Submission No 40

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Organisation: Marathon Health

Date Received: 4 September 2023

Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW – A response from Marathon Health

Introduction

Marathon Health is a not-for-profit, registered charity with a vision of enabling communities to thrive through improved health and wellbeing. We are passionate advocates for equal access to quality health services for people, wherever they choose to live.

We are the largest non-profit allied health workforce in regional NSW, last financial year contributing more than $24.2 million in wages into regional Australia. We pride ourselves in helping to create a sustainable multidisciplinary allied health workforce that works and lives in regional Australia.

We deliver a range of high-quality programs that focus on providing supportive care in a person-centred environment. This year 54% of our services are focused on mental health, within a recovery-oriented framework. This includes programs right across the mental health stepped-care spectrum, ranging from our six headspace centres to psychosocial support for people with severe mental illness, psychology support for people with mild to moderate mental illness and supporting people with psychosocial disability under the NDIS.

Our workforce of 300 includes more than 100 clinicians in speech pathology, occupational therapy, psychology, social work, counselling, Aboriginal health, dietetics and diabetes education. There are currently 29 psychologists and 27 social workers working at Marathon Health.

We have a strong focus on workforce development, with graduate recruitment and student placement programs that represent partnerships with universities across NSW, the ACT and Victoria to develop employment pathways.

In the past year, we hosted 77 clinical students on clinical placement from 12 institutions across nine disciplines and at varying stages of their studies. These students worked with staff at nine of our NSW locations and seven gained permanent employment with us on graduation.

In this submission, we address the following elements of the inquiry's terms of reference:

> (b) navigation of outpatient and community mental health services from the perspectives of patients and carers
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> (c) capacity of State and other community mental health services, including in rural, regional and remote NSW
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> (d) integration between physical and mental health services, and between mental health services and providers
>
> (g) benefits and risks of online and telehealth services.

(b) Navigation of outpatient and community mental health services from the perspectives of patients and carers

In our experience, people seeking support for their mental health – particularly in rural and remote areas - often experience **difficulty navigating between services** because they are unsure of the services available, the referral pathways and the eligibility criteria. This is partly due to low health literacy levels, but also the lack of integration of services and the frustration people feel when they encounter a wrong door. Many do not know if a referral will be accepted by a service, and they often feel traumatised from having to constantly retell their story.

The **lack of trauma-informed practice, integration of services and volume of paperwork** people have to complete are significant barriers to navigating their way to an appropriate outpatient or community-based service that meets their needs. These deterrents are impacting on health seeking behaviours and, as a result, we regularly undertake unfunded work to support health care navigation and coordination.

There is growing recognition of the value of support for mental health and for early intervention supports. Communities are looking for services, needing services, expecting services, but the system hasn't kept pace with changing needs and expectations.

Our recommendations

i. Linkages need to be improved to reduce the gaps between government and non-government services and to allow collaboration.
ii. All mental health service providers should be funded to train their intake teams in delivering trauma informed services.
iii. Wherever possible, intake processes should be centralised to reduce the need for clients to repeat their stories and ensure that providers can link people to the best possible supports available.
iv. More "one stop shop" approaches to service delivery should be funded, based on models such as Head to Health and Mental Health Locals.

(c) Capacity of State and other community mental health services, including in rural, regional and remote NSW

The challenge in recruiting a mental health workforce is of national concern. However, in rural, regional and remote areas, this challenge is significantly impacting on the continuity of care and ability to deliver services. Capacity is so limited in some communities that engagement is brief and only **people in crisis are being prioritised** to gain access to services. This eliminates the opportunity for people to seek care under a stepped care approach.

Across mental health programs, there is a strong focus on destigmatising mental health and ensuring people have access to services early. Yet the system is so under resourced, often people seeking support are told that they have to be really unwell or in crisis to be able to access any form of support.

Referrals to free mental health services such as our Strong Minds program (for people with mild to moderate mental health difficulties) are accessed via a referral from a GP and a mental health treatment plan. However, with **lengthy delays across rural and regional areas to gain a GP appointment** - and many GP practices closing their books to new patients - people experiencing mental ill health are facing

long waiting periods, when their mental health concerns may escalate. People being discharged from hospital also face difficulties accessing a GP to oversee their care and connect them to appropriate local services.

In our experience, mental ill health is having a growing impact on local communities, particularly with the global increase in isolation and loneliness since pandemic stay-at-home and public gathering restrictions were put in place. Our data suggests that the **complexity of issues is outstripping the capacity of programs** to support them. A larger volume of people are presenting to our services with more severe clinical presentations. In Strong Minds Western, the volume of referrals flagged as a high priority by the referring GP within the client's Mental Health Treatment Plan has increased from 18% to 31% over the past two years.

The data also shows that, of those clients whose referrals we accept, 17% are more complex than anticipated once assessed by a clinician, up from 10% in 2021. We are seeing the complexity of referrals increase well beyond the intended scope of funded services. This cohort then become part of the "missing middle", defined as people whose symptoms are too severe for Commonwealth funded primary care, yet not severe enough for State funded acute care.

Natural disasters have also had a significant impact on the mental health of people in rural communities. Since the impact of flooding across several Western NSW towns during August and September 2022, Strong Minds has experienced a 23% increase in referrals to a total of 158 per month. In one community, the increase was 225%.

Our recommendations

i. There is a need to support an increase in access to Mental Health Treatment Plans via Telehealth, where face to face access to a GP is not available. While a Commonwealth responsibility, state services need to be mindful of these access restrictions when discharging people to lower intensity services or not accepting a referral because another service is potentially available. There is a big difference between the potential for access and the reality that a person faces navigating the system to meet eligibility requirements.

ii. Additional funding is needed to deliver moderate to high intensity mental health programs. This currently falls in the gap between Commonwealth and state-funded services. Services are needed to join up services across the stepped-care spectrum and recognise the impacts of social determinants in mental health including social prescribing and service navigators and coordinators to achieve equity in rural and remote communities.

(d) Integration between physical and mental health services, and between mental health services and providers

In our experience, **multidisciplinary care teams** are best placed to deliver person-centred care and to recognise and understand the many contributing factors to a person's mental and physical health. This **knowledge sharing** approach regularly delivers improved outcomes and works well in GP practices and Aboriginal health services, including when specialist clinics are conducted.

Co-location works well for our teams in rural communities, with our primary health staff working alongside GPs in clinics across Western NSW and three staff now co-located within the Coonamble Aboriginal Health Service, which is proving extremely beneficial in creating awareness of services and opportunities. But these approaches and building the knowledge of what works and doesn't work in

communities, takes time – and time is something that most funded programs are always short of, with a focus on **fast-paced establishment**.

Some of the biggest barriers to people accessing services that support improvements in their health and wellbeing are social determinants, including the ability to pay, chronic disease, poor education, unstable housing, lack of social supports, and drug and alcohol issues. Research shows that **people with mental health concerns benefit from additional social prescribing** as part of their care plan.[1]

Very little funding is available in most mental health programs to provide the services that people are asking for – limiting the connection we can build in communities. Most programs are driven by the funder's **focus on psychological service throughputs** (occasions of service delivered), when it is clear that overcoming systemic barriers and social determinants – and hence improving mental health outcomes requires care coordination to support people to improve the way they live their lives in their community.

Our recommendations

i. Government procurement processes should recognise the time it takes during the establishment phase of a contract to build trust and tailor services that meet needs within a community, particularly in more remote locations.
ii. Mental health service delivery models should allow for the integration of multidisciplinary mental health teams that can cover the full spectrum of supports, with additional funding for universal health navigation and social prescribing determinant support – which might be in the form of a health linker, Aboriginal health worker, peer worker or health coach.
iii. More values-based funding opportunities should be provided, giving organisations the ability to break down service navigation barriers and deliver a more outcomes-focussed approach.

(g) Benefits and risks of online and telehealth services

COVID-19 significantly impacted on the service delivery modes available to out mental health services. While we were forced to transition away from face-to-face services, the switch to more phone and video services had a significant impact on our reach. Before COVID, we were servicing people in 60 communities in Western NSW. We are now reaching 124 communities, because more than half of our clients are comfortable with telehealth alternatives.

In 2019, we delivered 94% of our Strong Minds Western mental health services in person. In 2020, this dropped to 36%, with two-thirds of our services delivered by phone or video. Face-to-face service delivery rose to 42% in 2022 and 49% this year – still well below pre-COVID levels.

While people are reflecting that they **prefer a face-to-face service**, they are comfortable with a blended service delivery model and there is **very little difference in outcome measures**, with both in person and telehealth modes delivering an 80% improvement.

The benefits of providing the option of an in-person or virtual service delivery model include:

- Greater choice for clients, in keeping with our person-centred approach
- Better value for money by reducing travel and vehicle maintenance costs
- Reduced clinician fatigue and greater job satisfaction
- Digital health and technology give people access to specialist care that they cannot access in their local communities, especially psychiatry

- People who find it challenging to seek help in person have an alternative option
- Clients with a history of aggressive or other dangerous behaviour can receive services without risking staff safety.

The risks of online and telehealth services include:

- Lack of access to a reliable internet connection due to financial constraints or connectivity
- Screen and telehealth fatigue due to overuse of virtual services by staff and clients
- Reduced opportunity to build rapport with clients
- Limited opportunities for some clients to find a safe place for a telehealth appointment
- Increased clinical risk when non-verbal signals are difficult to observe
- Safety concerns for isolated clients whose condition might deteriorate during a session
- Increased administrative burden in collecting referral and patient data that is readily available when services are delivered in person at a GP practice
- Set up costs to ensure all aspects of privacy, clinical governance, confidentiality and cyber security are addressed.

Our recommendation

i. Continued funding is needed to ensure the cost of technology is not a barrier to clients receiving a service and that organisations can afford to train staff as systems change and improve

ii. The true cost of telepractice delivery needs to be understood, balancing both potential costs savings in some areas with increased administration and clinical governance efforts.

More information

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References

1. Hassan SM, Giebel C, Morasae EK, Rotheram C, Mathieson V, Ward D, Reynolds V, Price A, Bristow K, Kullu C. Social prescribing for people with mental health needs living in disadvantaged communities: the Life Rooms model. BMC Health Serv Res. 2020 Jan 6;20(1):19. doi: 10.1186/s12913-019-4882-7. PMID: 31906933; PMCID: PMC6945402.