

## **Inquiry: The Accessibility and quality of mental health services in rural and remote Australia**

### **Introduction**

MindsPlus is a private psychology service which focusses on supporting rural South Australian communities.

MindsPlus has been operating for over 10 years and in the past supported some government funded organisations that provide mental health services in rural South Australia by recruiting workforce and supplying psychology services on their behalf.

He last two years we have established private practices in rural communities with the aim to complement government funded services, reduce waiting times for appointments, continue to provide access to non-resident clinicians and ensure fully registered psychologists are still available in rural communities.

### **Terms of Reference**

- ***(a) the nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate;***

**Long waiting lists** – we are aware that in some communities waiting times to access mental health support has been up to at least 8 months. In one area establishing a private practice has contributed immensely to reducing the waiting list of government funded services. For those community members who can afford to contribute financially to their care they can now access psychology services immediately which has taken them off the waiting list for free government funded services and therefore reduced the time those not as financially well off are able to access support too.

**Stigma** – although efforts to normalise mental illness have been undertaken, many people still struggle with the shame of psychologically struggling and needing support.

**Privacy** - related to stigma, particularly in rural locations accessing services privately, not easily identified by other members of the community can be a barrier to seeking and accessing support.

**Dual relationships** – many rural clients prefer to see a clinician who they do not know, and is not a member of their community. For example, they do not want to discuss their personal lives with someone their sister plays netball with or they may see socially.

Fly-in-fly-out (FIFO) services have reduced over time as government funded organisations have moved to primarily only employ clinicians who reside in communities due to financial restrictions .

**Services available** – the availability of multi-disciplinary services has reduced over recent years. For many years now some communities no longer have access to psychologists in their community. Although the mental health nurses, social workers and counsellors are still available there is a gap in the team which has been noted and highlighted by general practitioners and

psychiatrists working in some areas. We understand some psychiatrists are considering ceasing their rural clinics due to concerns for client safety and the risk of continuing services without psychological supports available.

An employing only policy now favoured by government funded service providers has limited the clinicians available to those already residing in the community and who can be attracted to relocate to the area. We understand, more often than not, this has resulted in clinicians not fully registered (still in training) and less experienced clinicians than previously when contracted workforce was utilized as well as employed staff. Time will tell if this continues or if the clinicians in training stay once they have received their full qualifications although they are incentivised with the provision of often difficult to obtain supervision and financial support to relocate to rural areas. The ability to attract provisional psychologists in the future will also depend on whether the 4+2 training pathway remains which is currently under review by the Psychology Board of Australia.

**Lack of choice** – the ability for clients to choose support which is acceptable to them is limited. There is often only one main service provider available who service whole regions.

**Financial** – many potential clients are unable to engage with available timely services which are acceptable to them if they need to contribute financially towards their care. Basically they cannot afford these services and often have to go on waiting lists for support.

***(c) the nature of the mental health workforce;***

- **Limited availability of multi-disciplinary services**
- **Limited availability of experienced and fully qualified clinicians**
- **Limited availability of specialised services e.g. child psychologists**

***(d) the challenges of delivering mental health services in the regions;***

**Recruiting clinicians.** There are a limited number of clinicians who:

- reside in rural locations,
- who are willing to relocate to rural areas for work, and
- are interested in providing FIFO services

Who we can attract to provide quality services in rural locations is difficult due to limited financial incentives available. For private practice to succeed in rural locations requires a reasonable fee be charged for services to cover costs of running the services but does not allow much ability to provide financial incentives to attract more clinicians to provide services to rural areas.

**Service Provision costs.** The costs associated with delivering services in rural regions are considerably higher than in urban areas. To provide FIFO service so non-resident clinicians are accessible the travel and accommodation costs can be considerable. It is also necessary to remunerate clinicians well to attract and retain the services of experienced and fully qualified clinicians.

New Medicare item numbers for telehealth helps to reduce the costs of providing services as less frequent visits for in-person consultations is possible, however the ability to reliably have video picture during consultations can be problematic in rural areas.

**Ability of clients to financially contribute towards their care.** In areas with a large lower socioeconomic population the viability to have private services as an adjunct to other services is restricted.

This had been overcome previously in some areas when services were contracted to provide some consultations free to clients and also allowing the clinician to stay on in the community and provide additional private fee paying sessions. By combining contracted and private work during each FIFO visit to a region costs were service costs were reduced and the community had greater availability of timely services and choice. Without the contractual work some areas cannot sustain fee for service private practice due to the socioeconomics of the area.

**Two-tiered Medicare system.** The different Medicare rebates for registered psychologists and clinically endorsed psychologists reduces the viability of providing private psychology services especially in lower socioeconomic areas. The evidence from studies on the Better Access Initiative does not support this distinction; clinically endorsed psychologist and non-endorsed psychologists work with similar clients and achieve similar outcomes (Pirkis et al, Australia's Better Access Initiative: An Evaluation, Australian and New Zealand Journal of Psychiatry 2011, (45) pp 726-729).

This distinction also reduces the potential pool of clinicians available for recruiting which is already limited. In some areas it is only viable if a clinically endorsed psychologist is secured to be able to reduce the gap payment charged to clients. This in turn creates a threat to the service and continuity of care for clients and the community should that clinician leave – they can only be replaced with another clinical psychologist.

If a clinical psychologist cannot be secured (which is often the case) then no service is provided in that region although a need may have been identified and clinicians are available.

#### ***(f) opportunities that technology presents for improved service delivery;***

**Telehealth.** This has enabled the provision of services for people in more remote areas and increased provision for those in less remote areas. With clinicians visiting rural areas as well as providing telehealth consultations between visits has increased availability of services and reduced need for clients to travel as often and long distances to cities for support and therefore made it easier for them to get regular support.

The necessity to still access some support in person limits access for clients in very remote areas.

If there is a technological problem during the consultation the client's consultation needs to end under current Medicare requirements for this service rather than being allowed to switch to telephone to complete the consultation. This has potential to cause harm by exacerbating client distress and discourage engagement and ongoing and futures help seeking.

**Telephone.** This could be a beneficial means to encourage uptake of support as it provides private access (they do not have to present where they could be identified), is convenient and reliable.

## Recommendations:

- **Provide choice of services.** Whilst we continue to break down the stigma to mental illness we need to provide rural communities with as many choices as possible to access services which are acceptable to them by supporting :
  - an array of services (government, NGO, not-for-profit and private)
  - by a variety of clinicians (multi-disciplinary, in training and fully trained)
  - who can provide services by various modalities (e.g. in-person, telephone and video).

- **Financial support for private practices.** As an adjunct to government services, NGOs and not-for-profit organisations, private practice should be supported. Generally the only financial support required to enable these additional services is for travel, accommodation and office rental which is a small cost in comparison to fully funded services to substantially increase service availability and choice for clients.

This support was to be made available in South Australia for psychologists as it is for medical specialists including psychologists but did not proceed due to funding changes.

- **Value-add services and encourage collaboration.** Establish a program for government funded organisations to contract minimal service provision on their behalf when private practice is also provided in that community. This is a cost effective way of increasing service availability and encouraging multi-disciplinary teams in regions.
- **Have a rural loading on Medicare rebates.** The socioeconomic status of regions should be considered as well as the geographic classification. There are rural locations classified as MMM 3 where approximately 70% of the populations cannot afford to contribute towards the cost of their care. Even if they can contribute a nominal gap payment they do not have the funds to pay the full fee upfront even though the Medicare rebate claim can be processed online for them and received with a day or two.
- **Have more flexible Medicare rebate rules to make services more accessible.** Allow clients to only pay the gap payment and process the Medicare rebate directly to the clinician bank accounts or least enable allied health the ability to register with the 90 day payment scheme.
- **Make the Medicare rebate the same for all psychologists.** The different Medicare rebates penalises clients based on a non-evidence based system.

To receive a service, clients may be required to contribute a larger gap payment if they see a psychologist compared to a clinically endorsed psychologist to receive the same

level of service. This can make timely support unaffordable and reduces the possibility of service provision in rural areas as it makes it not viable to provide the service financially and hinders continuity of care and services with changes in clinicians.

- **Allow Medicare telehealth to be provided by telephone if there is a technological failure.** It can be distressing to clients who are expecting to get support at a particular time to have to reschedule their appointment to a later date due to a technological problem. A reliable service is required.
- **Allow clients in very remote areas to have ALL consultations by telehealth or telephone.** For those in very remote areas the requirement to travel for any consultations is prohibitive.
- **Support Telehealth in-person consults in communities.** Provide financial support for private practices already committed to supporting rural and remote areas and visiting regions for the required in person consultations. This will:
  - Ensure clinicians have an inside understanding of the region, its nuances, positives and challenges, other services available and fosters collaboration with other professionals in the area.
  - Recognise the commitment the service has to communities and will encourage and make it more viable that they can continue to provide more services to the community.
  - Reduce the financial and time burden on clients to have to visit their clinician outside the community.
  - Encourage retention of services and therefore continuity of care
  - Incentivise private practice companies rather than solo practitioners so when an individual clinician leaves a replacement is actively pursued rather than the community being left with a gap in services.
- **Provide incentives for private rural practice.** Provide support with the additional costs associated with running a rural practice including the ability to incentivise clinicians to help attract more clinicians to service rural Australia.