Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Dr Warren Kealy-Bateman

Name: Dr Warren Kealy-Bateman

Occupation: Clinical Director Mental Health Drug and Alcohol Dubbo and Regions, Western NSW Local Health District

1. This is an outline of evidence that it is anticipated that the witness will give to the Special Commission of Inquiry into Healthcare Funding.

2. I am the Clinical Director of Mental Health Drug and Alcohol Dubbo and Regions at Western New South Wales Local Health District (**WNSWLHD**). I have held that role since 2017.

3. I have been a psychiatrist within WNSWLHD since 2009, and I am a Board member of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). I have graduate training in Public Health from New York University.

Clinical Director of Mental Health Drug and Alcohol Dubbo and Regions

4. As a local Clinical Director of Mental Health Drug and Alcohol (**MHDA**), I am responsible for operational matters across a vast area spanning around 400km in each direction. This allows strategic learnings that informs the executive, arising from work in partnership with patients, their loved ones, our staff, other health care providers and the broader community.

5. **Challenges** in relation to MHDA services include:

    a. **Workforce**. We have far too few people available with high levels of competence at the frontier of concentrated, focussed, multidisciplinary and specialised healthcare (where we provide complex and integrated health services as teams, such as the large facility of Dubbo Hospital) and we need to be innovative to address this gap. This occurs in almost all areas across the health workforce. Innovation includes improved learning opportunities, as well as people and culture strategies to ensure the best possible experience in the workplace for recruitment, training and retention of staff. For example, in psychiatry we are on the cusp of completing the opportunity to fully train as a psychiatrist in Dubbo, which is to complete all five years of psychiatry training in this frontier location. That would stabilise the workforce and in time erode the reliance on fly in fly out specialists. Comparatively, Orange now has a growing resident specialist psychiatry workforce because of this opportunity for a complete end to end experience of training, allowing junior doctors (and often their families) to settle in the local area. The Department of Health Psychiatry Workforce Program (PWP) funds one of the three training posts at Dubbo Hospital. In future Dubbo MHDA hope to gain further funding for a much needed Child and Adolescent psychiatry trainee post.

    b. **The overrepresentation of First Nations people**. For example, of the 500 Dubbo Hospital mental health admissions each year, approximately 40% identify as Aboriginal. This is far greater than the background local government area populations we serve. Conversely there is often poor attendance of our community mental health teams and primary care. Similarly we have clear reports from some Aboriginal consumers and families that our key points of contact such as our emergency departments (**ED**s) are not always experienced as culturally safe, with

patients not engaging or following up with plans after leaving. Thus, in my view, there is a theme of poor attachment to community health care in all its forms because of transgenerational issues related to colonisation. It is important to unpack this because it is in understanding this that we find strategic pathways to the solutions. The differences in life expectancy, vastly elevated suicide and incarceration rates, and diminished income levels of First Nations peoples (Kealy-Bateman, Nash et al 2021) indicate losses that need to be sensitively navigated from the perspective of the person who is experiencing them. In working with Aboriginal health staff this appears to be an addressable health inequity.

c. **Insufficient inpatient beds.** For example, at Dubbo Hospital there are 20 mental health inpatient beds, for a population catchment of 140,000 and it is generally at capacity. Despite this the beds are used with absolute operational efficiency. The average length of stay (LOS) for inpatients in 2022/2023 financial year was: Gundaymarra (acute / gazetted) = 8.9 days; Barraminya (subacute / voluntary) = 7.4 days. Hospital admissions for Aboriginal people tend to be slightly less in duration (~ 1 day) when I looked at the data two years ago and this was a statistically significant difference. This in my view is not an issue of caregiver bias but of cultural safety and personal wish, that hospital is not as comfortable a place to be as home. The tension overall for Aboriginal people amid discharge planning is a trend to leave sooner than non-Aboriginal people.

d. **Geographic.** In Dubbo and Regions we are challenged by the distances we face. Our Northern region of WNSWLHD is more than twice the size of Tasmania. There are many transport hurdles in coordinating a multitude of services, for example between ambulance; police and health services. We also navigate a *Mental Health Act 2007* (NSW) that is firmly metro centric. It is written without consideration for the vast distances we navigate and the obstacles this entails. For example, in my experience, rural magistrates and then all in the cascade that follow are often deeply frustrated to find the nearest gazetted unit is many hundreds of kilometres from the court when a psychotic or suicidal patient appears before them.

6. **Opportunities** include:

a. **Strategic workforce agenda,** especially in frontier areas and when there are critical populations (Aboriginal, aged, geographic and transport issues):

i. Aboriginal Health Clinicians embedded within NSW Health

1. The experience we (in Dubbo MHDA) have of Aboriginal trainees (who often later become clinicians) and clinicians working with patients and their loved ones is that the trend of non-engagement with health services is reversed via their presence. This is especially true in the community and ED settings.

2. All staff learn from the co-location of Aboriginal people working within NSW Health teams amid clear systems of governance and support for all employees. This is a currently embryonic and a future opportunity for change and growth (in Dubbo MHDA) where we can hear from people in the community and thus consider opportunities to refine our care strategies. We do this often via individual stories that calibrate our system in an ongoing manner.

ii. Psychiatry Workforce Program (medical), RANZCP. Additional future funding places might add further training places in frontier rural sites in NSW, building our workforce and enhancing care.

iii. Nursing and Allied health programs to increase our current recruit, train and retain strategies.

b. **Improving culturally safe delivery of healthcare services**. The examples outlined above are some of the examples of culturally safe practice. Working with consumers and families more broadly, our suite of resources of information given to almost all patients and their loved ones is designed to ensure greater access. Many of these resources of WNSWLHD MHDA are designed by families and carers themselves increasing their fit for purpose feel. This can be delivered via text message whenever we interface with health care consumers.

c. **Increasing the role of family and the next of kin** (**NOK**) has allowed us to problem solve for future health care in an agile manner that is collaborative, successful and contextual. Future health care is also more likely to occur when it is agreed and not imposed. Dubbo MHDA focused on two areas of improvement. The first was our problematic discharge summary rate prior to 2020, which has now improved and is universally sitting at 100% since (ongoing audit has demonstrated this, with the Health Intelligence Unit picking up administrative errors only). The value is that every patient should have a discharge summary, as though they might be your very own family member. And likewise their NOK should be contacted. Rates of contact for inpatients approach 100% with few exceptions (Kealy-Bateman, Ouliaris et al 2021).

In the ED the WANTED project also focused on working with NOK (Kealy-Bateman et al 2023) and we found that in over 90% of cases we could work with NOK. We did not expect to reduce hospitalisations in this study but did so.

d. The emphasis on doing with, and not to or for our health care consumer (patients and NOK) has been a focus and must be a strategic focus going forward. Considering and attempting to address the gap in Aboriginal health needs addresses deficits in the provision of care for everyone, by striving for care with the highest level of excellence.

e. *Mental Health Act 2007* (NSW) legislative reform. Careful attention needs to be considered with rural input from magistrates, ambulance and other transport services, police and rural/remote clinical directors/clinicians. This would without doubt be productive financially but more importantly may meaningfully impact the care given to people.

References

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Kealy-Bateman, W., Stewart, D., Powell, H., Storrier, K., Mackenzie, M., & Dowton, C. (2023). Working alongside next of kin to enhance discharge: A quality improvement

collaboration to co-design discharge for mental health patients. Australasian Psychiatry, 31(6), 782-785.

WNSWLHD MHDA Information Guide (revised 2022)

WNSWLHD MHDA Information Guide for Families and Carers (2020)

WNSWLHD MHDA Information to Support Your Stay at Gundaymarra (reviewed 2022)

WNSWLHD MHDA Information to Support Your Stay at Barraminya (reviewed 2022)