



**S·A·R·R·A·H**

Services for Australian  
Rural and Remote Allied Health

Senator Rachel Siewert  
Chair  
Senate Standing Committee on Community Affairs References Committee  
PO Box 6100  
Parliament House  
Canberra ACT 2600

Dear Senator Siewert,

### **Inquiry into the accessibility and quality of mental health services in rural and remote Australia**

Thank you for the opportunity to comment on the significant issues relating to the accessibility and quality of mental health services in rural and remote Australia.

SARRAH is the peak body representing rural and remote allied health professionals (AHPs) working in the public and private sector. SARRAH was established in 1995 and advocates on behalf of rural and remote Australian communities in order for them to have access to allied health services that support equitable and sustainable health and well-being. AHP's are tertiary qualified health professionals who apply their clinical skills to diagnose, assess, treat, manage and prevent illness and injury.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that allied health professional services are basic and fundamental to the well-being of all Australians.

SARRAH also believes that support for the mental health and suicide prevention needs of Aboriginal and Torres Strait Islander people should be a priority, with the focus on the delivery of culturally appropriate services in culturally safe settings, such as through Aboriginal Medical Services and Community Controlled Health Organisations.

#### **What SARRAH would like to see**

1. A comprehensive health workforce strategy that includes allied health as full partners in delivering multi-disciplinary health care.
2. Commitment to a national Allied Health Rural Generalist Pathway with long-term funding.
3. Changes to the MBS Psychologist items enabling both Psychologists and Clinical Psychologists in the MMM 4-7 regions to access a loading to recognise rural and remote sustainability issues.
4. Access to MBS items for other allied health professionals supporting multidisciplinary mental health care in rural and remote communities.
5. An holistic response to the range of socio-economic barriers to mental health care and treatment in rural and remote communities that supports better access to transport, access to community care and treatment for alcohol and drug dependency and a focus on developing employment and educational opportunities in communities.

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With regard to improving mental health outcomes, SARRAH’s membership comes from a range of allied health professions that support people seeking services to support better mental health outcomes including but not limited to: Dietetics/Nutrition, Exercise Physiology, Occupational Therapy, Pharmacy, Psychology and Social Work.

AHPs are critical for the management of their clients’ health needs, particularly in relation to chronic disease, mental health and complex care needs. A team of allied health professionals can support an individual effectively working with local general practitioners (GPs) – for example, a young person with an eating disorder will need access to psychological and nutritional advice as well as GP support. They may also need to access an exercise physiologist to support them to make realistic exercise goals to maintain a healthy lifestyle.

But often in rural and remote communities, accessing even one of these professionals is difficult, let alone the team that may be vital to support recovery. In developing this submission, SARRAH sought advice from our members in the field who are working to make a difference every day. Their comments are that while they can see less stigma attached to mental health issues than in the past, there are many areas in which there has been little progress.

The reasons for this fall into three broad areas: workforce, funding models and socio-economic factors.

### Workforce

Unlike the medical and nursing professions, where significant investment has been made to improve the distribution of particularly GPs and nurses, there has been little focus on the need for the range of allied health professions vital to deliver the multi-disciplinary care that modern medical practice demands – for mental health, chronic diseases and complex care.

This has resulted in significant maldistribution of the allied health workforce, as illustrated in the table below.

**Selected Health Professions by Remoteness per 100,000 population 2015**

Remoteness Area	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
<b>Professions</b>					
Medical Practitioners	472.63	314.42	277.35	289.91	186.26
Nurses and Midwives	1497.91	1471.35	1368.68	1449.57	1256.27
Occupational Therapists	81.44	60.96	58.93	41.42	30.39
Pharmacists	133.62	95.98	90.39	72.25	44.11
Physiotherapists	131.12	84.04	67.42	57.92	43.62
Psychologists	158.34	90.43	63.44	52.94	32.35

Addressing this maldistribution will be an important element in a comprehensive plan to improve consumer accessibility to mental health services outside the major cities: a plan that should include both push and pull factors to encourage health professionals into rural and remote practice.

The Allied Health Rural Generalist Pathway (AHRGP), currently being trialled, is one way in which allied health professionals can gain the additional skills they need to support the complex needs of rural and remote communities. The AHRGP is a collaboration of SARRAH, James Cook University, the Queensland University of Technology, and state and territory health services, led by Queensland Health. It involves training generalist allied health professionals who are able to deliver a wider array of clinical services within an expanded scope of practice, including in-hospital, outpatient and community care and to meet the needs of different rural and remote communities for holistic and culturally appropriate care.

Rural generalist training positions have been trialled since 2014 in Queensland and have shown benefits for health services and local communities in terms of improved health outcomes and reduced hospitalisations. Trainee positions were extended to other states in 2017.

One of the key solutions to providing equality of access in rural and remote Australia is expanding the scope of service that any one health professional can provide. Access to allied health services improves health outcomes for communities and improves attraction and retention of allied health practitioners. The generalist pathway for allied health is a critical component for ensuring rural and remote communities have access to high quality, culturally appropriate, multi-disciplinary healthcare – particularly with regard to mental health, chronic disease and complex care.

The AHRGP is funded by the sector at present, led by Queensland Health. As this model is clearly demonstrating the effectiveness of this approach to developing the allied health workforce in rural and remote communities, the need for a national funding base is critical to ensure these gains continue and remain sustainable.

### Models of funding

One of the major disincentives for allied health professionals when considering rural and remote practice is the current funding model, which is sustainable in major cities but becomes less sustainable the further a health professional moves from a major city. While the Medicare rebate for mental health services is a positive move, it doesn't address the sustainability issues for rural and remote allied health practitioners.

One of SARRAH's members has described the issue...

*...as a psychologist in private practice, the rebate is not enough for me to bulk-bill clients and this means that some people will be unable to meet the gap fee... it is not financially viable for me to bulk-bill. The break-even cost of providing a 50 minute consultation is \$105, Medicare rebate is \$85 for a psychologist...*

SARRAH suggests that the use of a rural and remote loading for Psychologist and Clinical Psychologist practices in geographic areas that fall within the Modified Monash Model 4-7 classifications may represent the most appropriate response in this situation. SARRAH also supports actions to increase access to both Psychologists and Clinical Psychologists in rural and remote communities.

SARRAH members welcome the Medicare rebate for mental health services provided by video-link, noting that having an understanding of the community in which the service is being delivered presents an advantage. This form of service delivery can be greatly beneficial, but as another SARRAH member suggests, some people *prefer to sit in the company of their mental health worker and get a sense that the mental health worker actually understands the context they live in.*

Telepractice, using the telephony services to deliver a range of services, can also be of great assistance in rural and remote settings, but as with video-conferencing, some clients feel less comfortable in accessing these services. The result is that for both video- and tele- practice, those who are not comfortable with these service modalities may simply choose to go without support.

Consumers who are considering the range of health options that they may be able to access need to have easy to understand information on hand about these options. At present, the level of consumer knowledge is low.

Telehealth and video based services provide support, but should not be the only models of care for people in small and/or isolated communities. The reliability of internet and telephone services in remote communities is a further limiting factor for the uptake of these services.

### Socio-economic factors

There are multiple reasons why people living in rural and remote communities find it difficult to access affordable mental health services. As mentioned above, the stigmatisation of mental health issues has decreased, but simple issues such as transportation and slower rural economies create additional barriers. As a SARRAH Member describes, even in the larger rural centres, such as Rockhampton, barriers to access can include...

*...limited or no transportation options, inability to pay for bus fares, poor job prospects, a sense that they have been forgotten, the need for more industry to create employment prospects which includes on-the-job training at an entry-level for those with limited skills, confidence or literacy, job insecurity for those currently in the workforce and threats of business closures/downturns and pressures relating to low level of the Newstart allowance.*

These barriers can be further exacerbated by existing poor health, immobility, drug and alcohol dependency, break down in support and family networks, job insecurity, isolation, boredom, extreme weather conditions, loss of purpose, loss of connection and loss/absent sense of community.

Some clients have benefited from obtaining support to purchase other modes of transport, such as a bicycle. This also serves to improve their mental and physical health through behavioural activation and promotes a sense of purpose and empowerment for them. The limitations of this, however, include extreme heat in summer, where many communities experience conditions where it is simply too hot to ride a bicycle during the day.

Enabling Mental Health workers to approve the purchase of a bicycle for a client, or to approve access to travel vouchers for bus or taxi travel are other possible options for consideration to support client access to the mental health services they need.

SARRAH welcomes the discussions that this Committee is leading and would be pleased to contribute further if required.

Yours sincerely

Jeff House  
Chief Executive Officer  
11 May 2018