bendigo Community Health services

Submission
Productivity Commission
Inquiry into Mental Health

Prepared by Bendigo Community Health Services

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Working hand in hand with our community to achieve healthier lives

Executive summary

The Royal Commission into Victoria's Mental Health System presents a once-in-a-generation opportunity for mental health (and youth mental health) in Victoria, and Bendigo Community Health Services (BCHS) welcomes the opportunity to participate.

BCHS want to highlight some of the areas that warrant urgent consideration by the commissioners:

- mental health issues regarding resettled refugees in regional centres
- dual diagnosis (MH/AOD)
- consideration of the "missing middle" i.e. those who are falling between the gaps due to not being at the higher levels of acuteness and not meeting eligibility requirements for services funded to work with people with mild mental health presentations (especially those between 12 – 25 years)
- underfunded work with children around emerging mental health issues, and
- GP's in Schools program.

Summary of recommendations

1. More funding for work with children around their developmental stages, safety, resilience and wellbeing pertaining to emerging mental health issues.
2. More collective focus is required on dual diagnosis.
3. Increase access to effective mental health services and supports for young people across all stages of mental ill-health.
4. Improved tailored support responses for margionalised minority populations such as the refugee community.
5. More funding needs to be put into health promotion and early intervention instead of tertiary services always having the majority.

About our organisation

Bendigo Community Health Services is a not-for-profit organisation working hand in hand with our community to achieve healthier lives.

With sites in Central Bendigo, Kangaroo Flat, Eaglehawk and Elmore we care for everyone in our community - no matter who they are, where they live or how much they earn.

Our range of primary and community health services are mostly free or have minimal cost.

We have GPs for general health and services covering specific areas such as children, youth and families, mental health and counselling (including forensic mental health and headspace), alcohol and other drugs (including forensic AOD counselling), sexual health, men's and women's health clinics, the LGBTIQ community, refugee settlement and support.

We help people manage their particular needs through their allied health programs such as podiatry, speech therapists and occupational therapists and living with chronic conditions such as diabetes, respiratory or heart disease.

Bendigo Community Health Services is proud of our team of understanding, supportive and experienced health care professionals who work in partnership with other health services across central Victoria to deliver the care the community need.

Some areas that BCHS sees as needing urgent consideration

Refugee and Migrant background communities (especially from a Victorian regional/rural perspective)

Trauma experiences of refugees impacts significantly on their mental health with many requiring support for issues including depression, anxiety, PTSD and substance misuse. Language barriers, cultural beliefs and poor health literacy often prevent community members from seeking help from existing supports.

Pre-migration experiences of trauma, lack of access to health services before migration, as well as the difficulties of settlement, have been associated with poor health outcomes among refugees, including a high prevalence of post-traumatic stress disorder (PTSD) and psychological distress. Whilst previous studies have highlighted the long-lasting effect of PTSD of this population, less is known about the refugees' PTSD on the health outcomes of their families.

Bendigo Community Health Services has been integral in the settlement of newly arrived refugees for the last 10 years and has, identified via community consultation and provider feedback, increased awareness of refugee mental health issues over that period. Funded by Tandem & Victorian Mental Illness Awareness Council, the *Learning to Live Well project* was a project designed to help build the mental health literacy of our local refugee population by seeking to identify those at risk, understand

their lived experience, respond to risk and enhance the protective factors that influence mental health.

Throughout the lifespan of the project it was identified that a large percentage of Karen refugees settling in Bendigo were experiencing high levels of distress and anxiety, in particular those aged between 15 – 24 years. This highlighted the need to work intensely with our refugee and migrant communities to increase their understanding of mental health and improve pathways for service utilisation. Over the 12 month period we were able to gain a better understanding of the risk and protective factors that influence the mental health of this population as well as increase our understanding of the gaps in service and the barriers to utilisation.

Throughout this project we were able to begin to address the following objectives;

- Increase BCHS understanding of the service gaps and issues that the local Karen population experience
- Improve mental health literacy of Karen population through community contact – events and sessions
- Improve mental health literacy through developing resource materials (in translation)
- Improve mental health literacy by developing and supporting community leaders
- Build the cultural responsiveness of BCHS and other service providers

Given the positive changes the project has achieved there are a number of strategies we have put into place to ensure sustainability of outcomes, however we believe that while this project has initiated change, further dedicated resources are required to ensure ongoing sustainability.

If the project was to continue we would envisage that the program would grow through the continued development of community leaders and health messengers. We see a pathway to develop bicultural workers with specialised skills to work within the community to support a growth in knowledge and literacy and utilisation of health services that have become culturally diverse.

Looking forward we would also like to develop services specialised in working with refugee and migrant youth and the unique set of life experiences they face. It is vital that we support youth of refugee background to navigate resettlement, gain an education and maintain

culture and faith while building resilience and social cohesion in their new communities in order to prevent poor mental health outcomes.

A review of mental health assessment for new humanitarian arrivals is recommended. This should include capturing data on mental health status within the first 12 months of settlement to inform future work.

An important focus going forward would be to build the culture capacity of all service providers in the Bendigo region to better understand the lived experience of our refugee and migrant communities and the impact of culture, faith and connection. Ideally we would also see bench mark cultural competency standards developed to support organisation growth in sensitive practice.

Bendigo has been settling refugees intensely for the past 10 years. The current refugee settlement programs do not have the capacity to effectively address the mental health needs of the refugee community or build the capacity of service providers to provide a refugee sensitive practice. This community is at high risk of experiencing severe and enduring mental health, they often go undiagnosed, have poor mental health and service literacy, due to their lived experiences. Literature supports this notion. Service providers do not have an understanding of the pre settlement experience and impacts of a life of deprivation.

Youth – including thinking about the Doctors in Schools program

Urgent consideration of the "missing middle" i.e. those who are falling between the gaps due to not being at the higher levels of acuteness and not meeting eligibility requirements for services funded to work with people with mild mental health presentations especially those between 12 – 25 years, is required.

The experience and impact of mental ill-health during this life stage can derail key developmental milestones and significantly increase the risk of poor health, social, education and employment outcomes. This area of considerations must, therefore, be a priority focus.

It has been identified that in the Doctors in Schools program close to 70% of the GP workload in session at the school does relate to mental health care. Antidotally from the GPs they would like more access to counselling services directly linked to DiSS program as, psychological and counselling services vary so much from school to school. Importantly there is a clear

situation for an area of resilience and coping skills training identified. Also there is a real need for broader family mental health needs in this area and extreme sensitivities in how these matters are approached and managed.

Dual Diagnosis (MH/AOD)

It is commonly understood within the provision of alcohol and other drugs (AOD) support services, that service users will more often than not present with a diagnosed or self-disclosed psychiatric disorder. However, the extent of co-occurring presentations is often under-reported and rarely adequately responded to.

To emphasise the high proportion of people with dual diagnosis presentations being referred to AOD programs, Bendigo Community Health's Non-Residential AOD Team undertook a deidentified 'snapshot' survey of active clients as of the week ending June 7, 2019. A simple reporting tool recorded basic demographics and the mental health conditions of community members accessing the AOD activities; Generalist Counselling, Forensic Counselling, Care and Recovery Coordination, and Non-Residential Withdrawal. Staff collected evidence from clients' initial comprehensive assessment information or from therapeutic discussions occurring within AOD treatment.

As detailed in the table below; of the 55 active clients, 15 were female (with an average age of 40.7 years), and 40 were male (with an average of age of 36.7 years).

- Nearly all female clients (14 out of 15) either had a diagnosed mental health and/or a self-disclosed condition whereas the figure for the males was 82.5%.
- The female clients were better at seeking mental health supports with 64% of them linked to a mental health service whereas only 33% of the males reported receiving targeted services for their mental health condition/s.
- More males disclosed having experienced childhood trauma events, equating to one in every two males as opposed to one in three females.

	Number of active clients	Age range	Average age	Diagnosed MH condition	Self disclosed MH condition	Total with diagnosed or self disclosed MH condition	Linked to MH services	History of childhood trauma
Female	15	28 to 64	40.7	13 (86.7%)	1 (6.7%)	14 (93.3%)	9 (64.3%)	5 (33.3%)
Male	40	21 to 65	36.7	30 (75%)	3 (7.5%)	33 (82.5%)	11 (33.3%)	21 (52.5%)
Totals	**55**		**37.8**	**43 (78.2%)**	**4 (7.3%)**	**47 (85.4%)**	**20 (36.4%)**	**26 (47.3%)**

Results of this 'snapshot' survey highlight a prevalence of co-occurring presentations significantly higher than expected, although not surprising to staff delivering these programs. The results of this simple survey add to the increasing weight of evidence that the Mental Health and AOD sectors need an improved framework and additional resources to adopt a more integrated collaborative approach.

The ever-increasing complexity of presentations facing AOD workers requires a better co-ordinated dual response that adds value to all aspects of service delivery and provides clients with an optimum treatment. State and Commonwealth departments need to explore further investment in systems that provide tangible linkages between the two sectors, focussing on the promotion of collaborative long-termed planned responses for members of the community currently falling through the gaps.

Current health care responses fail to understand, and respond to, the biopsychosocial needs of dual diagnosis clients who's support needs are exacerbated by difficult to navigate systems. Intricate service system pathways impact not only clients but also their families, friends and broader community. This is further compounded for more marginalised individuals and communities.

Research indicates that males are especially reluctant to engage in support services however a large percentage are connected into AOD programs. As indicated by this survey over 70% of clients are men with over 80% being diagnosed or self-disclosing mental health conditions. Of these men only 33% are linked into formal mental health supports further indicating an opportunity to bring mental health responses into their AOD supports. This is one example of the opportunities that exist to provide more specialised responsive interventions if the Mental Health and AOD sectors truly collaborate to better understand, and respond to, co-existing disorders.

Work has already begun between BCHS and Bendigo Health but more collective focus is required.

Generalist Mental Health Counselling & Children's Counselling

The experience of BCHS is that Primary Mental Health services are getting tighter on who they see and who is eligible for acute service. BCHS's program funding criteria is for people experiencing mild to moderate mental health issues. However, the reality of the situation is that BCHS is having to see individuals with moderate to severe and enduring mental health issues which is extending the wait time for clients with mild to moderate mental health issues due to priority and risk identification.

In rural/regional communities there are less private practitioners, and the ones available have waitlists of up to 12 months.

BCHS sees many clients presenting with suicidal ideation. BCHS is currently funded by PHN to provide the Mental Health Clinical Co-ordination program and Psychological Treatment Services to assist a small number of clients. The demand for service however far outweighs the funding provided. BCHS's client would however benefit from receiving funding to provide the suicide prevention funding as we receive a high number of clients that fit this criteria. It would therefore be advantageous if BCHS could provide a rapid response to this high-risk group.

If tertiary services were more willing to work collaboratively with primary health services, it would be most helpful for the clients. All services in the field of mental health need to understand there are many 'experts' and everyone should work together for the benefit of the client and their carers and families.

Economic disadvantage and geographical location prevents individuals from accessing good mental health. Better funded outreach mental health models need to be funded to attend smaller rural communities who are disadvantaged by a lack of services and transport options to enable individuals to access larger towns and cities.

Often 'buckets of money' are given to many small organisations to do what already is already being provided by other organisations, when it should be given to existing services to improve and expand current services. This would decrease corporate costs and set up costs, enabling the funds to be used to put more clinicians on the ground.

Families need more support - we have taken privacy too far especially where risk is high and we are sending people back to their carers with minimal information. Service providers struggle to navigate the mental health system, it must be terrifying for families and cares who have no knowledge.

There needs to be consideration about the workforce and how primary health services do not attract workers easily as tertiary services pay more. The loss of mental health nursing within training has made it difficult as they are a sparse and an ageing workforce.

The sector would benefit from better pay for mental health clinicians with the provision and payment of external clinical supervision to assist workers to manage the complexity of the work and cases they are dealing with.

We need to educate and promote health from a very early age to ensure everyone can recognise when they are having difficulties and seek support or use strategies they have learnt from health promotion/education.

Conclusions

Operating in a rural/regional context presents challenges that are not as prevalent for our major city counterparts. There are many contributing factors that compound the issues for our communities in relation to the provision of mental health services. Demographic, geographic, economic, social and cultural factors, often culminate in rural and regional communities. This is particularly evident for rural and regional "cohorts" such as: young people; isolated people; people with psychosocial disability and LGBTIQ+ community members.

A key consideration is the appropriate allocation of scarce funding and resources to rural and regional mental health initiatives. We are advocating for greater emphasis on long-term, sustainable research and evaluation, and for prioritisation of evidence-based initiatives with proven efficacy.

It is acknowledged that the mental health system is extraordinarily complex with a huge number of competing demands on human and fiscal resources. Further, with increasing levels of awareness and expectations from consumers, carers and the community generally, the challenges of structural reform are immense.

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References

Learning to Live Well Report: Funded under the Small Grants Program "*Improving the mental health and wellbeing of refugee and migrant background communities by building capacity*" and managed by Tandem and Victorian Mental Health Illness Awareness Council (VMIAC)