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26 February 2016

Mr Steve Irons
Chair Standing Committee on Health
PO Box 6021
Parliament House
Canberra ACT 2600
Sent via email : health.reps@aph.gov.au

Committee member: Ms Lisa Chesters, Mr Steve Irons and Mrs Karen McNamara

Dear Members

Thank you for the opportunity to respond to concerns raised by Mr John Mulder, CEO of Bendigo Health regarding the evidence given to the Public Hearing of the Standing Committee on Health conducted in Bendigo in November 2015.

My evidence was focused on people with serious and enduring mental illness. The research studies that my evidence was based on indicate this group faces significant barriers to service access. Our research findings are supported by other studies, which have been conducted internationally and identify the major challenges in delivering services to this complex group.

I have contacted Mr John Mulder to clarify that most of my evidence was based on a recent study with people with serious and enduring mental illness in small rural communities. This was a large action research study that involved a group of people with serious mental illness, and service providers, who met five times over a six-month period for approximately two to three hours at each meeting. The group engaged in extensive dialogue, planning, action, observation and reflection about issues related to mental health service access in small communities. As part of this group's activity, twenty in-depth interviews were conducted with people with serious mental illness, or their carers, in small communities of less than 1500 people across the Southern Mallee Primary Care Partnership catchment area. The inclusion of people with lived experience of serious mental illness is mandated in health service design, delivery and evaluation, where their expertise has been identified as crucial in service planning. The people who were involved in our research were recruited via newspaper advertisements. From our study, many complex issues were identified that require a planned, whole of system response.

In John's correspondence he states that I made assertions that there is no discharge planning by Bendigo Health's Psychiatric Services division. I have carefully read the transcript of evidence and at no time did I state this. I did state that there is no discharge planning generally, as that was the consistent message from those we interviewed and the consumers involved in our research. The clinicians who were involved in our research agreed with consumer sentiments that the level of discharge planning from health services is generally poor. The people we interviewed discussed discharge planning from many health services, large and small, and there was a consistent message that major improvements are needed.

In my evidence, I went on to provide an example from our research where the person interviewed described her experience of no discharge planning. The example given of someone put out on the pavement with his or her suitcase was another direct example from a recent interview. Whilst John assumes that these examples were from Bendigo Health, it was, in fact, from other services. Having said that, many of the people that we interviewed did give examples where Bendigo Health was mentioned.

As John rightly points out, discharge from a health service is only a very small part of discharge planning. Our research demonstrates that successful discharge is multifaceted and includes attention to the social determinants of health. In our interviews, and the work of the group, many suggestions were made about how outcomes could be maximised by a whole of system approach. Some simple suggestions included greater involvement of schools in discharge planning for young adults.

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Our extensive and systematic reviews of the research literature indicate that inadequate discharge planning is an international problem. John's statement that GPs provide 80% of all mental health consultations is accurate and reinforces the need to ensure that all health professionals have the skills, knowledge and confidence to work with people with serious and enduring mental illness. The lack of confidence in this area amongst many rural health professionals is well documented.

In John's correspondence he indicates that there are visiting psychiatric services in Swan Hill. Our research was not conducted in Swan Hill, but in small communities where people consistently identified geographic, travel, financial and other barriers to service access in smaller communities. What was evident from our research was a lack of knowledge of any visiting services into the small communities in which we conducted our research. If these services currently exist, work needs to be done to highlight these services to consumers and health professionals in these areas.

John states that my comment that there are no services, like Headspace, in small rural communities is incorrect. He states that there is a Headspace under development in Swan Hill. I do not consider the City of Swan Hill a small rural community. In my evidence, I clearly state that 'if you get out into Wycheproof and Warracknabeal and places like that, there is no Headspace (page 13 of the transcript)'. I believe that this statement is true. Whilst the opening of a Headspace in Swan Hill is clearly positive for the City of Swan Hill, participants in our research suggested that geographic, travel and financial barriers would make access to this service difficult. As the Swan Hill facility has only recently opened, understanding of the level of outreach from this service into small communities is not yet known. Evaluative data will provide evidence on whether the Swan Hill Headspace extends into very small communities.

Thank you once again for the opportunity to respond to the correspondence received. One of the greatest values of research is to identify issues that can be addressed, and to prompt debate and discussion, so as to develop strategies to mitigate against them.

Kind regards

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PHD

cc: Professor Pam Snow, Professor Teresa Iacono