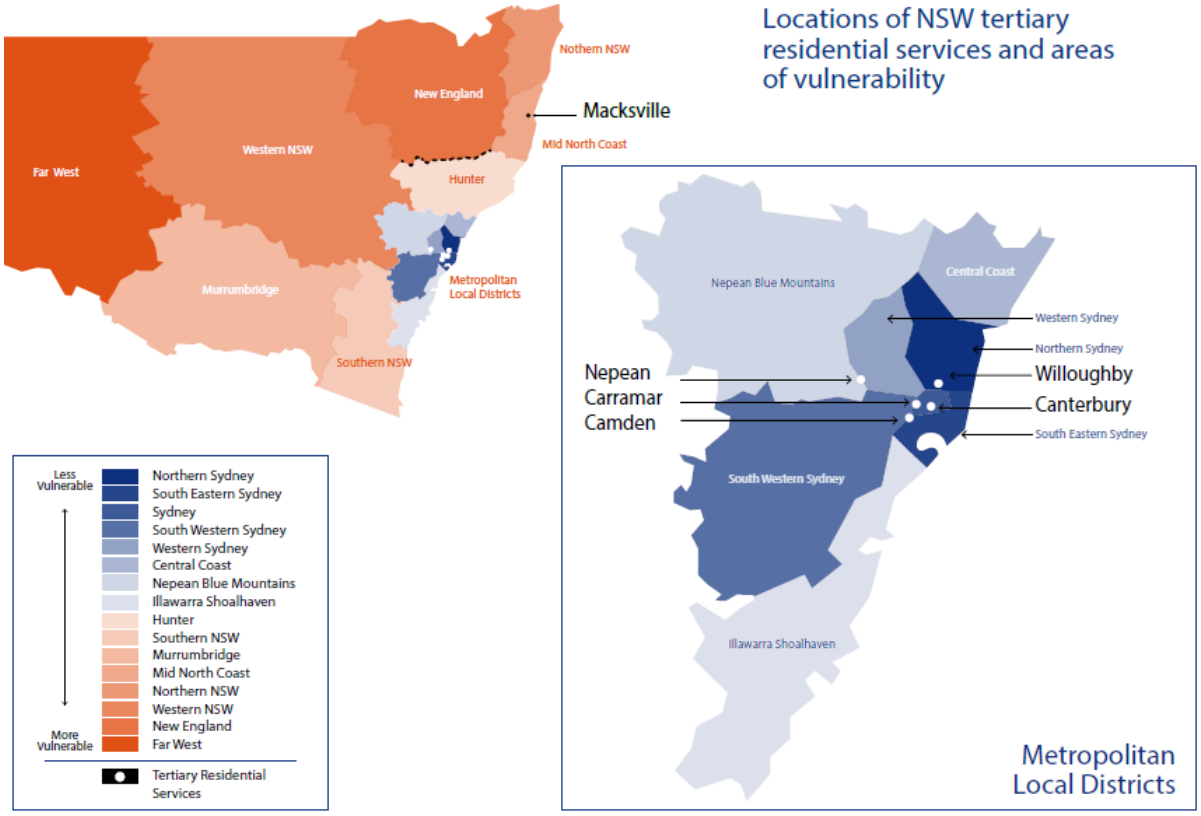
The NSW Department of Communities and Justice (DCJ) has performed extensive modelling of vulnerable populations under the TFM Family Investment Model, including the proportions of cohorts that experience multiple indicators of poorer outcomes, the locations of those cohorts across NSW, and the anticipated future costs to the NSW Government without further intervention. This modelling includes vulnerable young children aged 0-5 years, which are the key demographic targeted by Child and Family Health services.

This modelling clearly demonstrates that vulnerability amongst young children 0-5 years occurs much more frequently in regional, rural and remote regions of NSW. In some rural and remote areas, 1 in 2 children under 5 are considered vulnerable, compared to between 1 in 5 and 1 in 4 children for metro locations. The modelling shows that in New England, 49% of vulnerable children are expected to be the subject of a ROSH (Risk of Significant Harm) report in the future, while all metro districts show ROSH likelihood at under the NSW state average of 34%. In Far West NSW, the expected number is 51%. The proportion of children who are projected to have poorer outcomes, such as interactions with the justice system, need for mental health services, and becoming a young mother, are all much higher in regional and rural districts compared to metropolitan districts.

Karitane has mapped DCJ assessment of vulnerability amongst young children 0-5 years against all locations of intensive in-person residential parenting support services (including both those operated by Karitane and by other providers).

This mapping clearly demonstrates that **tertiary services are highly concentrated in metropolitan districts that exhibit lower levels of vulnerability** compared to the NSW state average.

Image 2: locations of tertiary residential parenting services in NSW and areas of vulnerability



Some regional, rural and remote families in need of intensive in-person tertiary parenting support must travel up to twelve hundred kilometres to access these services. This puts significant strain on family work commitments, schooling and other areas of life, and requires that families be treated outside of their communities and away from their local support networks. The stress that many rural and remote families feel when accessing services in metropolitan regions is usually understated – it is not only the burden of travel (which may take multiple days, given that public transport is not provided every day in rural areas, and require accommodation and multi-day childcare arrangements for any older siblings), but also the emotional strain of being in a metro environment can make service access very difficult for families.

Karitane is of the view that **intensive tertiary residential parenting services**, which can improve lifetime health outcomes for young children and their families, **should be available in a number of identified regional communities**. This would reduce the burden of travel for vulnerable rural and remote families and improve access. Rural families would be subject to less stress through accessing services at a regional centre rather than a metro centre (even if the travel required was the same), and many families would gain access to important services closer to their own communities, where they can retain access to their local support networks. It is noteworthy that Victoria is significantly boosting its number of intensive residential parenting support services, building seven new facilities including regional centres in Bendigo, Ballarat and Geelong.

The NSW Government can leverage the modelling already conducted by DCJ to **map vulnerability, demographics and tertiary health service & NGO distribution across NSW**. This should include key information about existing providers – their governance, workforce competencies, use of evidence based programs, clinical client outcomes, etc. While tertiary health services do require a significant population to be viable, there are regional areas of NSW that could support such services locally, considering both projected population growth and levels of vulnerability. For example, Hunter New England and Illawarra Shoalhaven both have demographic markers that suggest tertiary level early parenting services would be viable in these regions. Such services could act as a hub for other nearby regions that demonstrate higher vulnerability, such as Southern NSW, Central Coast,/ and Mid-North Coast, reducing the stress and burden of travel for vulnerable families in those regions. For example, a family from Eden experiencing multiple vulnerabilities would likely find it much easier to access a tertiary support service in Wollongong/Shellharbour than in South-West Sydney.

As much as possible, regional, rural and remote families should be able to access in-person secondary level parenting support services in their own community, or in a nearby regional hub. The NSW Brighter Beginnings First 2000 Days Strategy commits to “universal, evidence-based, seamless care and services” for all children, as well as “additional services for those who need specialised help, when they need it”. However, it is noteworthy that the Framework does not make any reference to regional, rural or remote families, or their specific needs, or service availability for specialised help in their communities. We know that that service availability is not evenly distributed across NSW.

Programs such as the evidence based Volunteer Family Connect (VFC) program fill a gap and can fulfil a step up and step down role for the support of parents and their babies in rural & regional areas of NSWVFC leverages the strengths of a volunteer led service building trust with families to identify their real needs, vulnerabilities and capabilities. The relationship between the Volunteer and families can facilitate referrals in to other services (e.g. relationships), early intervention (e.g. developmental delay) and prevention (e.g. risk of serious harm). The VFC randomized control trial demonstrates it role in the service continuum creating value for Government in terms of cost savings, cost avoidance and improved value for money. Greater investment in early intervention and prevention programs such as VFC in rural & regional areas is an effective and efficient use of targeted resources.

Planning for secondary and tertiary health services need to be introduced to regional and rural communities in a strategic way that is aligned with local demographics and vulnerability. Importantly, this strategy must also include **deeper engagement & co-design with local health services and community stakeholders** to truly understand what services are present in a community and what new services can complement and enhance those services, rather than competing or displacing existing supports (which may be community-led).

Karitane has also noted an increasing number of tertiary referrals for issues that have escalated due to a lack of primary and secondary services. Families are limited in their choice of alternative supports, and are therefore entering inpatient care models when they could and should be treated in the community – particularly metro families with fewer indicators of vulnerability. This reduces the availability of inpatient care to families experiencing high levels of need and displaying multiple significant risk factors, including rural families, and creates significant delays in service access due to longer waiting lists.

Recommendations

- Tertiary health services should be distributed according to need and vulnerability, not concentrated in metro locations
- The government should map need, vulnerability, demographics, population projections, and existing service availability to identify regional locations for new tertiary health services
- New services should be established in line with deep collaborative consultation with the local community and existing health services to ensure new services complement rather than replace existing community-led initiatives
- Wherever possible, care should be provided in the community and as close to home as possible in order to minimise the separation of families and communities, minimise risk, and improve family outcomes. Evidence based programs such as Volunteer Family Connect can enhance the effectiveness and efficiency of early intervention & prevention services for families in regional and rural areas.
- Referral pathways should change to ensure less vulnerable families can access primary and secondary supports before issues escalate, ensuring highly vulnerable families with complex concerns can access intensive tertiary services.

The need for funding model reform

The current funding model for parenting support services in NSW is fragmented, insecure and unsustainable through the NSW Department of Health, the NSW Department of Communities and Justice, and the Federal Department of Social Services. This has significant flow-on impacts, including workforce impacts, strategic planning impacts, overlap of service delivery, underserviced regions, competing and abundant strategic plans and substantial regulatory burden.

As an affiliated health organisation (public hospital), Karitane receives a combination of state government, federal government and own source revenue to deliver a wide range of child and family health services. This includes service level agreements at the Local Health District level, one-off or multi-year grants from the federal and state governments supporting specific programs, Medicare and private health insurance rebates for some services, and philanthropic grants and donations (both tied and untied). The regulatory burden imposed by uncoordinated funders with diverse reporting and accountability requirements creates large corporate overheads, reducing funding efficiency. Service providers working across multiple acquittal and data-gathering requirements must meet a range of different standards, KPIs, requiring significant time and skill to meet reporting requirements. Karitane advocates for the importance of rigorous accountability

requirements across parenting support services, however the diversity of requirements over different funding streams is costly and reduces organisational efficiency. Further, **most of the in-person service funding is bound by strict geographic parameters,** preventing delivery into regional, rural and remote communities which have no other access to evidence-based parenting support services.

The funding for Karitane's NSW tertiary level residential Child and Family Health beds is allocated through South Western Sydney Local Health District (SWSLHD), and Karitane is under the joint governance of the Karitane Board and SWSLHD. Karitane has a strong and positive relationship with SWSLHD. This funding model enables an exemplary level of support for families in South-West Sydney and surrounding districts. At present the current funding model does not enable secondary or tertiary parent support services to be delivered in other parts of NSW where there is unmet demand.

We recommend that intensive residential parenting support services should be reserved for the most complex families experiencing multiple vulnerabilities, with emphasis on ensuring a specific proportion of places are available for regional, rural and remote families. Under the current service structure many families with moderate adjustment to parenting concerns are referred to residential services. These families could be better supported through other place-based parenting support initiatives, such as Volunteer Home Visiting, Virtual Home Visiting, Virtual residential unit, day stay units, perinatal infant mental health services, and parenting centre consultations. This would free up resources to deliver better in-person service availability to the most vulnerable and complex families, particularly those from regional, rural and remote areas.

Since the introduction of the Universal Health Home Visit (UHHV) program, NSW Health primary services has been highly focused on achieving set KPIs for UHHV, creating some gaps in other universal/primary services. This has also led to a reduction in secondary service availability across the state. As one of the few remaining secondary service providers in NSW, demand for Karitane services has increased. However, access to our services is restricted due to set geographical boundaries and limitations of access put in place through funding agreements. Karitane already has significant capacity to deliver secondary and tertiary parenting support services to regional and rural communities across NSW – **but current funding mechanisms and geographical restrictions prevent us from helping these families**.

Scarce and insecure funding creates considerable problems for tertiary service providers like Karitane, limiting our ability to deliver a long-term strategic vision for our organisation and our sector. Significant competition between service providers for scarce funding resources magnifies financial instability, increasing risk in developing and delivering innovative models of care. Multiple evidence-based programs run by Karitane, including Parent Child Interaction Therapy (PCIT) which is recognised as a gold standard intervention of best practice for disruptive behavioural disorders in toddlers rely on philanthropic support top-ups which is uncertain and at risk year on year and more so through the COVID pandemic.

Recommendations

- Funding for secondary and state-wide tertiary health service delivery should facilitate geographic service cover across the state.
- Funding for services that can be accessed from anywhere, such as virtual services, should not be allocated purely on a geographic basis – rather, these services should be able to be accessed across NSW for families for whom they are clinically suitable
- Funding should be long-term to offer greater security to the workforce and deliver proven models of care

- A whole of government approach to funding should be developed for Child and Family Health & perinatal infant mental health services, with clear delineation between the Department of Health and the Department of Communities and Justice, ensuring service providers are not bounced between agencies when seeking government support
- Regulatory requirements on funding should be rigorous but not onerous, and streamlined across funding sources where possible.

Integrated policy as a key enabler for complex and vulnerable families

A siloed approach to policy in health, social services and education creates gaps which vulnerable families fall through. This concern is more acute in regional and rural areas that have low service density. While service providers on the ground often make significant efforts to enable local coordination mechanisms, policy level issues remain siloed. Given the role that the social determinants of health play in lifetime health outcomes, a more integrated policy approach is recommended.

Referral pathways are negotiated separately in each PHN, under a policy that recognises that each region has its own unique ecosystem of service providers. However, for secondary and tertiary health services like Karitane, this results in significant duplication of effort. While referral pathways should be tailored for each PHN, the requirement to renegotiate the establishment of Child and Family Health referral pathways in each PHN creates regulatory burden that leads to unequal access across NSW.

NSW has a wide range of strategy and policy documents, with many lacking an intersectional approach. For example, the Brighter Beginnings First 2000 Days Framework makes no specific reference to regional, rural or remote communities. The NSW Aboriginal Health Plan makes some mention of geography in identifying relevant demographics, but no specific strategies are identified to meet the differing needs of regional, rural and remote Aboriginal people compared to their metro counterparts. Health policies need to consider the unique needs, service access barriers and workforce issues faced by regional, rural and remote communities.

Recommendations

- Policy must be more integrated across health, social services and education to prevent families falling through the gaps
- Referral pathways should be streamlined across PHNs, and take into account families who enter the system through social services pathways
- Overarching health policies and frameworks must consider the unique needs and barriers for rural, regional and remote families in NSW – understanding that not all strategies developed for metro regions will translate for regional & rural regions.

Workforce growth and support

Workforce is a key driver of service availability in regional and rural NSW, and in Child and Family Health more generally. There is a shortage of trained and skilled workers, particularly Child and Family Health nurses and perinatal infant mental health professionals, and this is worse in regional and rural areas. Rural areas are caught in a self-reinforcing loop. There is a need to have a coordinated workforce plan to replenish the Child and Family Health nursing workforce as existing workers approach retirement. This is exacerbated by low remuneration, difficulties recruiting and retaining qualified practitioners, and poorly defined career paths, with problems more pronounced

in regional and rural areas. Time-limited funding provision means staff are often employed on year-to-year contracts, creating low job security and reducing staff retention as skilled workers seek greater stability.

New graduate programs, incentive schemes, and improved pay and conditions could all help to attract more people to training and entering parenting support service careers. Karitane has implemented an innovative New Graduate Program for Child and Family Health Nurses. This program is the first of its kind in NSW, and is expected to have a positive impact on the Child and Family Health workforce. However, this has been delivered through own-source revenue only - no workforce funding has been made available to support this type of new initiative, and no support to reach regional and rural workers has been provided. Lack of agreed or standardised workforce models across the parenting support sector, such as staff ratios in parenting residential units, leads to inconsistent service delivery across providers and a variable experience for vulnerable families. There is also a clear lack of Aboriginal and Torres Strait Islander staff to engage Aboriginal families who are experiencing parenting issues, including in rural areas. Increased Aboriginal workforce would support better engagement of Aboriginal families, who are often overrepresented in disadvantaged groups. Lessons need to be learned and implemented from the work of Aboriginal Controlled Medical Services.

Workforce challenges in regional and rural areas can stem from low population density, with difficulty in delivering services in sufficient volumes to support both junior and senior staff with appropriate clinical supervision. This can be overcome through better use of modern communications technologies. Many clinical services are delivered successfully into rural areas using a remote clinical supervision model. Carefully designed and implemented, this can deliver strong clinical outcomes, a connected and engaged team environment, and greater geographic health service reach. This enables smaller teams in dispersed geographies feel connected and supported in their work. Remote clinical supervision models should be well-designed and implemented to expand in-person service availability in parts of NSW with low population density.

There are also significant opportunities to build education, capacity building and networking opportunities that bridge the metro-rural divide. These skill share opportunities go both ways – there is much that metro practitioners can learn from their rural and regional counterparts. In the early 2000s, Karitane had a strong skill share partnership with Child and Family Health practitioners in Broken Hill, which resulted in significant benefits to both parties. However, funding was discontinued and the program ceased. Such programs offer significant opportunity for skill expansion, but must be sustained over a prolonged period. Virtual skill share opportunities offer an option to do this at a lower cost, but funding and support is still required.

With increasing use of telehealth and support for rural, regional and remote families to access specialist care from metro practitioners, there is growing need to build the competency of the metro workforce to work with rural, regional and remote families. Like policy makers, many metro practitioners lack an understanding of the unique circumstances and challenges faced by rural and remote families such as isolation, limited access to a wide range of services, and the complexities of small community dynamics. For families experiencing significant stress (which is common in adjustment to parenting issues), this lack of understanding can exacerbate issues and prevent treatment. This is of even more concern for more complex families with higher levels of vulnerability in remote and rural locations. Training that addresses rural and remote competency should be developed to support all health practitioners delivering telehealth services into rural and remote areas. This could be modelled of existing training offered to GPs relocating to rural areas, such as that offered by the NSW Health Education and Training Institute.

Recommendations

- NSW must develop a coordinated workforce plan for the Child and Family Health workforce that considers need in both metro and rural regions and focuses on key enablers
- Models of remote clinical supervision should be adopted to enable service delivery in areas of low population density
- Education, capacity building, and networking opportunities should be funded to enable skill share between metro and regional locations
- Metro practitioners who work with rural families via telehealth should undertake rural and regional competency training.

Strategic support for integrated care hubs

Integrated Care Hubs are emerging as a strong and effective place-based model of care that co-locates multiple service providers in a central community location such as a shopping centre. With the support of philanthropists and SWSLHD, Karitane has established an exemplar integrated care Hub at Oran Park in South West Sydney. This model creates a soft entry point, free of stigma that allows all families opportunistic access to professional parenting advice and support. This includes emerging vulnerable families through to highly vulnerable families, with a particular emphasis on families who are unknown to support providers. With further philanthropic support, we have established two additional integrated care hubs in late 2020 at Shortland (Newcastle) and Shellharbour (Illawarra).

This model has enormous potential in regional NSW. The shopfront/integrated care hubs take parenting support services to where families already are. Co-location with GPs, allied health and a range of health and social services helps integrate primary and secondary care, making the service journey easier for families to navigate and preventing families from falling through gaps in the referral process. This model extends the reach of early parenting services and through early identification and intervention in the community, reduces pressure on tertiary service waiting lists for the most vulnerable families. It prevents deterioration and the requirement for more intensive resources such as residential unit admission or perinatal mental health services, and provides evidence-based low-level intervention to families that match their needs.

Expansion of the integrated care hub model requires a strategic approach in consultation with government with a view to equitable distribution of such hubs across NSW, including regional and rural locations. At present, integrated care hubs are emerging in an ad hoc, opportunistic and uncoordinated way that is led by service providers and philanthropists and will potentially result in service overlap and gaps. There also needs to be careful consideration of the needs of each community.

Recommendations

- The government should develop a strategic method to expand integrated care hubs across NSW in partnership with providers and local healthcare services, and fund this expansion
- There should be rigour in the design and operation of the hubs, with built in evaluation processes.

Telehealth as an enabler – but not the whole solution

Telehealth has unrealised potential to break down service and access barriers in both metro and regional, rural and remote locations. However, it cannot be the sum total of service options outside major cities. Telehealth must be complemented by in-person service delivery that meets the needs

of complex and vulnerable families. This will ensure maximum utility of scarce resources, and the best outcomes for families across NSW.

Telehealth is sometimes perceived as a second-best option compared to in-person service delivery, however it is important to recognise that some services for some families achieve better outcomes when delivered by telehealth. For example, a US-based 2017 randomised control trial of Parent-Child Interaction Therapy (PCIT, recognised as the gold standard in treatment of severe toddler conduct disorders) showed that PCIT delivered via webcams over the internet (knows as I-PCIT) was actually *more* effective than PCIT delivered in a standard clinic setting (Comer et al. 2017). Karitane is the leading Australian provider of I-PCIT, and our clinical research has made similar findings. This is because when treatment is offered in the home, it is offered in the exact setting in which the problems are occurring, making it easier to generalise new parenting skills to the real world. Similar results have been noted for Virtual Breastfeeding Support, with new mothers able to connect with lactation consultants at the time and place where feeding difficulties occur, rather than at a clinic-based appointment that may not coincide with a baby's feeding needs. This can result in very efficient use of resources – telehealth consultations are typically less resource-intensive than clinic-based services, with costs up to one third lower.

However, it must be noted that these high-quality virtual services are the result of careful clinical design. They are not simply in-person services delivered via webcam, rather they represent a specific and high-quality design based around patient needs and the capabilities of technology. Telehealth services need the same clinical design rigour that goes into in-person services, with careful and considered design, telehealth can achieve great outcomes.

We recognise that telehealth is not appropriate for all families at all times. This is, of course, true of both metro and rural families, yet rural families can sometimes be "pushed" to telehealth as their only option. Comprehensive triage is needed to ensure that the right care is offered to families based on their needs.

Telehealth is an enabler of better secondary and tertiary health service delivery to regional, rural and remote parts of NSW, but it is not the whole solution. Telehealth must be supported by local, skilled, in-person service delivery that supports vulnerable families and connects them to services which cannot be delivered virtually. Blended models of care incorporating local place-based care through a key worker and external expertise delivered virtually have potential to meet the needs of complex families in rural and remote areas. This requires careful clinical design and consideration of appropriate models of care. Karitane has seen strong positive results in trials of blended PCIT and I-PCIT, with some sessions delivered in a clinic and some into the home.

In-person services must be available for families experiencing high levels of vulnerability and complexity, especially those from rural and remote areas of NSW. However, services can be taken up by low-complexity families in metro locations, which extends waitlists and delays access for complex vulnerable families. Where suitable, metro families should be provided with telehealth services where clinically appropriate. Increasing metro client usage of clinical tertiary telehealth services for less complex and vulnerable families would reduce waitlists for the most vulnerable families to access high intensity in-person care, without compromising client outcomes. This would result in more efficient service delivery, and stronger capability to serve regional, rural and remote families across NSW.

Effective telehealth is underpinned by quality communications infrastructure. This is still lacking in many regional, rural and remote locations. We seek further government steps to improve vital communications infrastructure as a key driver of better health, education and social outcomes in rural, regional and remote NSW.

Recommendations

- The government supports providers to unlock the unrealised potential of telehealth – but also recognise that it cannot be the sum total of service delivery to rural, regional and remote families
- There should be support for blended models of telehealth and in-person service delivery that achieve optimal outcomes for families
- More support and funding should be provided to proven tele models of care, such as I-PCIT, Virtual Breastfeeding Support, and Virtual Residential Care Units
- More metro families should access telehealth services, to enable more vulnerable and complex rural and regional families to access in-person services
- The government must act to improve vital communications infrastructure as a key driver of better health, education and social outcomes in rural, regional and remote NSW.

Support for proven programs to expand to regional areas

A Wide range of proven programs support families with complex and vulnerable needs in metro areas. Many of these programs would be highly suited to delivery in regional and rural communities, but are not yet funded by government.

For example, Karitane is a partner providing the proven Volunteer Family Connect service in South Western Sydney. This program connects families experiencing vulnerabilities with volunteers who provide valuable support. An EY study found that the program delivers $1.78 in social value for every $1 invested. The program is delivered by a number of partner providers (Benevolent Society and Save The Children), including into the rural town of Bairnsdale in Victoria, where it is successful.

There is enormous potential to scale the Volunteer Family Connect program to regional and rural communities across NSW. This would support vulnerable families with key early parenting challenges, particularly those who are isolated.

Recommendations

- The government should support the expansion of the Volunteer Family Connect program to regional and rural communities in NSW.
- The government should examine other programs with proven track records that are delivered in metro locations and explore options to expand delivery to regional and rural locations.

Closing

Thank you again for the opportunity to respond to this inquiry. We look forward to discussing these outcomes with you so that we can better support families in rural, regional and remote NSW.

Grainne O'Loughlin

CEO, Karitane