Australian Government

Department of Health

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

INQUIRY AND REPORT INTO

THE ACCESSIBILITY AND QUALITY OF MENTAL HEALTH SERVICES IN RURAL AND REMOTE AUSTRALIA

Submission from the

Department of Health

May 2018

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Contents

Foreword

This submission is made on behalf of the Australian Government Department of Health.[1]

The submission is made in response to:

> On 19 March 2018, the Senate referred the following matter to the Senate Community Affairs References Committee for inquiry and report:
>
> > *The accessibility and quality of mental health services in rural and remote Australia, with specific reference to:*
> >
> > - *the nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate (see Parts 2-3)*
> > - *the higher rate of suicide in rural and remote Australia (see Part 6)*
> > - *the nature of the mental health workforce (see Part 7)*
> > - *the challenges of delivering mental health services in the regions (see Part 2)*
> > - *attitudes towards mental health services (see Part 2)*
> > - *opportunities that technology presents for improved service delivery (see Part 8)*
> > - *any other related matters.*

[1] *Note:* for the purposes of this document 'Australian Government' is used to refer to the responsibilities of government departments and agencies, while activity described in this document is limited to that within the portfolio of the Department of Health. 'Commonwealth' refers to financial or other resource investment.

1 Executive Summary

In August 2017, all levels of government endorsed the Fifth National Mental Health and Suicide Prevention Plan. In doing so, each agreed to a collaborative approach to provide better mental health and suicide prevention services in Australia. In 2016-17 the Department of Health's total expenditure on mental health was over $4 billion covering Medicare Benefits Schedule rebates for mental health services, contributions through the Pharmaceutical Benefits Scheme as well specific mental health grant programs.

The key to the Australian Government's contribution has been to support Primary Health Networks (PHNs) as leaders in regional planning, coordinated funding and commissioning of mental health services. This will complement local general practitioner (GP) activity and address service gaps. PHNs are required to tailor services to local needs, making this an important development for accessibility and quality of mental health services in rural and remote Australia.

Some of the current innovations and trials are having immediate impact, while others will take time to consolidate and develop. The new minimum data set will provide information at a more refined level to inform future policy and local service decision-making. Through such initiatives, the Australian Government is contributing to improved mental health and suicide prevention services in rural and remote Australia, but there is still some way to go.

1.1 Background

Mental illness is widespread in Australia, as it is in other developed countries. Data from the Australian Bureau of Statistics (ABS) indicates that one in five people aged 16 to 85 years will experience one of the common forms of mental illness in any one year[2]. Almost half of all Australians will experience a mental illness at some point in their lifetime.

The impact of mental illness on peoples' lives varies, with different levels of severity and implications for functional impairment. Some people may experience a single episode and recover fully, while others may experience ongoing effects on their quality of life, and that of their families. Over 4 million Australian adults are estimated to have common mental disorders, while for 3 per cent of Australians their mental disorder is severe.

The Australian Government recognises this impact, including the emotional, social and economic cost of mental illness for individuals, families and communities. It also recognises the long-standing challenge of access to health services in rural and remote communities, as well as the associated risk factors that compound mental health need.

The improved mental health of Australians has been a national priority for over 25 years. Over that time, there has been increased public awareness of the impact of mental illness and the role of all governments in supporting access to mental health and suicide prevention services. Currently, the total spending of all governments on mental health-related services and suicide prevention in Australia each year is $9 billion.[3] .

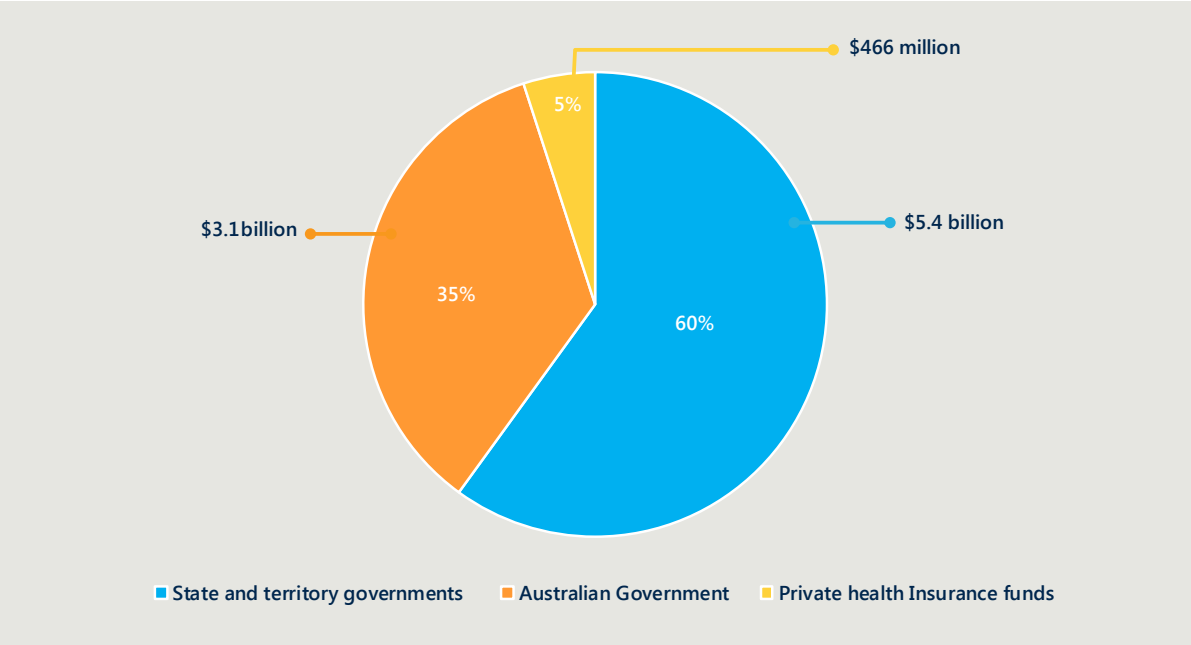
1.2 Health portfolio expenditure in mental health

Australian governments invest significantly in mental health-related services for all Australians. In 2015-16, the Australian Institute of Health and Welfare reported 7.7 per cent of all government health expenditure was dedicated to mental health-related services, while national spending on mental health services

[2] Australian Bureau of Statistics. Media Release: One in five Australians have a mental illness: ABC, October 2008
[3] Australian Institute of Health & Welfare. Media release: Mental health spending hits $9 billion, 2 February

totalled almost $9 billion in 2015-16. Of that expenditure, most was by state and territory governments (about 60 per cent of total mental health spending, or $5.4 billion), followed by the Commonwealth (35 per cent, or $3.1 billion) and private health insurance funds (five per cent, or $466 million) (Figure 1 below).

Figure 1: National spending on mental health services 2015-2016[4]



The Commonwealth provides direct or indirect funding to the major private sector services (including private psychiatrists and general practitioners) through the Medicare Benefits Scheme (MBS), as well as medications through the Pharmaceutical Benefits Scheme (PBS).

In 2016-17, the Department of Health's total mental health expenditure was over $4 billion, covering MBS and PBS, the Commonwealth's share of public hospital funding and private insurance rebates, and mental health programs. This also included $712.8 million for grants based mental health programs such as those supporting primary care, promotion and prevention, psychosocial support and suicide prevention. The Australian Government also provided $1.485 billion to states and territories specifically for public hospitals, through which mental health services are delivered.[5]

In this way, the Commonwealth, state and territory funding partnership provides the foundation for accessible and quality mental health and suicide prevention services in Australia.

1.3 The role of public, private and non-government sectors in mental health

Mental health service provision within the Australian health care system is characterised by multiple providers working in primary, specialised mental health and other, often community-based health services.

These services are provided across the public, private and non-government sectors.

[4] Australian Institute of Health and Welfare. Mental health Services in Australia- web report 3 May 2018, Expenditure on mental health-related services 2015-16 – Key Points; Australian Institute of Health & Welfare. Media release: Mental health spending hits $9 billion, 2 February.

[5] Department of Health internal projected estimates.

Public sector mental health services include psychiatric hospitals, psychiatric units in general hospitals, community residential units and community mental health services.

The term private sector refers to a range of providers including private psychiatrists, general practitioners, private psychiatric hospitals and private allied health professionals. The Commonwealth makes a significant contribution to this sector through the MBS rebate arrangements and its contribution to private health insurance rebates.

The non-government (NGO) sector includes not for profit and community managed organisations, which promote independence and mental wellbeing, provide support and advocacy, or provide specialised information, accommodation and rehabilitation services.

1.4 National mental health and suicide prevention activities

The 2014 National Mental Health Commission review found that the national mental health system was poorly planned, fragmented, badly integrated and lacked accountability.[6] In response, all levels of government, private and non-government sectors have committed to working together to deliver quality mental health care in Australia.

The Fifth National Mental Health and Suicide Prevention Plan, released in 2017, bring together Commonwealth, state and territory governments, and consolidates existing partnerships, in a single national approach that emphasises the need to be responsive to the specific needs of different regions.

The Australian Government has adopted a 'plan nationally, act locally' approach to build on its past leadership and leverage new and existing funding commitments. A key feature of the Commonwealth's new role has been to support PHNs as the vehicles of integrated regional planning, coordinated funding and targeted commissioning of mental health services. This allows a clear line of sight, transparent accountability and direct links between policies, resourcing and local delivery for quality mental health and suicide prevention services.

1.5 Mental health through regional Primary Health Networks (PHNs)

The Australian network of 31 PHNs is a key mechanism to support the Australian Government's delivery of mental health and suicide prevention services (see Appendix B). PHNs have been provided with a new flexible funding pool to coordinate and commission mental health services at a local level. They have quarantined funding for early intervention, youth and Indigenous mental health services and have been entrusted with the coordination of a range of other mental health initiatives. Accordingly, it is the role of PHNs to engage with general and mental health practitioners to ensure the provision of quality services to individuals.

This role of PHNs is required, as many people in rural and remote areas do not have easy access to local mental health professionals. In recognition of this, the Commonwealth has allocated mental health flexible funding with significant weighting for rurality, Indigenous status and socioeconomic status. These three factors are known to be associated with higher levels of need and lower rates of access to services.

Devolving national resources to provide maximum local benefit will provide significant benefits for rural and remote communities, and will support the improved quality of care that comes from delivering services through a stepped model that matches support to intensity of need (as discussed in Section 4).

[6] National Mental Health Commission. Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services, 2014.

The innovative mental health programs, initiatives and trials being developed by PHNs across Australia are still in their early stages but success stories from this approach in rural and remote Australia are growing.

1.6 The role of PHNs and Aboriginal Community Controlled Health Services (ACCHs)

Primary Health Networks

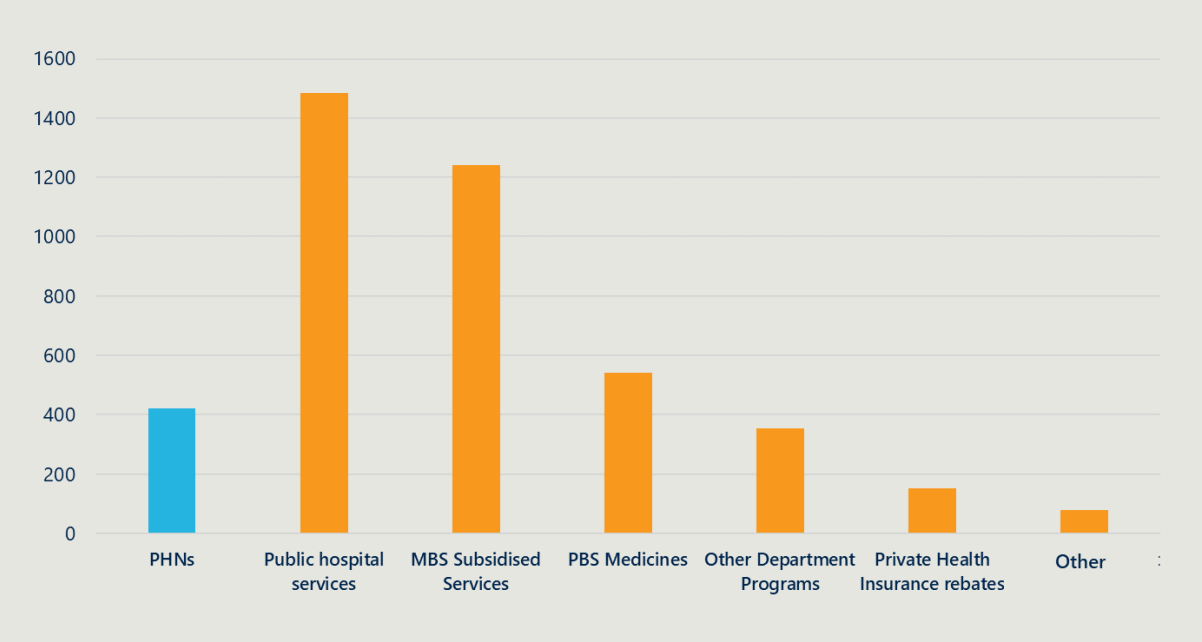
The Australian Government has provided PHNs with a new flexible mental health care and suicide prevention funding pool to plan, integrate and commission mental health services at a local level, in partnership with relevant services. This regional approach identifies what services are available to address service gaps where needed, including in rural and remote communities. This role is vital for mental health and suicide prevention services in rural and remote communities, where most people do not have access to local mental health specialist services, and local GPs are the first (sometimes only) available service.

In 2018-19, around 59 per cent of funding to PHNs will be fully flexible. This flexible funding component includes provision for a range of low intensity to severe youth services and severe/complex adult mental health services. It also provides for suicide prevention and delivery of psychological services for harder to reach groups (such as those in rural and remote areas). This flexible funding incorporates the previous Access to Allied Psychological Services (ATAPS), Mental Health Services in Rural and Remote Areas (MHSRRA) and Mental Health Nurse Incentive Program (MHNIP). It is expected that PHNs will invest this flexible funding into programs that will continue the principles and success of these previous initiatives while meeting the specific needs of their communities.

Additional funding to support integration of Indigenous mental health services with other complementary services is quarantined and can only be used to improve access by Aboriginal and Torres Strait Islander people to culturally appropriate care for mental health issues. In 2018-19, this quarantined funding will make up the remaining 41 per cent of PHN mental health funds to PHNs with 32 per cent tied to youth psychosis and headspace initiatives. It also provides specific support for Aboriginal and Torres Strait Islander mental health (9 per cent).

As can be seen in Figure 2 below, while funding to PHNs is important, it is only the fourth largest contribution to mental health and suicide prevention services within the Health portfolio. In 2017-18, this contribution is anticipated to be approximately $423 million.

Figure 2: PHN funding in the context of mental health spending in Health portfolio 2017-18 ($million)[7]



The total PHN funding to mental health and suicide prevention is not distributed evenly across Australia. In recognition of the specific challenges of mental health service delivery in rural and remote communities, the Commonwealth has developed and applied a model to allocate mental health flexible funding with significant weighting for rurality, Indigenous status and socioeconomic status. These three factors are known to be associated with higher levels of need and lower rates of access in rural and remote regions. As a result, PHNs with populations resident outside major city/metropolitan areas receive over double the per capita funding of metropolitan PHN regions (see Table 1 below).

[7] Department of Health public resource document.

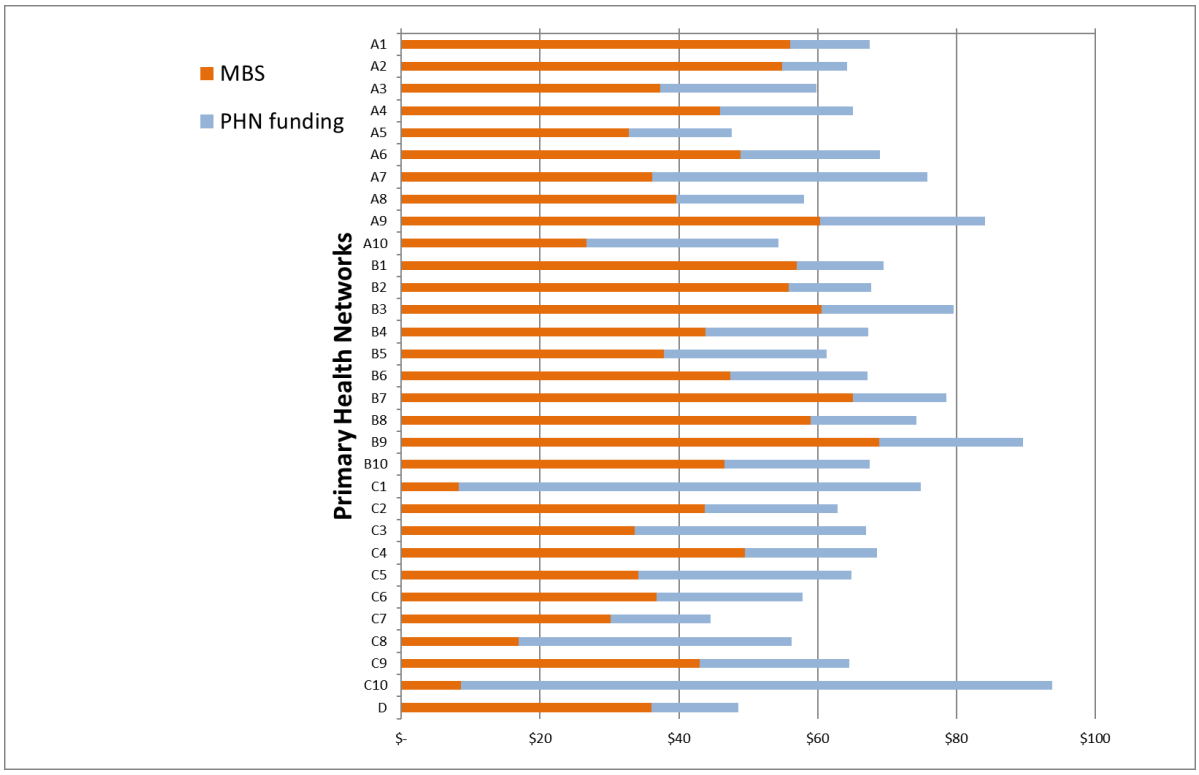
Table 1: Mental health flexible funding to PHNs – predominantly non-metropolitan regions vs metropolitan regions (2018-2019 estimate) [8]

Programs	Number of regions	Percent of Australian population	Percent of PHN funding 2018-19	Per capita funding 2018-19
Non-metro PHN regions: with predominantly (>50%) non-major city populations	15	33%	50%	$24.70
Metro PHN regions: predominantly (>50%) major cities populations	16	67%	50%	$11.95
Total	**31**	**100%**	**100%**	**$16.14**

Comparison with MBS expenditure

The Department has projected MBS 2018-19 expenditure based on the previous three years expenditure covering mental health specific items only, delivered by allied health professionals and psychiatrists. (see Figure 3). Figure 3 below also shows the corresponding PHN funding for each region.

Figure 3: Funding allocation to PHNs per capita vs MBS funding (2018-19 estimate) [9]



[8] Department of Health public resource document.
[9] Department of Health public resource document.

This analysis illustrates the significant variation in MBS funding across PHN regions. The Australian Government, through its funding arrangements with PHNs, is able to reduce this discrepancy using appropriate weightings on the funding provided to each PHN region.

Specific Areas of Need

The Australian Government's model of funding through regionally based PHNs enables resources to be targeted to specific areas of need. This mechanism is particularly beneficial in times of extreme need including following natural disasters where funds can be made available swiftly to established local providers to ensure that the required additional services are available quickly within the local communities.

An example of this is following the recent bushfires in Tathra, New South Wales, and south-west Victoria the Australian Government provided emergency relief funding to support mental health counselling services for residents affected by the fires. This funding was provided through local PHNs to boost their capacity to provide counselling support to meet the needs arising from the trauma and loss associated with the bushfires. In response to natural disasters the regionally based PHNs work with local providers to ensure that appropriate additional services are available to support the community over the next year or so.

Aboriginal Community Controlled Health Services

The Australian Government supports the provision of culturally appropriate mental health services to Aboriginal and Torres Strait Islander people living in rural and remote Australia through a number of clinical models. PHNs have been funded $85.7 million (2016-17 to 2018-19) through the Indigenous Australian's Health Programme (IAHP) to provide Aboriginal and Torres Strait Islander people with access to effective high quality mental health care services in urban, regional, rural and remote locations across Australia.

This funding is dispersed through Aboriginal Community Controlled Health Services (ACCHS), wherever possible and appropriate, as well as through mainstream services delivering comprehensive, culturally appropriate primary health care. PHNs are expected to undertake regional needs analysis in collaboration with relevant local Indigenous organisations including ACCHSs and peak bodies and with mainstream primary health care organisations to identify the specific mental health needs and service gaps for Aboriginal and Torres Strait Islander people.

Aboriginal communities operate over 140 ACCHs across Australia. ACCHs are distinct from other health services that focus on providing care to Aboriginal and Torres Strait Islander people because of the community controlled model. There is also a number of Aboriginal Medical Services (AMSs) operating across Australia, which are usually funded and run by a State or Territory Government or not-for-profit entity. AMSs predominantly operate in the Northern Territory and Queensland.

ACCHSs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, which rely on Aboriginal health workers and/or nurses to provide the bulk of primary care services, often with a preventive, health education focus. Primary health care, within the holistic health provision of an ACCHS, provides the sound structure to address all aspects of health care arising from social, emotional and physical factors. It incorporates numerous health related disciplines and services, subject to its level of operation, available resources and funding.

The services form a network, but each is autonomous and independent both of one another and of government. The Australian Government provides funding to ACCHs through various mechanisms including grant funding to support the operation of the health service, specific grants for targeted programs including those related to child and maternal health and drug and alcohol services. The Australian Government also supports the provision of services through allowing Medicare rebates to be provided for services provided by the ACCHs via a Direction under Section 19(2) of the *Health Insurance Act 1973*. Funding for mental health programs through the PHNs add to the capacity of the ACCHs.

2 Mental health in rural and remote Australia

Mental health is a state of emotional and social wellbeing where the individual can cope with the normal stresses of life and achieve their life potential. It includes being able to work productively and contribute to community life. On the other hand, mental illness refers to the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people.

Mental illness has a substantial impact across Australia. However, there are higher levels of need experienced within rural and remote communities, and suicide is a significant concern, particularly amongst Aboriginal and Torres Strait Islander people. This section will outline the prevalence of mental illness in rural and remote Australia, as well as the significant challenges and substantial cost to all Australians.

2.1 Prevalence of mental illness in rural and remote areas

In Australia, as in many other countries, the prevalence of mental illness and suicide is high. In 2007, the Australian Bureau of Statistics (ABS) conducted the second National Survey of Mental Health and Wellbeing. The survey involved approximately 8,800 people aged over 16 years and living in private dwellings in all states and territories of Australia. It reported prevalence of mental illness at approximately 20 per cent.[10] That means that one in five Australians will experience a mental disorder in any given year, no matter where they live.[11]

The prevalence of mental illness in Australia, combined with the significant disability associated with it, results in a substantial personal burden of disease. Over 45 per cent of Australians will experience a mental illness during their lives.[12] The burden of mental illness is ranked only behind heart disease and cancer in contribution to the total burden of disease in Australia[13]. Depression and anxiety account for over half of this burden, with depression being the leading single cause of disability among all disorders. Most Australians have been affected by mental illness, either directly or indirectly, by being involved with someone who has a mental illness.

The latest AIHW report[14] on mental health services reported that approximately 2.4 million Australians received Medicare-subsidised services in 2016-17. In that same year, 4 million people received mental health-related prescriptions. While prevalence of mental illness is consistent between metropolitan and non-metropolitan areas[15], several indicators point to higher levels of need in rural and remote communities. This is of note because lower access to early intervention through MBS services or other services can result in intensification of need, comorbidity, chronic conditions and greater hospitalisation.

[10] Australian Bureau of Statistics, 4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007, p.21,2,7

[11] Royal Flying Doctor Service accessed 1 May 2018

[12] Australian Bureau of Statistics, 4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007 p.1

[13] Australian Institute of Health & Welfare, Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011, p.vii

[14] Australian Institute of Health & Welfare, Mental health services in Australia – web report, 3 May 2018, Prevalence and policies

[15] National Rural Health Alliance, Fact Sheet – December 2017, Mental Health in Rural and Remote Australia

In 2016-17 there were 495 MBS funded mental health encounters per 1,000 people in major cities, compared with 297 and 145 encounters per 1,000 people in outer regional and remote areas respectively.[16]

2.2 Unique mental health challenges in rural and remote communities

People in rural and remote areas face a range of stressors that are unique to living outside major cities. These include a greater prevalence of some chronic conditions and disability, and generally poorer health. Rates of smoking, risky drinking and illicit drug use are also higher. Patients are more likely to present during the later stages of illness, and they do not have the same access to primary care and early intervention services. This often results in higher rates of complex comorbidities. Together, these influences can compound the risk factors for poor mental health.

Health challenges in regional areas are also compounded by social problems. Loneliness and isolation are acute issues and are in part a result of the gradual depopulation of remote and rural areas to cities. This is particularly challenging for young people growing up in these areas.

2.3 Social and economic cost of mental illness and suicide in rural and remote Australia

The social cost of mental illness can be high. This includes the intangible costs of reduced wellbeing, emotional distress, pain, and other forms of suffering. The stigma associated with mental illness can prevent people from discussing their condition with loved ones, being open about it in the workplace and from seeking professional assistance. In many communities there remains significant stigma and discrimination associated with mental illness. As the awareness of mental illness grows, many individuals, families and communities are better able to understand mental illness and provide support and assistance to those experiencing mental illness.

When symptoms of mental illness present they can have a significant social impact on individual sufferers. The severity of this social impact varies across regions and is often compounded by a range of social factors. For example, Aboriginal and Torres Strait Islander people, and those who are marginalised based on their sexuality or gender, can face compounded pressure on their condition particularly when they live in an isolated rural or remote community.

The economic cost of mental illness can also be high. The OECD estimates that the average overall cost of mental health to developed countries is about four per cent of Gross Domestic Product (GDP).[17] At a national level, the economic costs of mental disorders are substantial. Mental illness accounts for substantial losses in the workplace through sick leave lost working days and reduced productivity. The National Mental Health Commission estimated the annual cost of mental illness in Australia is more than $60 billion, which represents about $4000 for every tax payer.[18] It has been estimated that mental illness results in around 12 million days of reduced productivity a year for Australian businesses.[19]

[16] Australian Institute of Health & Welfare, Mental health services in Australia – web report, 2 February 2018, Medicare services 2016–17 tables, Table MBS.10: Medicare-subsidised mental health-specific services, by provider type(a), patient demographic characteristics, 2016–17

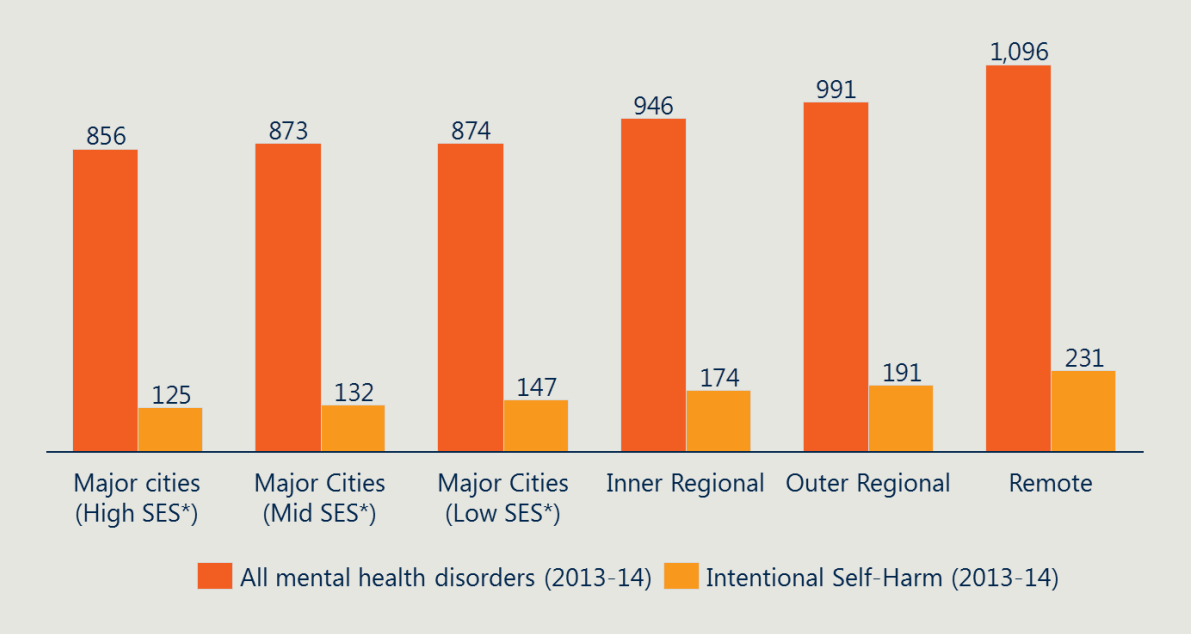
[17] OECD: Making Mental Health Count, 2014

[18] National Mental Health Commission. Economics of Mental Health in Australia, 2016

[19] Professor Allan Fels, National Mental Health Commission media release. The economic cost of physical ill-health and serious mental illness – 2016 web report, accessed 2 May 2018

Amongst the direct financial costs of mental health in regional areas are those to government through hospitalisation. The AIHW 'Healthy Communities' Report highlighted that the rate of hospitalisation from mental health conditions as well as drug and alcohol use and intentional self-harm, is higher in remote areas than major cities (as seen in Figure 4).[20] In 2013-14 the overall mental health overnight hospitalisation rate was higher in regional areas when compared with metropolitan areas.[21]

Figure 4: Age standardised rate per 100,000 population of same-day and overnight mental health hospitalisations, 2013-14[22]



**SES refers to Socio-Economic Status*

While data indicates significant differences in the rates of hospitalisation in rural and remote Australia compared with major cities, it also reveals significant variation within regions – the rates of hospitalisation in some communities can be almost eight times higher than for other communities of the same level of remoteness.[23]

To assess the economic cost of mental illness in rural and remote Australia, it needs to be recognised that rural and remote communities contribute significantly to the country's economy. Recent data shows that approximately 67 per cent of the value of Australia's exports comes from these areas.[24] This means that loss of productivity or lack of healthy workers not only has an impact on the national economy, but also on regions and towns that rely heavily on one industry or export.

[20] Australian Institute of Health and Welfare. Web update: Hospitalisations for mental health conditions and intentional self-harm in 2014-15, 16 February 2017

[21] https://www.myhealthycommunities.gov.au/our-reports/mental-health-and-intentional-self-harm/february-2017/web-update

[22] Australian Institute of Health and Welfare. Health Communities – Hospitalisations for mental health conditions and intentional self-harm in 2013-14: Table 4: Age-standardised rates of same-day and overnight hospitalisations related to intentional self-harm, per 100,000 people, by local area (SA3) remoteness and socioeconomic status, 2013–14, p.30.

[23] Australian Institute of Health and Welfare. Health Communities – Hospitalizations for mental health conditions and intentional self-harm in 2013-14

[24] National Rural Health Alliance: Economic contribution of regional, rural and remote Australia

2.4 The distribution of mental health services in rural and remote Australia

Medicare item usage provides one important measure of the Commonwealth's contribution to mental health services. It also provides a mechanism to assess the distribution of services across Australia according to patient demographics.

The distribution of Medicare-subsidised mental-health specific services indicates a large difference in access to services in rural and remote areas as compared to major cities.

Table 2: Number of people and rate (per cent of population) receiving Medicare-subsidised mental health-specific services, by remoteness area (2016–17)[25]

Remoteness area	Number of people	Rate (per cent of the population)
Major cities	1,754,938	10.2
Inner regional	457,817	10.4
Outer regional	168,166	8.1
Remote	14,872	4.8
Very remote	5,326	2.8

Table 1 indicates that 2.8% of people access Medicare subsidised mental health in very remote areas – nearly five times less than in major cities where over 10% of people access Medicare subsidised services.

Further, in addition to the number of people accessing Medicare subsidised mental health services being significantly lower; the rate at which they access services is also significantly lower in rural and remote Australia. For the 2016-17 period there were 495 Medicare-subsidised mental health-specific services per 1,000 population in major cities, over three times that of remote and six time that of very remote Australia (refer to Table 3).

[25] Australian Institute of Health & Welfare. Mental health services in Australia – web report, Medicare Services 2016-17 Tables, May 2018, Table MBS.5: People receiving Medicare-subsidised mental health-specific services, by provider type, remoteness area, 2016-17

Table 3: Number and rate per 1,000 population of Medicare-subsidised mental health-specific services, by remoteness area (2016-17)[26]

Remoteness area	Number	Rate (per 1,000 population)
Major cities	8,535,456	495.3
Inner regional	1,920,417	437.8
Outer regional	619,577	296.6
Remote	44,680	145.2
Very remote	15,664	80.9

These figures demonstrate the high variability in MBS mental health service usage across Australia. Some groups have attributed this difference to the lower number of mental health care professionals in rural areas (see Table 4). In regional areas the numbers of psychiatrists, mental health nurses and psychologists, are respectively, 36 per cent, 78 per cent and 57 per cent of those in major cities, with even poorer comparisons in remote areas.[27]

Table 4: Number of mental health professionals (Clinical FTE per 100,000 population) by remoteness (2015) [28]

	Major Cities	Inner Regional	Outer Regional	Remote	Very remote
Psychiatrists	13	5	4	5	2
Mental Health Nurses	83	74	46	53	29
Psychologists	73	46	33	25	18

The reduced access to care highlighted above is also reflected in MBS data. When MBS expenditure on mental health services is analysed by remoteness, per capita expenditure in cities in 2015-2016 was just under four times that of remote areas and more than six times that of very remote areas (see Table 5).

[26] Australian Institute of Health & Welfare. Mental health services in Australia – web report, May 2018, Medicare Services 2016-17 Tables, Table MBS.14: People receiving Medicare-subsidised mental health-specific services, by provider type, remoteness area,2016-17

[27] National Rural Health Alliance. Mental health in rural and remote Australia: Fact Sheet December 2017, accessed 1 May 2018

[28] Australian Institute of Health & Welfare. Mental health services in Australia – web report, 3 May 2018, Mental health workforce 2015 tables, Table WK.4: Employed psychiatrists, Table WK.12: Employed mental health nurses, Table W.20: Employed psychologists

Table 5: Per capita MBS expenditure, mental health services, by remoteness 2015-2016[29]

	Major Cities	Inner Regional	Outer Regional	Remote	Very remote
All Professionals	$52.42	$43.43	$29.40	$14.58	$8.26

The Commonwealth is committed to addressing these issues of relatively lower service access through non-Medicare based approaches. This is demonstrated through a series of national initiatives over the past three decades (see Section 4).

2.5 Underlying causes for lower access to mental health services outside of metropolitan areas

As outlined above, fewer mental health professionals result in fewer services being available when and where they are needed.[30] People in rural and remote areas also face difficulties accessing mental health services from further afield. Factors such as distance and travel cost can result in delays in obtaining assistance, which contributes to greater acuity and in some instances hospitalisation.

The Better Access and telehealth initiatives (discussed in detail in Section 8) aim to address these exact issues by improving access to specialist mental health services that complement the established trust between general practitioner and patient with confidential, high quality, expert services that are matched to intensity of need.

[29] Australian Institute of Health and Welfare. Mental health services In Australia - web report 3 May 2018, Expenditure on mental health-related services 2015-16 tables, Table EXP.22: Australian Government Medicare expenditure on mental health-specific services per capita ($), constant prices, by provider type, remoteness area, 2006–07 to 2016–17

[30] Royal Flying Doctors Service, Media ready resources, accessed 1 May 2018

3 Initiatives in rural and remote health and mental health

A feature of many Australian Government initiatives to improve health care in rural and remote Australia has been the inclusion of significant mental health components. This emphasis was enhanced by the endorsement of the Fifth National Mental Health and Suicide Prevention Plan by COAG.[31] This enables the Commonwealth to continue its leadership role as part of a coordinated national approach to mental health service delivery and suicide prevention.

3.1 National Mental Health Commission Review

In 2014, the Australian Government tasked the National Mental Health Commission with conducting a national review of mental health programmes and services. The focus of this review was on assessing the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental illness and their families.[32] The findings of this review highlighted extensive challenges within Australia's mental health system and advocated a 'plan nationally, act locally' response that relied on the established network of Australian PHNs. The Australian Government response to this review endorsed the PHN approach and foreshadowed the development, through the PHN mechanism of new innovative models of care for rural and remote mental health services supported by flexible funding models. These directions were to provide the foundation of the Fifth National Mental Health and Suicide Prevention Plan, which was released in August 2017.

3.2 Fifth Plan - an integrated approach to regional service delivery

The release of the Fifth National Mental Health and Suicide Prevention Plan marked another key point in the development of current mental health policy and services. For the first time, one plan committed all governments to work together to achieve integration in planning and service delivery at a regional level. It articulates the importance of planning for service delivery at a regional level with PHN and LHNs working together to jointly identify and address service gaps. Importantly, it required that consumers and carers shape the way in which services are planned, delivered and evaluated.

The Fifth Plan also supports person-centred care models. This approach aligns with a population-based model that aims to match available resources to identified need, placing emphasis on population groups which are at higher risk or have special needs.

The increased focus on person-centred stepped care and consumer focussed health outcome evaluation through PHNs will provide new opportunities to improve evidence-based practice. The partnership between the Commonwealth and local PHNs to create a national minimum data set will collect new information to support richer research into accessible and effective mental health care.

[31] COAG. The Fifth National Mental Health and Suicide Prevention Plan, 2017, p.19-20

[32] National Mental Health Commission. Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services, 2014.

3.3 The safety and quality of mental health services in rural and remote areas

The Australian Government is committed to providing all Australians with access to high quality and safe mental health services, where and when required. Its approach to delivering quality mental health services in rural and remote areas is underpinned by national quality standards, a focus on quality within the design of PHN local service coordination, and a range of resource supports for mental health professionals.

At a national level, the Australian Commission on Safety and Quality in Health Care has responsibility for leading and coordinating improvements in safety and quality across the healthcare sector. In August 2017, the Commission published the *National consensus statement: Essential elements for recognising and responding to deterioration in a person's mental state*[33]. This statement will help health services in the implementation of the National Safety and Quality Health Service (NSQHS) Standards, including in mental health. A range of National Standards have also been specifically developed to support improved quality in mental health services, called National Standards for Mental Health Services (NSMHS).

Driving quality and continuous system improvement is also captured in two priorities of the Fifth National Mental Health and Suicide Prevention Plan by:

- *making safety and quality central to mental health service delivery; and*
- *ensuring that the enablers of effective system performance and system improvement are in place.*

A fundamental implication of the Fifth National Mental Health and Suicide Prevention Plan is the emphasis on the partnership between PHNs with Local Hospital Networks (LHNs) to ensure that the national approach to mental health service delivery is effective at the local level.

Flexible funding is provided to enable PHNs to respond to identified national priorities as determined by the Australian Government and to respond to PHN-specific priorities by commissioning required services. This funding is used to achieve health outcomes that are measured by national and local performance indicators. National indicators reflect government priorities and were selected because of their alignment with PHN objectives. Currently, mental health treatment rates (including for children and adolescents) are amongst the key national indicators for PHNs.

Local indicators are also produced by each PHN. These are derived from their analysis of the health needs of local populations to enable better targeting of available resources and services. These indicators are orientated around a stepped care system approach. While this approach predated the new role for PHNs, its inclusion at the core of PHN regional planning, funding and commissioning was an important new contribution in improving quality service delivery. The Department of Health has developed guidance to help PHNs carry out this role including providing advice of best practice examples in stepped care.

As part of their planning processes, PHNs are expected to select, periodically review and revise their indicators to allow measurement of PHN priorities and drive quality improvement activity in their region.

In these ways, the Australian Government's strategy to implement its responsibilities under the Fifth National Mental Health and Suicide Prevention Plan (through an emphasis on PHNs) provides the foundations and framework to partner in new initiatives to improve access and quality of rural and remote mental health services.

[33] Australian Commission on Safety and Quality in Health Care. National consensus statement: Essential elements for recognising and responding to deterioration in a person's mental state, 2017

4 Current initiatives to improve access and quality of mental health services

The Australian Government is driving integrated regional planning through PHNs which will link high-level planning to local specific need.

4.1 Community innovations

The Commonwealth's investment in the delivery of mental health and suicide prevention services is resulting in exciting innovations in rural and remote communities. The following case studies illustrate the good work around improved accessibility of mental health services and suicide prevention.

Case Study: Partnering with local business to support older men with depression and anxiety

For many inner regional, rural and remote areas, mental illness amongst men is a common problem. One suicide prevention trial in the Esperance-Goldfields region of Western Australia has devised an innovative way to connect men with mental health services. By training hardware and agricultural store staff to spot the signs of depression and anxiety, this community is reducing the stigma and lifting the profile of local mental health services.

This region has a large proportion of famers and fly-in-fly-out workers. The isolation of working on the land and rarely getting respite is a key risk factor, as is constant FIFO travel and long periods away from family support. Unfortunately, many men do not seek help for their concerns due to pride in their independence and the stigma associated with seeking mental health services.

The WA PHN is working on ways to tackle these issues through targeting resources to 'where blokes go'. This includes training staff from local businesses and agriculture firms or putting up posters in pubs and clubs, to identify and provide information to men who may be suffering from depression and anxiety. Although this trial is still in its early stages, there has been strong local support and high levels of engagement in the community co-design process.

Case Study: RFDS and headspace partnering to provide support to youth in very remote areas

The Royal Flying Doctor Service is a national icon, having served rural and remote communities for 90 years. The national headspace network of services provides holistic care for young people aged 12 to 25 years. Through the coordination of Country SA PHN, these two services have come together to provide face-to-face support to children in remote areas for the first time.

Accessing mental health services is challenging in remote areas of Australia. Transport costs, travel times and fears around stigma are real challenges for everyone in these communities. They can be even more so for young people who must rely on adults to support their accessing help. Country SA PHN is working with the RFDS and headspace to target these specific barriers for young people.

The Royal Flying Doctor Service is one of the largest and most comprehensive aeromedical organisations in the world and its services include far northern South Australia. The Country SA PHN is currently funding a trial which sees youth mental health clinicians joining RFDS flights to remote areas to provide face-to-face support. These sessions are supported by follow-up telehealth consultation if required. This innovative model provides mental health services that young people and their families in rural and remote Australia would previously not been able to access..

Case Study: Collaborating regionally to address mental health workforce pressures

Regional communities struggle to access the mental health services they require. This is due to a shortage in clinical and non-clinical mental health support. One model in the Dubbo region of New South Wales has an innovative approach to attracting and retaining mental health professionals.

One of the key priorities of the local PHN is to find ways to ensure people in their region have access to high quality care that matches their need. The PHN is working closely with two local health districts and the rural doctors' network on ways to make mental health professionals more accessible.

In March this year, the PHN provided funding to the Royal Flying Doctor Service to bring in mental health nurse support to work with local general practitioners. The nurses are already helping alleviate the pressure on general practitioners to treat patients with severe and complex mental health problems. To date, the community feedback has been very positive, with GPs praising the impact of this new program.

Case study: Reducing suicide rates amongst young men in regional WA

A community south of metropolitan Perth has had long term problems with depression and suicide amongst their young men. Since the commencement of a local suicide prevention trial with the Western Australia PHN eight months ago, there have been no suicide deaths within the target 15 to 26 age group.

The inland location of this community makes it hard for its young men, many from the Maori community, to find work and stay or seek respite in the city or at the coast. Its location also means that this community has struggled to access the mental health services it needed to, prevent suicide.

In line with the national approach to regional PHN service coordination and the principles of the national trials, community leaders have engaged deeply in the trial design process. This has given the community a real sense of ownership. Across the whole community there is a consistency of language and a concerted effort to raise the profile of mental health, to increase awareness and reduce stigma.

One member of the community spoke publicly about the trial, describing it as empowering them to take better care of their community at a time when they did not know what to do.

Case Study: Developing and performing drama that deals with mental illness

In Australia's far north, one group is tapping the deep creative resources of its community to be more resilient in social situations and to better understand their mental health. Supported by the Northern Territory PHN, a group of locals of all ages recently performed 'In My Skin' at the Darwin Fringe Festival.

Australians from all walks of life draw confidence, respite and delight in the performing arts. Dramatic performance can help people work through life scenarios, adopt different perspectives on issues or have an outlet for intense emotion. Joining a drama group can create new relationships, build social confidence and provide new avenues of growth. When the focus of this dramatic activity is people's personal mental health journeys it can provide personal legitimation, combat stigma and reduce the sense of being alone with one's struggles.

Supported by the NT PHN, a drama group was formed to perform 'In My Skin', which marked the culmination of months of sharing and reflecting on their experiences of living with a mental illness.

One member of the group, an older Aboriginal man, publicly shared the impact this performance had on his life. He observed it was rare that he felt safe and not judged. He said it was the first time he felt like he was moving closer to recovery and greater functionality.

4.2 Managed support for younger Australians

The headspace network of services provides holistic care for young people aged 12 to 25 years in four key areas – mental health, related physical health, alcohol/drug use, and social and vocational support. Currently, there are 110 Headspace locations across Australia. Of these, 57 are in rural or remote areas.

PHNs commission services for young people within their local regional through headspace and together they are responsible for leading community consultation and decision making in the establishment and operations of services. Each headspace service must establish a consortium of local organisations and a Youth Reference Group of local young people to guide and advise the operations of the service. This means that lead agencies in rural and remote areas are expected to demonstrate that they can provide services responsive to the needs of local young people.

headspace has had success in reaching people who live outside cities. The proportion of rural young people accessing headspace is greater than that in the general population, while the proportion of those accessing the service in remote areas is similar to the general population (although numbers are small). Service provision through headspace is dependent on attending a dedicated centre. This can present a barrier to rural and remote young people accessing the service. In recognition of this, the Australian Government has committed $28.9 million to establish an additional ten headspace services by 2019 with a specific focus on increasing access in rural and regional areas.[34] It also continues its support for eheadspace which complements the centre-based program.

The following case studies illustrate the potential contribution to accessibility and quality of headspace services in rural and remote Australia.

Case Study: Delivering headspace to youth in North Coast NSW

Early intervention continues to be one of the leading ways to reduce the impact of mental illness. Acting when signs of mental illness first appear with in young people is an important early intervention strategy. Communities, who regularly experience the tragedy of youth suicide, feel the need to act even more urgently.

Currently, the Grafton and Clarence Valley communities in regional New South Wales are embracing the services that headspace provides. In response to the rate of suicide amongst youths this region, the North Coast PHN worked closely with GenHealth and the Clarence Valley Council to establish a headspace centre in Grafton in 2017. In line with PHN and headspace principles, the service was co-designed around the specific health needs of the local youth community.

An important aspect of this model was mental health first aid and early intervention training for local health professionals. It has also set up a support program for families and communities following a suicide. This model is a clear example of using headspace as a catalyst to whole of community responses to protect their youth at risk.

Case Study: Communities seeking out headspace services and support

The location of a headspace service at Whyalla in South Australia was the result of strong community action. As a community with a history and high risk of youth suicide, the local community identified that the 80-kilometre trip to Port Augusta to access headspace services was too great a barrier. Working together, the Country SA PHN and community leaders successfully secured funding to open Whyalla headspace in April 2017.

[34] Department of Health 2016-17 Health Portfolio Additional Estimates Statements, p.8

This service ensures that local youth have access to a range of services including counselling and mental health professionals. Another service that is offered helps young people to hold and find work, which is a key factor in mental health and a significant challenge for a community where unemployment is 12.4 per cent (almost double that of the rest of Australia).[35] A Youth Reference Group has been established to provide advice to the PHN and headspace centre on what young people need, and to also play a key role in determining which specialised programs will be rolled out.

4.3 Managed support for senior Australians

The Australian Government is establishing new mental health services for older Australians with a diagnosed mental disorder living in residential aged care facilities (which will be available from early 2019). The funding for this initiative will be formulated according to eligible population, rurality and disadvantage and will be managed by PHNs. This measure will ensure that mental health services for senior Australians will be more equally distributed and ensure better access for those living in rural and remote areas.

4.4 New data sets to target and improve local health outcomes

The Primary Mental Health Care Minimum Data Set (PMHC MDS) will provide the basis for PHNs and the Department of Health to monitor and report on the quantity and quality of service delivery. Where confidentiality and ethics requirements permit, this data will be shared to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Government. This data collection and collation activity will provide a more localised data picture than has been available through previous mental health data collection mechanisms. While it will take up to a decade to consolidate a robust database to inform national policy and decision-making, this information is already available to PHNs to support them in their planning.

[35] Australian Bureau of Statistics. 2016 Census Quick Stats- Whyalla, Table: People - Employment, accessed 1 May 2018

5 Reducing suicide in rural and remote Australia

Despite considerable government investment over many years, suicide continues to be a significant health issue in Australia, particularly in rural and remote communities. The Australian Government's renewed approach to suicide prevention details an integrated regional approach to suicide prevention led by PHNs in partnership with LHNs. This section explores the prevalence of suicide in rural and remote communities and details several programs relating to suicide prevention.

5.1 Prevalence of suicide in rural and remote Australia

The impact of suicide on all Australians is significant. According to research from Suicide Prevention Australia and the University of New England, each suicide death can impact hundreds of people. Their findings also indicate that 85 per cent of their respondents knew someone who had died by suicide.[36]

Suicide and mental illness are closely interlinked, with mental illness being the major risk factor for suicide. The rate of suicide in regional and remote areas tend to be higher than in major cities, particularly among marginalised groups, including Aboriginal and Torres Strait Islander people and disadvantaged males.[37]

In 2016, there were 2,866 suicide deaths in Australia which equates to a suicide death rate of 11.7 deaths per 100,000 population.[38] The rate of death by suicide was one and a half times higher for people living outside capital cities (15.3 deaths per 100,000 population) compared to those living within capital cities (10.0 deaths per 100,000 population)[39]. In 2016, 47 per cent of all suicides occurred outside capital cities, even though these areas account for only 32 per cent of the total population.

The gap between the rate of suicide between people who live in and outside capital cities also grew over this period (Figure 5).

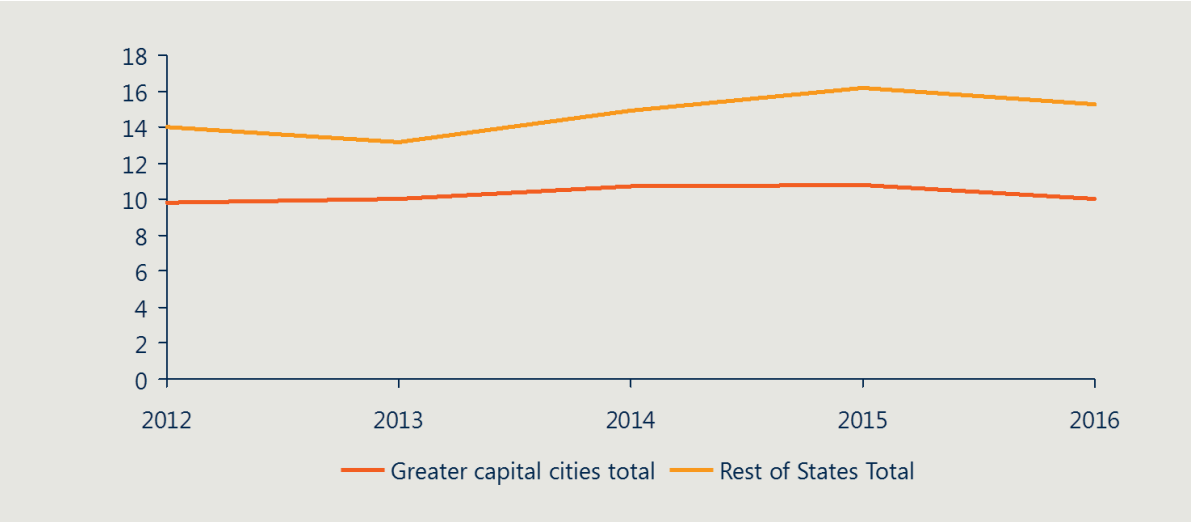
[36] Maple, M., Kwan, M., Borrowdale, K., Riley, J., Murray, S. & Sanford, R. (2016). *The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia.* Sydney: Suicide Prevention Australia.

[37] National Rural Health Alliance, Fact Sheet – December 2017, Mental Health in Rural and Remote Australia

[38] Australian Bureau of Statistics. Causes of Death, Australia, 2016, Suicide in Australia, September 2017

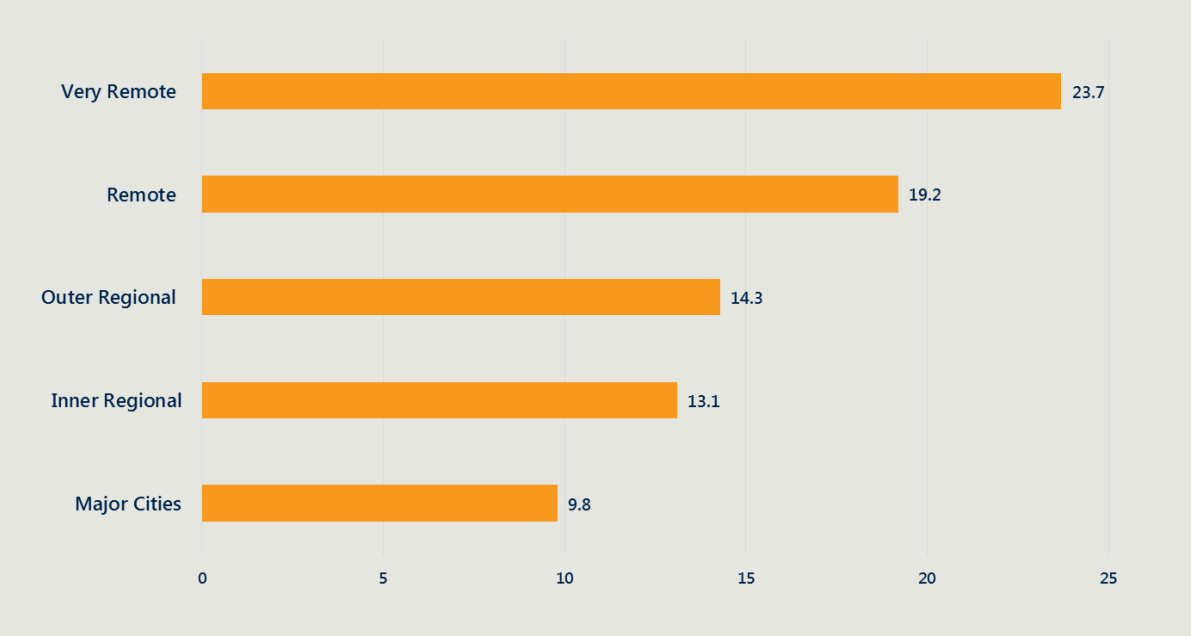
[39] Australian Bureau of Statistics. Causes of Death, Australia, 2016, Table 11.16 Intentional self-harm, Region of usual residence, Age-standardised death rates, 2012-2016, accessed 1 May 2018

Figure 5: Age-standardised suicide deaths within and outside Australian capital cities, Intentional self-harm, Region of usual residence, Age-standardised death rates, 2012-2016[40]



Suicide becomes more likely as remoteness increases (Figure 6). Between 2010 and 2017, the suicide rate in remote locations was double that of major cities, while the rate in very remote regions was almost 2.5 times that of major cities.

Figure 6: Avoidable deaths from suicide and self-inflicted injuries, persons aged 0 – 74 years, 2010 – 2014 (%)[41]



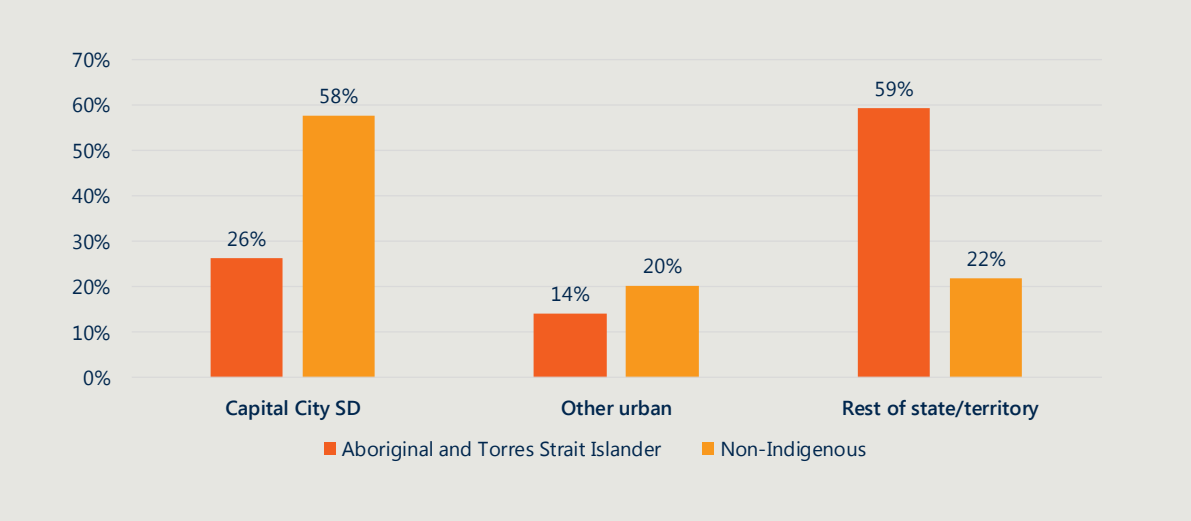
Another factor contributing to poorer health outcomes in rural and remote Australia is the rate of suicide amongst Aboriginal and Torres Strait Islander people. The overall high rate of suicide in remote and very

[40] Australian Bureau of Statistics. Causes of Death, Australia, 2016, Table 11.16 Intentional self-harm, Region of usual residence, Age-standardised death rates, 2012-2016, accessed 1 May 2018

[41] PHIDU Social Atlas. Avoidable deaths from suicide and self-inflicted injuries 2010-2014, 2017, accessed 30 April 2018

remote locations is driven in part by very high suicide rates for Aboriginal and Torres Strait Islander peples within these locations. In 2010, there were 946 suicides by people who identify as Aboriginal or Torres Strait Islander, of which 59 per cent occurred outside of cities or other urban areas. Among the non-Indigenous population, only 22 per cent of suicides occurred in these locations (Figure 7).

Figure 7: Number of suicide deaths as a percentage of total suicides by geographic region and Indigenous status (NSW, QLD, SA, WA, NT, 2001 – 2010).[42]



The experience of mental illness for Aboriginal and Torres Strait Islander people can be exacerbated by additional historical and cultural factors, which can contribute to higher levels of suicidal ideation and possible attempts (see Section 5).

5.2 Unique challenges for preventing suicide in rural and remote communities

The factors that contribute to high suicide rates in rural and remote communities are in most respects like those that lead to poor mental health. These include personal isolation, stigma, lifestyle pressures and lack of awareness of available support. However, there are other specific factors that contribute to high suicide rates in rural and remote areas.

Availability of means to attempt suicide, including firearms and pesticides, contributes to higher suicide rates in rural and remote communities. Compared to residents of major cities, rates for hospitalisation and death by firearm are four times higher for residents of remote areas and six times higher for residents of very remote areas (note that this includes both intentional self-harm and other firearm injuries)[43].

For young people, having friends move to urban areas for work, community attitudes to sexual orientation and higher levels of drug use can all be impacting factors. Another factor that can contribute to higher rates of suicide, particularly amongst older farmers, is the limited opportunity for time away from work and the stress caused by unpredictable seasons or natural events.

Compounding these factors further are challenges to accessing mental health support that are unique to rural and remote communities.

[42] Australian Bureau of Statistics. Suicides, Australia 2010: Geography, accessed 2 May 2018
[43] Australian Institute of Health and Welfare. Firearm injuries and deaths fact sheet, 2017, accessed 1 May 2018

5.3 A renewed approach to suicide prevention

The Australian Government has outlined a renewed approach to suicide prevention through a systems-based regional approach. It has tasked PHNs with planning and commissioning of regionally appropriate suicide prevention services in partnership with LHNs, states and territories, and other local organisations. PHNs are also required to identify the suicide prevention needs of Aboriginal and Torres Strait Islander communities within their region and support the implementation of culturally appropriate suicide prevention activity. In addition, the Australian Government is moving to implement follow-up and support arrangements for people who have attempted suicide or are at high risk of suicide.

5.4 National Suicide Prevention Trial

In June 2016, the Australian Government announced additional measures to strengthen mental health care in Australia. As part of this commitment, the Government is providing $36 million over three years (to 2018-19) for the National Suicide Prevention Trial to fund twelve suicide prevention trial sites in identified priority areas. Trial sites have been established across Australia including in rural and remote locations such as the Kimberly, Western New South Wales and country South Australia.

On 14 May 2018, the Minister for Health announced the extension of the National Suicide Prevention Trial for a further 12 months, through to 30 June 2020. An additional $1 million has been allocated to each of the 12 trials sites to support work in this additional year.

The 12 month extension will provide trials sites with additional time and resources to implement innovative approaches to suicide prevention and enable the evaluation to capture and report on a greater level of activity.

An additional $1 million will also be available for additional evaluation and trial site support activities.

The Trial will improve understanding of what strategies are most effective in preventing suicide at a local level and for at-risk populations (including veterans, young people, men, and Aboriginal and Torres Strait Islander people). Trial sites are being led by PHNs in consultation with local communities, service providers, and other local organisations. This will allow the trial sites to design and deliver services that are tailored to the needs of different metropolitan, rural and remote communities. A key focus is to coordinate existing services, while ensuring professionals and the community are aware of referral pathways and treatment options.

The Trial is being independently evaluated by the University of Melbourne and will draw on information collected from mental health services, suicide prevention services, other relevant service providers, and from consumers of services. Findings from the trial will be made available to all PHNs to guide future suicide prevention activities.

5.5 National Suicide Prevention Leadership and Support Program

The Australian Government has also strengthened its national leadership role in suicide prevention through the establishment of a National Suicide Prevention Leadership and Support Program. The aim of the Program is to deliver national suicide prevention activities and reduce the rate of suicide and suicidal behaviour. It also aims to increase the preventive capacity of individuals and communities to respond to suicide.

Several projects funded under the Program provide support to people living in rural and remote areas who may be at heightened risk of suicide. For example, the StandBy Response Service provides a 24-hour face-to-face service for those bereaved or affected by suicide, training for front-line emergency response services in the community, and coordination of suicide responses. The Program also supports research on

suicide through the University of Melbourne's national leadership role in suicide prevention and the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention.

5.6 Support around suicide hotspots

In the 2017-18 Budget, the Australian Government announced two elements that seek to prevent suicide in specific locations (or hotspots), where suicide incidents repeatedly occur. The Government has committed over $11 million over three years to deliver hotspot initiatives.

Hotspot infrastructure projects

The Australian Government has committed $9 million for state and territory governments to deliver approved infrastructure projects to improve safety at suicide hotspots. Approved infrastructure projects include fencing, physical and anti-trespass barriers, signage and removal of objects that could enable access to high-risk locations.

Research indicates that people intending to end their life often prefer a means which may include a specific site. The reasons why particular locations become hotspots is unclear, but they are often scenic or iconic public structures or sites, around which a certain history, infamy or mythology has developed.[44] Rural or secluded locations such as car parks have also become known suicide hotspots. Projects identified as suitable under the measure will be in urban and regional areas across Australia.

Funding for Lifeline Australia

Lifeline Australia is responsible for the operation of a 24-hour dedicated telephone crisis support line (13 11 15) for people who may be contemplating suicide. Funding of $2.1 million over three years commencing in 2017-18 will be provided to Lifeline to increase their capacity to deliver these activities, with a focus on meeting additional demand around Australian suicide hotspots. In addition, Lifeline is receiving $2.5 million over two years from 2016-17 to trial a new text service for crisis support and suicide prevention (Text4Good).

This funding is in addition to the 2018-19 Budget measure that will provide $33.8 million from 2018-19 to 2021-22 to enable Lifeline Australia's 13 11 14 telephone service to meet increasing demand; provide a more responsible, high quality and consistent service; and improve connectivity to other services in order to provide a seamless user experience. Lifeline currently receives $9.4 million in 2017-18 to operate this phone service.

5.7 Other 2018-19 Suicide prevention Budget initiatives

Aftercare following a suicide attempt

Under this measure the Government is contributing $37.6 million over four years to expand the *beyondblue* Way Back Support Service aftercare model across Australia. Up to 25 PHNs will be funded to support the roll out of the Way Back Support Service in their region in partnership with beyondblue and local referring hospitals of Local Hospital networks.

The Way Back Support Service is a model of service delivery developed by beyondblue and is designed to drive continuity of care by providing outreach, follow-up care and practical support to individuals discharged from hospital after a suicide attempt.

The measure aligns with the priorities under the Fifth National Mental Health and Suicide Prevention Plan and moves a step closer to national coverage by the service, including in rural regions of Australia.

Suicide Prevention Campaign

[44] University of Melbourne. (2011). *Preventing suicides at suicide hotspots*, Victoria, p. 6.

Through this measure, $1.2 million will be provided to SANE Australia to develop and test a suicide prevention campaign targeting people contemplating suicide – the Better Off With You Campaign. This campaign will challenge perceptions of people who are contemplating suicide that they are a burden on their family, friends and other people.

The campaign will be trialled in three PHN regions – Western Victoria, North Queensland and Sydney North – and will target people from a number of groups who are at heightened risk of suicide including people from rural and regional areas.

5.8 Commonwealth support for a stronger evidence base

The Australian Government is committed to research-driven and evidence-based approaches to improve access and quality of all mental health and suicide prevention services. This commitment is reflected through the funding and establishment of several key initiatives, including:

- **National Suicide Prevention Research Fund:** As part of its commitment to *Strengthen Mental Health Care in Australia* the Australia Government is providing $12 million over four years for a National Suicide Prevention Research Fund managed by Suicide Prevention Australia. This fund is designed to provide sustainable financial support for Australian suicide prevention research and ensure outcomes have the greatest impact by addressing nationally agreed priorities. Research with a focus on the needs of rural and remote focus will be included as part of this process. The Fund will support targeted research and a Suicide Prevention Best Practice Hub.
- **Suicide Prevention Best Practice Hub:** The Suicide Prevention Hub: Best Practice Programs and Services is the first investment made by the Fund. It provides an online resource supporting communities to find quality, evaluated, suicide prevention programs and services. One aim of the Hub is to assist the work of PHNs and others involved in community-based suicide prevention. The Hub is the first resource of its kind in Australia.
- **National Suicide Prevention Leadership and Support Program** (discussed in Section 5.5): As part of its role, the Program supports research on suicide through the University of Melbourne's national leadership role in suicide prevention and the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention.
- **National Suicide Prevention Trial** (see Section 5.4): This trial will improve understanding of what strategies are most effective in preventing suicide at a local level and for at-risk populations (including veterans, young people, men, and Aboriginal and Torres Strait Islander people). The Trial will be independently evaluated over the funding period, with The University of Melbourne appointed to lead this evaluation. Findings from the trial will be made available to all PHNs to guide future suicide prevention activities.
- **National Centre of Excellence in Suicide Prevention:** The aim of this Centre of Excellence is to provide advice around evidence-based best practices and evaluation in suicide prevention and inform the approach of the Australian Government, non-government agencies, academics and community groups in their suicide-prevention initiatives. The objectives of the centre are to:
    - Enhance awareness of the work of the National Centre of Excellence in Suicide Prevention;
    - Provide evidence based practical assistance to organisations;
    - Provide advice to the Department of Health on evidence-based best practice in suicide prevention activity, approaches to evaluation of suicide prevention activities, development of evaluation frameworks and credibility of suicide prevention data and data issues; and
    - Provide bi-annual critical literature reviews to the Department.

6 Mental health and suicide prevention for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people with mental illness experience extremes of social and psychological divorcement. Alienated from their families and country of origin, and hence from their identity, many are out of touch with traditional networks of help. This has important implications for the nature of services to be provided. Primary prevention requires a greater focus on the social determinants of mental illness amongst Aboriginal people. This includes the need to recognise and address the historical trauma created by the experience of colonisation and dispossession as well as the specific trauma of the Stolen Generations.

Aboriginal and Torres Strait Islander people are a large proportion of remote and rural populations and experience problems consequent to that isolation.

Aboriginal and Torres Strait Islander mental health services can be provided through a variety of avenues including ACCHSs, and Aboriginal Medical Services (AMSs), as well as mainstream services which may include Local Hospital Networks (LHNs), headspace or suicide prevention services. Mental health services need to be supported by clinical evidence and delivered by an appropriately skilled workforce.

Culturally appropriate health services and providers facilitate effective mental health service delivery and improved mental health outcomes for Aboriginal and Torres Strait Islander people. This requires cultural awareness, cultural respect, cultural safety and an understanding of the cultural determinants of health.

Aboriginal and Torres Strait Islander people require access to mental health services that is joined up, integrated, culturally appropriate and safe, and designed to holistically meet the mental health and healing needs of people at the local level.

6.1 Funding for mental health services to Aboriginal and Torres Strait Islander people

The Australian Government is providing $1.2 billion to 2018-19 for PHNs to commission primary mental health and suicide prevention services through the mental health flexible pool. As part of this funding, approximately $85.7 million of funding is specifically for Aboriginal and Torres Strait Islander mental health.

Indigenous mental health funding is provided from the Indigenous Australian's Health Programme (IAHP). The objective of the IAHP is to provide Aboriginal and Torres Strait Islander people with access to effective high-quality health care services in urban, regional, rural and remote locations across Australia. This includes through Aboriginal Community Controlled Health Services (ACCHS), wherever possible and appropriate, as well as through mainstream services delivering comprehensive, culturally appropriate primary health care.

Indigenous mental health funding is specifically quarantined to improve access to culturally appropriate mental health services for Aboriginal and Torres Strait Islander people. This funding builds on mainstream mental health funding provided to PHNs and aims to increase access to culturally appropriate and safe mental health services for Aboriginal and Torres Strait Islander people.

6.2 The role of PHNs in mental health support for Aboriginal and Torres Strait Islander people

The Fifth National Mental Health and Suicide Prevention Plan includes provision for governments to work with PHNs and LHNs to implement integrated planning and service delivery for Aboriginal and Torres

Strait Islander people at the regional level. PHNs are to work with mainstream service providers, the Aboriginal Community Controlled Health Sector and peak bodies to ensure culturally appropriate programs are implemented as part of the ongoing mental health and suicide prevention reforms.

Funding allocations to PHNs for primary mental health and suicide prevention services are weighted for rurality, Indigenous status and socio-economic disadvantage. In 2018-19, 9 per cent of quarantined funding to PHNs will be devoted to mental health services that are coordinated, culturally appropriate, and designed to meet the needs of Aboriginal and Torres Strait Islander people at the local level.

PHNs take a flexible and innovative approach in meeting the mental health needs of Aboriginal and Torres Strait Islander people in their regions. A joined up, innovative and integrated approach is needed to bring together programs which are currently designed to separately support services such as social and emotional wellbeing, suicide prevention, and where appropriate alcohol and other drug services, to improve support for Aboriginal and Torres Strait Islander people.

Each PHN is expected to undertake regional needs analysis in collaboration with relevant local Indigenous organisations including ACCHSs and peak bodies and with mainstream primary health care organisations to identify the specific mental health needs and service gaps for Aboriginal and Torres Strait Islander people. This analysis is done in the context of providing holistic, culturally appropriate and safe mental health services. Local engagement with Aboriginal and Torres Strait Islander communities will also help to identify community needs.

As part of their regional planning, mental health plans with a specific focus on Aboriginal and Torres Strait Islander needs are required. In preparing this plan, PHNs will take into consideration existing service arrangements provided through a variety of organisations and services in the region, including those delivered by ACCHSs.

Case Study: Working with Aboriginal health care services to deliver headspace services

In Katherine, NT, young people aged between 12 and 25 now have access to a range of support in mental health, alcohol and drug and social and vocational support from their local headspace centre. Katherine has been shown as an area of high need, and with young people making up to nearly 23 per cent of Katherine's population, it is important that they have access to the right support, as early as possible. A focus of this headspace service will be on supporting Aboriginal and Torres Strait Islander community who make up about 60 per cent of young people in Katherine. Anglicare NT, with funding from Northern Territory PHN, has established and manages Katherine's headspace service. In carrying out this role they work closely with local stakeholders and the Aboriginal community to tailor health care services to community and to share lessons learned with other regional headspace initiatives (such as Darwin).

6.3 Programs funded under the Indigenous Advancement Strategy

The Department of the Prime Minister and Cabinet is responsible for investment through the Indigenous Advancement Strategy (IAS), which funds social and emotional wellbeing services and mental health first aid in rural and remote communities.

In 2017-18, about $18 million (ex-GST) has been committed to 81 rural and regionally-based organisations to deliver social and emotional wellbeing activities in rural and regional Australia (ASGC Remoteness Areas RA2, RA3, RA4 and RA5, as per the National Strategic Framework for Rural and Remote Health: this excludes all national and whole-of-state services). Funded activities include counselling, family tracing and reunions, and healing projects that strengthen connections to family and community, address grief and trauma, and build the capacity of individuals to respond to life stressors.

The Australian Government is also funding the National Indigenous Critical Response Service through the IAS to respond to the needs of Aboriginal and Torres Strait Islander people affected by suicide-related trauma or other critical traumatic incidents, and the provision of Indigenous mental health first aid training to frontline workers in remote Indigenous communities and to select high-risk remote communities. At 30 April 2018, 147 workshops have been held in 88 remote communities with about 2150 participants.

Additionally, the Department of the Prime Minister and Cabinet and the Department of Health co-fund the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) to provide advice to the Australian Government on mental health, suicide prevention and social and emotional wellbeing of Aboriginal and Torres Strait Islander people. These projects are designed to support and complement mental health and suicide prevention activities and funding provided by the Department of Health and state and territory equivalent agencies.

6.4 Aboriginal and Torres Strait Islander suicide prevention trials

The Australian Government has committed to reducing the prevalence of Aboriginal and Torres Strait Islander suicide and the impact on individuals, their families and communities. In 2016, suicide was the fifth leading cause of death for Aboriginal and Torres Strait Islander people. The standardised death rate of 23.8 deaths per 100,000 population for Aboriginal and Torres Strait Islander people was twice that of non-Indigenous people.

As part of the National Suicide Prevention Trial program, Aboriginal and Torres Strait Islander people were identified as an at-risk population. Two Indigenous-specific suicide prevention trial sites have been established in the Kimberley and Darwin regions, with a further five sites also supporting Aboriginal and Torres Strait Islander people as part of trial activity. Each trial site is receiving $3 million over three years in funding to 2018-19.

On 14 May 2018, as part of the Budget Package, the Minister for Health announced the extension of the National Suicide Prevention Trial for a further 12 months, through to 30 June 2020. An additional $1 million has been allocated to each of the 12 trials sites to support work in this additional year.

The 12 month extension will provide trials sites with additional time and resources to implement innovative approaches to suicide prevention and enable the evaluation to capture and report on a greater level of activity.

In 2016, the Australian Government released Solutions that Work – the report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation project which provides a blueprint for the provision of culturally appropriate suicide prevention services in Aboriginal and Torres Strait Islander communities. This blueprint is informing the activities of the Kimberly and Darwin Suicide Prevention Trials.

6.5 Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

Through the National Suicide Prevention Leadership and Support Program, the Department is providing $1.75 million in funding to the University of Western Australia (to June 2019) to establish a Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention. Activities of the Centre include supporting the development of suicide prevention activity tailored to specific community needs, providing evidence-based information and advice, building the capacity of PHNs, and supporting Aboriginal and Torres Strait Islander communities to act on to suicide and self-harm in their region.

7 Expanding and upskilling the mental health workforce

A mental health workforce must have enough clinicians from the various professions to meet the growing need for care. These clinicians must be appropriately trained, experienced and accessible if people are to access quality care when they need it.

7.1 Mental health workforce composition

The Australian mental health workforce operates through a complex set of interrelated services, where consumers rely on a range of public, private and community providers for treatment and support. Due to services being provided in a range of settings and being funded by different levels of government (or departments), it can be difficult to develop an exact estimate of the size and distribution of the mental health workforce.

Data collected by the AIHW indicates that general practitioners comprise a significant proportion of the primary health workforce, and as a single group of providers, deliver most of mental health care to people experiencing mental illness (see Section 1). They are a vital first point of contact and referral to specialised mental health support. They are not, however, the only important component of the national mental health workforce. Other key professions include mental health nurses, psychiatrists, psychologists, social workers, occupational therapists, vocationally qualified mental health workers and community care workers. A key change from recent decades is that mental health care is now being delivered primarily in community settings. As a result, a substantial non-government mental health workforce has developed and continues to grow.

This shift away from traditional institutional to community approaches potentially enhances the tailoring of mental health service delivery to local need. However, a scarcity of psychiatrists, clinical psychologists, and other mental health professionals in rural and remote areas has been recognised as a barrier to providing people with mental health services.

7.2 Workforce issues in rural and remote areas

The issues around recruiting, training, supporting and retaining mental health professionals in rural and remote areas are like that of other health professionals. Negative perceptions of rural employment and lifestyle opportunities present a barrier. Lower wages, cost of living and availability of quality housing are all considerations; while there can be concerns about adequate support for family needs, such as education and health services. For private providers, such as general practitioners, the viability of business models in smaller communities can be a concern, as can the difficulty securing locums or other services to cover periods of leave. Another disincentive can be the prominence of individual health professionals in local communities, where people fear they will always be on call in addition to having limited professional support.

Together, the shortages of accessible and appropriately trained mental health professionals can have significant implications. Crisis events can result in less skilled mental health professionals undertaking complex clinical responsibilities for which they have not been fully trained. Mental health demand on local general practitioners can be much greater because of a lack of other local options, often when they do not have specialist mental health training. And when opportunities for further training are sought, the time lost to travel and training can be prohibitive, and it can be difficult to secure locum or other support to cover absences.

The Australian Government recognises these and the other issues around the mental health workforce in rural and remote Australia. In response, it provides leadership and support through a range of initiatives that aim to attract, train, retain and deliver a more accessible mental health workforce.

7.3 Australian Government commitment to health care in rural and remote Australia

Many Australian Government initiatives have been introduced to address the challenges of delivering health services in rural and remote Australia were driven by a need to address the shortfall in supply of general practitioners in rural areas, and to provide incentives for medical practitioners to relocate to rural areas. These practitioners are the front line of primary care as well as the main referral gateway to specialist mental health care.

7.4 Leading a national response to rural workforce accessibility

The Australian Government supports a range of nation-wide measures to improve the accessibility of health professionals in regional areas. Many of these initiatives include a dedicated component to improve mental health services.

National Rural Health Commissioner

The National Rural Health Commissioner is an integral part of the Government's broader agenda to reform rural health in Australia. The Commissioner's priority is to provide advice to Government on the development of a National Rural Generalist Pathway. This is a medical training pathway that will attract, retain and support doctors in rural and remote areas. It is widely recognised that rural generalists often have advanced training and a broader skill-set than is required by doctors in metropolitan centres. In many instances, they perform duties in areas such as general surgery, obstetrics anaesthetics and mental health. They not only work longer hours but are frequently on-call after-hours in acute care settings, such as accident and emergency hospital admitted patient care.

In developing the National Rural Generalist Pathway, the Commissioner will consult with the health sector and training providers to define what it means to be a Rural Generalist. The role will also include consultation with stakeholders to consider the nursing, dental health, pharmacy, Indigenous health, mental health, midwifery, occupational therapy, physical therapy and allied health needs in rural and remote Australia. Further, the Minister for Rural Health recently announced the Collingrove Agreement. This Agreement brings together the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine to build a strong, sustainable and skilled national medical workforce to meet the needs of Australia's rural and remote communities.

Rural Workforce Agencies (RWAs)

The Australian Government funds Rural Workforce Agencies (RWAs) in each state and the Northern Territory to deliver the Rural Workforce Agency Program. Under this program, RWAs are funded around $86 million over three years to 2020 to deliver a range of activities aimed at improving health workforce access, quality and sustainability. Developed in consultation with the RWAs and other areas of the department, the programs will focus on meeting the current and future community health workforce need through three program areas.

- *Access* (Health Workforce Access Program): improves access and continuity of access to essential primary health care, particularly in priority areas, through a jurisdictional workforce assessment process involving health workforce stakeholders.

- *Quality of access* (Improving Workforce Quality Program): builds local health workforce capability with a view to ensuring communities can access the right health professional at the right time, reducing the reliance on non-vocationally recognised service providers in rural communities.
- *Future planning* (Building a Sustainable Workforce Program): grows the sustainability and supply of the health workforce with a view to strengthening the future health workforce.

A key element of the RWA program is the establishment of Health Workforce Stakeholder Groups who will develop a shared understanding of rural workforce needs and develop strategies to best meet those needs. RWAs are also funded to deliver the Health Workforce Scholarship Program ($11 million per year to 2020), which aims to increase access to health services in rural and remote areas experiencing skill shortages through the provision of scholarships and bursaries to increase the skills, capacity and/or scope of practice of health professionals committed to rural service. A rural return of service obligation may be attached to some higher value scholarships to provide a greater return on investment.

Royal Flying Doctor Service (RFDS)

The Royal Flying Doctor Service (RFDS) is funded to deliver emergency aeromedical evacuations, primary health clinics, medical chests (containing pharmaceutical products and associated medical supplies), remote (telephone) consultations and dental outreach services in areas beyond the normal medical infrastructure and in locations of market failure. The RFDS is responsible for the needs assessment, prioritisation and delivery of outreach health services.

In recognition of the important contribution that the RFDS is making in rural and remote Australia, in March 2018 the Prime Minister announced the provision of an additional $84 million over four years (to 2021-22) to increase the availability of dental services, deliver new mental health services and continue traditional services to rural and remote Australia. This is in addition to the recurrent funding that will be provided to the RFDS over the same period to deliver services to people living in rural and remote Australia.

General Practice Rural Incentives Program (GPRIP)

The General Practice Rural Incentives Program (GPRIP) aims to encourage medical practitioners to practise in regional and remote communities and to promote careers in rural medicine through the provision of financial incentives. The program aims to retain these medical practitioners in regional and remote locations by providing incentives to continue to work in these areas. The GPRIP supports medical practitioners, and GP Registrars on approved training pathways, who provide eligible primary care services and/or undertake eligible training in Modified Monash (MM) 3-7 locations in Australia. Currently, over 7,000 medical practitioners are receiving GPRIP incentives for eligible services in regional, rural and remote Australia. The GPRIP was redesigned in 2015 to better target incentives to doctors working in smaller regional towns, and in rural and remote communities. The GPRIP will be consolidated into a new Workforce Incentive Program (WIP) through the Stronger Rural Health Strategy.

Rural Health Outreach Fund (RHOF)

The Rural Health Outreach Fund (RHOF) aims to improve access to health services for people who live in regional, rural and remote locations, investment of more than $82.9 million is being provided over three years to 2019-20. This fund improves access to medical specialists, GPs, allied and other health professionals. There are four identified health priorities under the RHOF, including mental health. Funding is provided to address a range of disincentives incurred by health professionals seeking to provide outreach services (such as travel, accommodation, room hire and lease of equipment). Needs assessment and service planning is done in consultation with a range of stakeholders including PHNs, location communities, regional working groups and Indigenous health organisations. RHOF service plans are developed annually and services are prioritised according to greatest needs. In 2017-18, around $4.7 million is being provided under the RHOF for 393 planned services related to mental health nationally.

The Rural Locum Assistance Program (RLAP)

The Rural Locum Assistance Program (RLAP) is funded under the Health Workforce Program to address an identified workforce disincentive around lack of back up for specialist absences and to generalist medical practitioners undertaking specialist training. Funding of $35.6 million will be provided to the RLAP to 2019.

The RLAP is an amalgamation of three programs: The Nursing and Allied Health Rural Locum Scheme (NAHRLS), the Rural Obstetric and Anaesthetic Locum Scheme (ROALS) and the Rural Locum Education Assistance Programme (Rural LEAP). Funding is provided to enable locum relief support to organisations in rural and remote Australia to backfill specialists (obstetrics and anaesthetics), procedural general practitioners (obstetrics and anaesthetics), nurses, midwives and allied health professionals in rural Australia. This is in order that they can take leave and/or undertake Continuing Professional Development (CPD) activities. The RLAP also benefits urban health professionals wishing to experience rural or remote practice by undertaking a locum placement or for GPs to undertake additional training so that they can undertake locum work in non-urban Australia.

CRANAplus

The Australian Government provides core funding to CRANAplus to deliver programs that help to improve access to health services in rural and remote areas. This includes increasing the quality of health care provided in rural and remote areas and improving the safety and security of the remote area health workforce. CRANAplus achieves this in three ways.

As a registered training organisation, CRANAplus offers accredited professional development courses to the remote health professionals at an affordable cost. Ready access to professional development opportunities helps reduce the professional isolation that may be experienced by health professionals working in remote locations, increasing retention rates and the quality of health care provided in rural and remote locations.

Through the Bush Services Support Line, CRANAplus provides a telephone and internet-based counselling service to remote health professionals and their families. The Bush Services Support Line is available 24 hours a day, seven days a week. This service helps remote health professionals maintain their mental health, reducing burn-out and improving retention rates. CRANAplus also offers short courses to help remote health professionals gain the knowledge, confidence, ability and skills to identify and respond to potential or actual episodes of aggression and violence.

The Australian Government's Stronger Rural Health Strategy

Building on these activities, the Australian Government announced the Stronger Rural Health Strategy as a centrepiece of the 2018-19 Budget. It is a 10 year plan to meet current and future health workforce challenges. The Strategy will deliver a comprehensive package of reforms with initiatives that will assist in addressing the challenges in delivering mental health services in rural and remote Australia outlined below:

- The Australian Government will establish five rural medical schools in the Murray-Darling region. This will be a major boost in tackling the rural doctor shortage as evidence shows that doctors who train in rural areas are more likely to go on and practise in rural areas.

- The Workforce Incentive Program will provide targeted financial incentives to encourage doctors to deliver eligible primary health care services in regional, rural or remote areas that have difficulty attracting and retaining doctors. It also provides financial incentives to support eligible general practices to employ nurses, including allied health professionals and Aboriginal and Torres Strait Islander Health Workers/Practitioners. The Workforce Incentive Program will replace the Practice Nurse Incentive Program (PNIP) and the General Practice Rural Incentives Program (GPRIP). These targeted incentive payments will be implemented to promote team-based and multidisciplinary models of primary health care that respond to the increasing number of Australians with chronic and complex health conditions. The WIP will commence on 1 July 2019.

- Changes to how GPs are funded through Medicare will better recognise their level of expertise and the quality of service they provide. GPs who have achieved vocational recognition will claim the full Medicare item fee. New non-vocationally recognised doctors will get a lower rebate. Non-vocationally recognised doctors currently in the system will be grandfathered and supported to reach vocational recognition status over the next five years. This will encourage more GPs to attain higher specialist qualifications.

- The streamlining of GP training and qualification arrangements will provide an easier pathway for more Australia trained doctors to attain specialist GP qualification. The two GP colleges — the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine — take over management of the Australian General Practice Training Program.

- Junior doctors will be supported to practise in private practice in rural and remote areas and provide much needed services to the community while completing their training. Junior doctors will be encouraged to move out of metropolitan hospitals to train and work in rural and remote areas, and receive salary support to work in private hospitals. The Junior Doctor Training program will provide funding for education support for junior doctors working and training in rural primary care settings, increase postgraduate rotations in rural general practice and provide supervision and training support for junior doctors to work in rural general practice.

- Bonded medical programs, which give students a medical place in return for a commitment to work in areas of workforce shortage, will be improved, streamlined and better targeted. The bonded placements will go from 12 months to 3 years and be better regulated, removing the need for individual contractual arrangements.

- The Workforce Incentive Program will provide incentives for doctors to work in rural and remote areas, and for practices to employ nurses, including allied health professionals and Aboriginal and Torres Strait Islander Health Workers. These targeted incentive payments will be implemented to promote team-based and multidisciplinary models of primary health care that respond to the increasing number of Australians with chronic and complex health conditions.

- In addition, changes to bulk billing incentive payments will ensure they only go to doctors working in rural areas, and not to doctors working in areas that were once classified as rural, but are now metropolitan, such as the Sunshine Coast, QLD, Gawler, SA, and Mandurah, WA.

- As recently announced, the Rural Flying Doctor Service will get additional funding for new and existing outreach services, including dental and mental health and aeromedical services, and will improve access to health care in rural and remote areas.

- Funding will support and develop the growing Aboriginal and Torres Strait Islander health workforce, improving access to appropriate, culturally safe health care for Aboriginal and Torres Strait Islander people.

These recent budget announcements will be further defined over coming months with implementation commencing in 2018/19. A number of these initiatives will impact on the access to, and quality of, mental health services in rural and remote Australia.

7.5 Training and supporting appropriately skilled rural and remote workforces

In Australia, as in comparable countries, mental health treatment, care and support continues to evolve as it moves away from the historical focus on institutionalised care. The need for clinical services remains high, but approaches are shifting toward person-centred and stepped care approaches. Further, the opportunity for better mental health care from constantly developing technology also brings with it new challenges and new skill demands. All of these require an adequately trained and appropriately skilled regional mental health workforce. The Australian Government provides support for targeted workforce training initiatives that impact on the delivery of quality mental health services in rural and remote areas.

Australian General Practice Training (AGPT) program

The Australian General Practice Training (AGPT) program is a Commonwealth funded postgraduate vocational training program for medical graduates wishing to pursue a career in general practice. The training standards for the delivery of training on the AGPT program are set externally by the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine and includes training on mental healthcare. A minimum of 50% of registrar training on the AGPT program occurs in rural and remote Australia resulting in greater access to mental healthcare for rural and remote communities. As part of the Stronger Rural Health Strategy, the Commonwealth will continue to fund 1,500 AGPT program training places per year across the two College pathways, and will fund an additional 100 Rural Generalist places from 2021. Targets for the distribution of places across training regions and remoteness areas will ensure a continued focus on rural and remote GP workforce distribution.

Specialist Training Program (STP)

The Australian Government has improved access to psychiatry services in rural communities through the Specialist Training Program (STP). The STP funds specialist medical training in expanded settings, while STP trainees provide specialist services, including psychiatry, to the community throughout their training. The Government has recently implemented two key reforms through the STP that will bring significant benefits to rural and remote communities. These include increasing the rural training target under the program from 2018 and funding 100 additional dedicated rurally focused training posts. Trainees in these posts must undertake at least 66 percent of their fellowship training in regional, rural and remote areas. The STP also has additional rural raining posts for psychiatry as part of the Integrated Rural Training Pipeline (IRTP) initiative. Under the IRTP initiative, there are 31.3 FTE funded psychiatry places in rural areas each year from 2018 to 2020.

Remote Vocational Training Scheme (RVTS)

The Remote Vocational Training Scheme (RVTS) offers GP registrars an alternative pathway to Fellowship of the Royal Australian College of General Practitioners (RACGP) and/or the Australian College of Rural and Remote Medicine (ACRRM). RVTS is an independent (Commonwealth-funded) program with its own application process and intake quota. RVTS brings educational opportunities to General Practitioners practicing in areas where accessing mainstream training is impractical or impossible. Training is provided via distance education and remote supervision, allowing RVTS registrars to practice in some of Australia's remotest locations while training for fellowship.

Rural Health Multidisciplinary Training Program

The Australian Government has provided funding for the Mental Health Academics (MHA) Project, delivered through the Rural Health Multidisciplinary Training (RHMT) Program. While the overall aim of the RHMT program is to make a measurable impact on addressing the maldistribution of the rural health workforce, the MHAs are placed in University Departments of Rural Health (UDRH) to ensure that there is

an availability of mental health services across all universities associated with the RHMT program.[45] The key goals of the Mental Health Academics project are to:

- support increased access for communities to mental health services;
- ensure rural health professionals are better equipped to recognise and deal with mental health problems in individuals;
- engage with rural communities to increase awareness of mental health issues; and
- create clinical training capacity to provide support for the expansion of training places in mental health disciplines.

As a part of the RHMT program, in early 2017 an additional $54.4 million of funding was committed to establishing 26 regional health training hubs and bringing the number of URDHs across remote and rural Australia up to 15.[46] Both initiatives are components of the Integrated Rural Training Pipeline (IRTP) for Medicine and have associations with universities in each state to help ensure high quality training networks and service provision across rural communities Their objectives include identifying and prioritising activity around regional workforce needs. [47]

Rural Mental Health Nurse Workforce (MHNW) project

The Australian Government is providing $1.5 million to the Australian College of Mental Health Nurses for the Mental Health Nurse Workforce (MHNW) project. This project will deliver education and training to develop the mental health care skills of the existing primary health care nursing workforce. It will also support a program to support the transition of mental health nurses across the acute and primary care sectors to develop a flexible and sustainable mental health nursing workforce. Whilst not specific to rural and remote areas, practice nurses will be able to access on-line learning modules to improve their mental health literacy and clinical skills for working in primary health care settings. One day face-to-face workshops are also being rolled out and include regional areas.

National framework for mental health in nursing programs

The Australian Government is also funding the Australian College of Mental Health Nurses to review the mental health content of undergraduate nursing degrees and clinical nursing placement in mental health settings. The findings will inform the development of a national framework for mental health content in undergraduate nursing programs, which will be distributed to Australian universities, and provided to inform the Australian Nursing and Midwifery Accreditation Council review of Registered Nurse Standards. Whilst not specific to rural and remote area this project aims to support the development of a suitably quailed nursing and midwifery workforce to improve the mental health and wellbeing of all Australians.

Mental Health Professional Online Development (MHPOD) tool

The Mental Health Professional Online Development (MHPOD) tool is a national web-based professional mental health education resource for professionals and allied health workers. It is available to mental health nurses, social workers, occupational therapists, psychiatrists and psychologist working in mental health in Australia in their first two years of practice. It is also available to GPs, consumer workers, carers, Aboriginal health workers and other allied health workers. Due to its being an online resource, this provides important training opportunities for mental health professionals in rural and remote areas.

The Mental Health Professionals' Network (MHPN)

The Mental Health Professionals' Network (MHPN) provides practitioners with an opportunity to participate in locally-based interdisciplinary networks and national online professional development

[45] Department of Health. Rural Health Multidisciplinary Training (RHMT) Program, 2017, accessed 30 April 2018
[46] Assistant Minister for Health, The Hon Dr David Gillespie, MP. Media Release: Government announces 26 regional training hubs and 3 new University Departments of Rural Health to boost clinical training in regional Australia, 2017
[47] Department of Health. Regional Training Hubs, 2017, accessed 29 April 2018

webinars. The opportunities facilitated by MHPN are open to a wide range of mental health workers but are particularly important to address the challenges of professional isolation in rural and remote locations.

Recently, the MHPN partnered with the Commonwealth Department of Health to deliver a webinar on improving practice using Better Access' new Telehealth options. This webinar occurred pre-implementation of the new MBS telehealth items and targeted allied mental health practitioners. The webinar considered an interdisciplinary approach focusing on improving practice through use of the new Better Access Telehealth options. The webinar was endorsed for professional development points, credits or hours by the Royal Australian College of General Practice, the Australian College of Rural and Remote Medicine and the Australian College of Mental Health Nurses. Additional webinars are currently in planning.

8 Using new technology to improve service delivery

The 2014 National Mental Health Commission's review of mental health programs and services noted that digital technologies can be used to provide mental health services that are more flexible and less stigmatising for people with mental health difficulties.[48] While many of these initiatives are phone or web-based and accessible nationally, the potential impact of having reliable and confidential professional support at all times in rural and remote regions is immense. Further, with the constantly improving national coverage of internet and mobile services, as well as new Government initiatives to supplement 'black spots' in these digital services, means more Australians have access to these services than ever before.

8.1 The potential of digital technology in rural and remote areas

Digital technologies are transforming Australia's mental health system. These technologies align with the new national approach to regional service delivery because they can be an accessible part of a person-centred stepped care approach.

Digital technologies have been identified as an important way to address specific barriers to accessibility and quality of mental health services in rural and remote areas. Digital mental health services can, help address inequity due to higher levels of unmet need in rural and remote communities. These technologies can also improve quality of services by connecting people to best practice and leading practitioners, where the delivery of mental services by inexperienced professionals has been identified as a challenge in rural and remote areas. Digital technologies can also ensure mental health services are delivered with privacy in and at all hours of the day or night.

The Australian Government is maintaining support for face-to-face community-based services, while at the same time substantially increase capacity for crisis support through new online and voice-activated technologies. It has committed funding to several national digital approaches that have specific benefit in rural and remote communities. It also recognises that while 88 per cent of Australian households in Australian cities have internet access, this falls to 79 per cent in outer regional and remote areas. That is why it is rolling out new telephone phone support services for internet-based programs (such as headspace) and introducing privacy mechanisms for its digital services so that they can be used in local centres (such as community libraries).

As part of the national approach, PHNs and LHNs have been tasked with the responsibility of identifying and harnessing the potential for digital technologies to better integrate and provide mental health services. The Australian Government provides specific funding to PHNs to innovate in this space and draw on the rapidly expanding range of supports in the digital space.

Case Study: Expanding rural and remote access through the online MindSpot service

Prior to the establishment of the Western Australia PHN, there were areas of Western Australia where people had minimal, if any, access to mental health services. Now, as the result of a range of initiatives by the Western Australian PHN, people can access high quality clinical care via telephone, online or face-to-face any time day or night.

MindSpot is a free telephone and online service for people experiencing depression or anxiety. The WA PHN is working in collaboration with Macquarie University to expand this into a state-wide service.

[48] National Mental Health Commission. Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services, 2014.

Through MindSpot, general practitioners and nurse practitioners can automate referrals to Aboriginal Health Workers or other mental health professionals. The online support allows people to be referred to psychologists, psychiatrists and mental-health workers for counselling. MindSpot has improved quality of services across many parts of regional WA and provided access to a level of care that previously was not available. One of the greatest advantages of MindSpot is that it uses technology to keep local general practitioners constantly updated on the progress of the clients they refer.

Since rolling out a suite of digital and online services the WA PHN has found that 20 per cent of access to digital services/telephone services from the country is from Aboriginal and Torres Strait Islander people. This figure is far larger than expected. This highlights the importance of providing a range of different channels through which people seek support.

There are also potential opportunities for the use of digital mental health and electronic health records in coordinating care at the local level. While sharing clinical records amongst treating practitioners is best practice always, the scarcity of mental health professionals in rural and remote areas, as well as the distances between their practices, can present a significant challenge.

8.2 Head to Health

Central to the Australian Government's mental health reform is making optimal use of digital mental health services, including through the development of a consumer-friendly digital mental health gateway.[49] The Head to Health website aims to provide a genuine and trusted gateway to early intervention and lower-level mental health services. It does this by helping people more easily access information, advice and digital mental health treatment options. This service provides flexibility and choice by linking directly to eighteen different digital mental health services, all of which complement or act as an alternative to face-to-face services.

The Australian Government has been listing online information about mental health services since 2006. However, since its launch in October 2017, Head to Health has provided three important additional functions for rural and remote users. These are:

- a page dedicated to information for rural and remote people;
- a search function (that includes a regional filter); and
- a decision support 'chatbot' tool.

A strong governance and advisory structure has ensured Head to Health is informed by its potential users. This has included a Core Community Group representing diverse populations groups, including rural and remote areas to assist in system design.

8.3 Better Access initiative

Under this initiative, Medicare rebates are available for patients with a mental disorder to receive up to ten individual and up to ten group allied mental health services per calendar year. These services are generally provided in courses of treatment, with each course of treatment involving up to six services provided by an allied mental health professional. At the end of each course of treatment, the allied mental health professional must report back to the referring medical practitioner on the patient's progress and the referring practitioner assesses the patient's need for further services.

[49] See: Department of Health. Head to Health

In the 2017-18 Federal Budget, the Australian Government announced funding of $9.1 million over four years to enable Australians who live in rural and remote Australia to access Better Access services via telehealth.[50] This support takes the form of a psychological therapy service that is delivered via video conference where both a visual and audio link has been established between a patient and their treating allied health professional. People are eligible for this service through residence in rural and remote areas according to the Modified Monash Model (MMM 4-7).[51]

A requirement of this initiative is that one of the first four Better Access sessions is delivered face-to-face to facilitate a personal connection with the treating allied health professional, as well as help support and retain mental health specialists outside metropolitan regions. After this, clinicians are able to deliver up to seven out of the total ten Better Access consultations by videoconference. These new provisions allow people to meet promptly, conveniently and privately with mental health professionals after referral by their medical practitioner. This initiative helps address the challenges associated with a scarcity of mental health professionals working in rural and remote communities.

8.4 Life in Mind portal

Life in Mind is a national initiative that connects organisations, programs, researchers and professionals working in suicide prevention to each other, and the community. It does this by providing a digital platform for knowledge exchange around suicide prevention activities across Australia. Life in Mind is supported by funding from the Australian Government under The National Suicide Prevention Leadership and Support Program.

The project's overall objective is to reduce suicidal behaviour, rates and better support people to communicate about, and respond to, suicide and its impacts. The Life in Mind website[52] explains that it aims to:

- link policy to practice, communities to help-seeking and practitioners to the evidence base through the development of an online portal;
- support coordinated, consistent messaging around suicide prevention through the operationalisation of the National Mental Health and Suicide Prevention Communications Charter; and
- promote leadership and support in the communication of the project to the sector, and to the broader community, through the implementation of a National Champions Leadership Group.

This initiative has specific importance to regional Australia because it can connect organisations, local services and rural communities to the latest information, activities, evidence-based resources and research. This contribution will be particularly valuable to PHNs and mental health professionals working outside of metropolitan areas so that they can keep abreast of the latest developments and practices in suicide prevention.

8.5 Online initiatives for special populations

The Australian Government is also supporting several other measures to use technology to improve mental health and suicide prevention services in rural and remote locations.

[50] See: Department of Health. Telehealth, 2015
[51] See: Department of Health. Modified Monash Model, 2016
[52] See: Everymind. Life in Mind program, accessed 1 May 2018

beyondblue

beyondblue is an Australian, independent non-profit organisation working to address issues associated with depression, anxiety disorders and related mental disorders. It works in partnership with health services, schools, workplaces, universities, media and community organisations. *beyondblue* takes a public health approach to anxiety and depression, focusing on improving the health of the whole population, across the whole lifespan. It also works with specific population groups in a range of settings to be accessible to as many people as possible. Amongst its suite of offerings is information and links to support men facing the challenges of living in rural and remote communities. The service is supported by the Australian Government and every state and territory government.

ReachOut.com

Recent research shows that more than fifty percent of young people turn to the internet for help with mental health. ReachOut.com uses the internet to make digital self-help available for young people and aims to improve mental wellbeing as well as prevent and intervene early in the onset of mental health problems in young Australians. It draws on the latest evidence and works with experts to deliver safe, relevant and trusted selfhelp tools.

ReachOut provides online support via website and online forums and offers pathways to further support young people in crisis by referring them to Kids Helpline (ages 5 to 25) and the National Suicide Call Back Service (for ages over 15). These services are a vital resource given the impact of youth suicide in rural and remote communities. ReachOut is a free service funded by the Australian Government, as well as corporate, community and philanthropic donations.

QLife service for LGBTI communities

QLife is Australia's first nationally-oriented counselling and referral service for people who are lesbian, gay, bisexual, trans, and/or intersex (LGBTI). QLife provides nation-wide, early intervention, peer supported telephone, online chat and web-based services to people of all ages. QLife will enable communities to work towards better health outcomes by providing a place to talk about mental health, the challenges associated with coming out, and other concerns. This service also supports LGBTI Australians in rural and remote areas to reduce the potential impact of isolation and stigma in their local community. QLife is funded by the Australian Government.

Perinatal Depression support trial

International studies show that up to one in ten women experiences depression while pregnant, and one in seven women in the year after birth. The Australian Government has identified a gap in online self-help support tools and services specifically tailored to and targeted toward pregnant women and new mothers with perinatal mental illness. In response, it has contracted the Parent-Infant Research Institute on behalf of the Perinatal Depression e-Consortium to deliver, manage and trial three new technological supports. These include:

- an online self-directed treatment program for women with or at risk of perinatal depression
- a smartphone app providing support for expectant and new mothers experiencing stress (but not necessarily experiencing a mental disorder)
- a landing website that hosts a range of evidence-based perinatal mental health resources and psychoeducational tools.

The Commonwealth is in the early stages of collecting data on the effectiveness and uptake of the treatment through this important trial. It is anticipated that these supports will specifically assist people who are unable to access professional face to face services due to geographical isolation.

eheadspace

Young people who are unable to access a headspace service can seek support through the eheadspace service, which provides the headspace model of services free, either online or over the phone. The eheadspace service is delivered across Australia via synchronous webchat, telephone and email. The service operates as both an alternative to centre-based treatment, and as a form of support that complements the centre-based program. Designed specifically for young people and families who have limited access to support across rural and remote areas, the eheadspace service plays a role in linking young people in regional areas and boosting the capacity of headspace to have an impact in rural and remote areas.

The Australian Government prioritises eheadspace support for young people and families who have limited access to support across rural and remote areas. Since eheadspace commenced in 2012, 25.5 per cent of serviced clients were in rural or remote locations. This compares with 28.2 per cent of Australians living outside major cities. An independent evaluation of headspace in 2015, found that almost one third of headspace clients that received services at a centre also used eheadspace. Hence, the online service can play a role in linking young people in regional areas and boosting the capacity of headspace to provide services in rural and remote regions. Recent five-year data on eheadspace usage also indicates that overall, there has been a gradual increase in service usage amongst young people in these areas, which is a measure of success.

eMHPrac mental health training

In line with Australia's move towards a stepped care model of mental health treatment, models of care are being developed to ensure that the needs of each patient are matched with the intensity of care they receive. The e-mental health in practice (eMHPrac) programs have been developed as a suite of online training modules, webinars and e-resources designed to introduce health professionals to online programs and tools, and to demonstrate how e-mental health technologies can be integrated into primary care. These programs are evidence based low-intensity online programs available to practitioners, in most cases, at no cost. [53]

[53] Black Dog Institute. e-Mental Health in Practice, accessed 2 May 2018

9 Conclusion

The impact of mental illness touches every Australian. For some it may be a profound decline in quality of life, while for others it might be the personal pain of seeing the effect on a loved one. Although the prevalence of mental illness is similar in urban and rural and remote Australia, barriers of awareness, accessibility and quality of mental health services contribute to higher levels of need in rural and remote locations.

For several decades, the Australian Government has had a strong commitment to improving health care in rural and remote Australia, including in mental health. Amongst these have been numerous initiatives to encourage better access to local GPs, who are often the first point of contact in accessing mental health services in rural and remote communities.

The Fifth National Mental Health and Suicide Prevention Plan built on this prior commitment by bringing together a national approach for the Commonwealth, states and territories to provide better mental health and related services in Australia. This Plan demonstrates the Australian Government's commitment to working collaboratively to deliver mental health services in an integrated system.

A key feature of the Fifth National Mental Health and Suicide Prevention Plan is its emphasis on integrated local planning at the regional level. While the role of the Australian Government in this field is not new, the Plan demonstrates its commitment to drive this new emphasis, while ensuring national consistency in implementation and local flexibility to design stepped-care models. This focus on regionally and locally tailored approaches will be crucial to ensuring improved access to mental health services in rural and remote areas.

The Australian Government through Primary Health Networks supports integrated regional planning, better coordinated funding and commissioning to complement local service gaps. Currently, the Australian Government is supporting rural and regional PHNs to develop innovative new models and trials of integrated mental health care. The headspace program, which is coordinated by local PHNs, is another example of the Australian Government's focus on local service delivery and responding to individual needs A series of trials and new sites for this program are currently being placed in regional areas to support services that respond to local and individual needs.

The growing recognition of the national significance of the impact of suicide in the Fifth National Mental Health and Suicide Prevention Plan, particularly in rural and remote regions, has also been endorsed by the Australian Government. Currently, it is funding national suicide prevention trials and new infrastructure around suicide hot spots. The Australian Government is also delivering on its commitment to provide digital responses to support mental health and suicide prevention, with services including more rural online access to the Better Access initiative and complementing other mental health initiatives with expanded telehealth support.

These actions have already made a difference for the mental health needs of people in rural and remote areas. Some initiatives are having immediate impact, while others will take time to consolidate.

Since the Australian Government's response to the National Mental Health Commission's Review of Mental Health Programmes and Services, considerable progress has been made in improving the access and quality of mental health and suicide prevention services for rural and remote areas. A strong foundation has been laid for current and future action, including through the Fifth Plan.

Appendix A Abbreviations, acronyms and references

The following acronyms have been used in this submission.

Acronym	Definition
ABS	Australian Bureau of Statistics
AIHW	Australian Institute Health and Welfare
AON	Areas of need
ATAPS	Access to Allied Psychological Services
COAG	Council of Australian Governments
DWS	District of workforce shortage
FIFO	Fly-in-fly-out
GP	General Practitioner
GDP	Gross domestic product
LHN	Local Hospital Networks
MBS	Medicare Benefits Scheme
MHPOD	Mental Health Professional Online Development
MHNIP	Mental Health Nurse Incentive Program
NGO	Non-governmental organisation
NSMHS	National Standards for Mental Health Services
NSQHS	National Safety and Quality Health Service
OECD	Organisation for Economic Cooperation and Development
PBS	Pharmaceutical benefits scheme
PHN	Primary Health Network
RAMUS	Rural Australian Medical Undergraduate Scholarship
RFDS	Royal Flying Doctor Service
SES	Socioeconomic status

Appendix B Australia's Network of PHNs