Submission to Inquiry into Regional Australia

AUGUST 2020

AASW
Australian Association of Social Workers

Enquiries regarding this submission can be directed to:

Debra Parnell
Manager, Policy and Advocacy
[redacted]

Dr Sebastian Cordoba
AASW Senior Policy Advisor – RMIT Industry Fellow
[redacted]

The Australian Association of Social Workers

The Australian Association of Social Workers (AASW) is the professional body representing more than 12,000 social workers throughout Australia. We set the benchmark for professional education and practice in social work, and advocate on matters of human rights, discrimination, and matters that influence people's quality of life.

The social work profession

Social work is a tertiary qualified profession recognised internationally that pursues social justice and human rights. Social workers aim to enhance the quality of life of every member of society and empower them to develop their full potential. Principles of social justice, human rights, collective responsibility and respect for diversity are central to the profession, and are underpinned by theories of social work, social sciences, humanities and Indigenous knowledges. Professional social workers consider the relationship between biological, psychological, social and cultural factors and how they influence a person's health, wellbeing and development. Social workers work with individuals, families, groups and communities. They maintain a dual focus on improving human wellbeing; and identifying and addressing any external issues (known as systemic or structural issues) that detract from wellbeing, such as inequality, injustice and discrimination.

Regional Australia and mental health

Regional Australians are experiencing a significant need in mental health supports due to the devastating summer bushfires and now COVID 19.[1] Unfortunately, people are not accessing the

1 https://www.abc.net.au/news/2020-07-15/mental-health-system-leaving-regional-australians-behind/12414988?nw=0

supports they need due to a range of factors, or are falling through the cracks in the system.[2] The experience of social workers is that distance from a capital city is not the sole, or even the most important, determinant of community attitudes to mental health and willingness to use mental health services. Rather, the level of community acceptance of mental health services appears to rely on a variety of other localised factors. Because distance from an urban centre is not the main factor in people's attitudes to mental health services, this submission does not make a distinction between regional, rural and remote communities. This submission uses the terms 'regional, rural and remote' to refer to the inner regional, outer regional, remote and very remote locations as identified in the modified Monash model; as that is the model used by the Department of Health.

In this submission, the AASW will propose that existing policy frameworks create opportunities for improving accessibility and quality of mental health services in rural and remote areas in response to COVID 19 and the bushfires. The AASW argues that what is lacking is a dedicated commitment from all levels of government and across all portfolios to improved mental health outcomes for people in regional, rural and remote locations.

The AASW looks forward to playing a role in the enhancement of the mental health of people in these communities and welcomes the opportunity to contribute to this inquiry.

RESPONSE

The needs for mental health supports

The literature concerning the scarcity of specialist mental health services, and the lower rate at which people use those services, often conflates these two phenomena, resulting in a chicken-and-egg style confusion as to which one is the cause, and which is the effect. Against this backdrop, and in relation to the purposes of this inquiry, it is more important to note, therefore, that various opportunities exist for responses:

- Evidence that people in rural and remote communities visit General Practitioners (GPs) at a similar rate as people in metropolitan locations;[3]
- The continued existence of community and self-help groups in many regional and rural communities;
- Better availability of information and communications technology based services;
- Proven success of numerous innovative projects which have been extensively documents and have a bank of community trust;

2 https://www.abc.net.au/news/2020-07-15/mental-health-system-leaving-regional-australians-behind/12414988?nw=0

3 ttps://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-157#Sec19

With respect to the underlying causes of people's use of services, the data relating to service use is collected at a general level, which obscures demographics. This makes it impossible to identify the mental health status for sub-groups in rural and remote locations: children and young people, people working beyond retirement age; people with a disability or work related injury, for example. Given that the Fifth National Mental Health Plan places a priority on monitoring and quality improvement processes, data collection processes need to enable these distinctions.

Regardless of the factors contributing to the low levels at which people consult specialist mental health services, the acceptance of GP's creates an opportunity for a platform from which people in remote and rural locations can be referred to specialist mental health care in a non-threatening way.

Recommendations:

• That the National Mental Health Commission be directed to collect data concerning the mental health outcomes for particular sub groups by age, ability level, and occupation status, thereby enabling the ongoing monitoring of their use of services. This data will ascertain patterns of access and need, which can then inform the development of targeted mental health initiatives.

The higher rate of suicide in regional, rural and remote Australia

Reducing the rate at which people take their own lives is an important and urgent task for the entire health sector, and a responsibility of government. It is both an indicator of distress on the part of some individuals and a cause of distress for their family and communities. It is therefore imperative that reducing the rate of suicide is included as a goal in the Fifth National Mental Health Plan and that suicide reduction be identified as an indicator of the overall national mental health situation. Similarly, the inclusion of suicide reduction as priority for PHN's highlights its importance.

However, neither of these initiatives specify rural and remote communities as particular locations for this reduction, despite current modelling estimating an alarming 25% increase in suicide rates in regional and rural communities where existing unemployment, declining tourism and other stressors have been exacerbated by COVID-19 restrictions.[4] More importantly, there is currently no system of performance indicators or targets for this goal. This situation limits the ability of the service system to allocate resources for solutions specific to these communities. For example, the 2018 Federal Budget allocated extra money to Lifeline for counselling and to Beyond Blue for their program to assist people after a suicide attempt; however neither of these are specific to rural areas. For that reason, the AASW recommends that these initiatives be amended to ensure that they respond to the particular needs of people in these locations.

Recommendation:

4 https://www.abc.net.au/news/2020-08-04/coronavirus-lockdown-fatigue-mental-health-depression/12519698

• That the National Mental Health Commission be allocated the task of setting targets, collecting data and reporting on progress against the goal of reducing the rate of suicide in regional, rural and remote areas.

• That the Federal government specify to Lifeline and Beyond Blue to create more targeted services for the needs of rural and remote communities.

The nature of the mental health workforce

The size of the specialist mental health workforce declines in a direct relationship with distance from a major centre. Even when calculated as Effective Full-time Equivalent positions per 100,00 people, the numbers of professional mental health staff decrease markedly as remoteness increases, leading the Royal Flying Doctor Service (RFDS) to report a crisis in mental health in rural communities. While operating as a general practitioner service, it reports having conducted 24,000 mental health consultations last year.

This demonstrates the importance of a well-respected GP service as the gateway to appropriate mental health services. Despite the low numbers of specialist personnel, the continuing trust in GPs presents a significant opportunity to provide appropriate services. The government has created the Better Access program which is designed to improve accessibility to community based, mental health care. Because it is accessed through a visit to a GP it is ideally placed to respond to people's reluctance to initiate contact with a specialist mental health service.

However, the AASW is concerned that the transition to the NDIS will have a detrimental impact on mental health services for people with a complex psycho-social disability. In some states, the transition to the NDIS has been accompanied by the withdrawal of the Commonwealth funded community based mental health services, resulting in the loss of workforce and expertise in existing services. In many cases, state services have also withdrawn, compounding the reduction in services for these people. The AASW welcomes the recent announcements of funding to continue to support for people accessing PIR and PHaMs who are not eligible for the NDIS.

The AASW also welcomes the continued funding for the psychosocial support for people not eligible for NDIS, which will be delivered through PHNs. In the absence of details about how these measures will be delivered, the AASW is concerned that the absence of a long- term commitment for funding levels will make it difficult to attract experienced mental health workers into rural and remote areas. Long-term commitment to funding will assist in the attraction and retention of staff, as many professionals may not consider re-locating to work in precariously funded services. If the workforce is reduced as a result of the NDIS implementation process, the outcomes for people in rural and remote areas, will be particularly serious.

Given rise in the provision of mental health services through telehealth, and work from home arrangements more generally in response to COVID-19 restrictions, where many professionals live is no-longer geographically constrained by work. The flexibility of working remotely from home as a part of the new 'Covid normal', paired with existing housing affordability in regional/rural areas,

makes relocation more feasible and more attractive than before[5] for many metropolitan based professionals. This opportunity can be grasped by government by further incentivising the de-centralisation of mental health professionals into regional and rural communities. Expansion of telecommunications and further investment from government in telehealth and incentivised re-location will make rural, regional and remote communities more attractive for many mental health professionals.[6]

Recommendations:

- That incentives be commenced to attract more mental health professionals to re-locate to rural areas
- That incentives be in place to encourage allied mental health staff to work out of rural and remote General Practitioner clinics
- That incentives to encourage bulk billing by rural and remote GPS be increased

The challenges of delivering mental health services in the regions

As described above the challenges in delivering services in rural and remote areas are:

- reluctance to self identify;
- difficulty of access due to distance;
- fewer services;
- inability to spend time away from small businesses and farms;

Nevertheless, the literature provides many examples of small-scale initiatives that effectively addressed mental health needs of rural and remote communities. Many were innovative, drawing on the accumulated practice wisdom of experienced workers, including members of the AASW; many were designed in partnership with existing community groups in response to specific local conditions and implemented through those partnerships; and many were evaluated and shown to be effective.9 The experience of our members is that the only problem with these services has been their pilot project status and temporary funding.

While it is common to call for pilot projects and research, many mental health professionals are in a position to effectively re-commence these projects. The AASW suggests that what is needed is a permanent source of funding and a mechanism for integrating these into the existing service system so that they function as part of the overall system, rather than as short term pilot projects.

[5] https://www.abc.net.au/triplej/programs/hack/coronavirus-covid-19-moving-to-the-country-working-from-home/12274084
[6] https://www.theguardian.com/australia-news/2020/apr/12/rural-australia-is-used-to-isolation-but-covid-19-gives-it-a-whole-new-meaning

PHNs have the potential to fulfil this role. They already have the responsibility to develop needs based services and programs that can be offered by the mental health services. Unfortunately, current limitations of the funding cycle are hampering the ability of PHN's to plan and commission these services for the medium term.

Recommendation:

• That existing funding arrangements for PHN's be extended for another three years to enable stability in funding of locally responsive community mental health services and that PHN's be empowered to continue them as part of the commissioning process.

Attitudes towards mental health services

As has already been described, the fact that people in rural and remote communities hold attitudes towards mental health which make them less likely to use specialist mental health services can be counteracted by the acceptance of GP's.

The accessibility of mental health services can be improved by paying attention to the avenues through which people can make and maintain contact with services. As discussed above, the importance of continuing trust in General Practitioners provides an avenue to the Better Access programs which links people to community based, mental health care.

As well as overcoming the barriers to obtaining help, the Better Access program is significant for another reason as it is the platform for one of the government's major improvements to accessibility for mental health. Through this initiative, some of the sessions with a mental health professional can be delivered through an audio and video connection, once a personal relationship with a mental health professional has been established. Given the obvious potential of this to overcome the geographic and attitudinal barriers to accessing services, it is important that the use of these services be formally monitored as part of the Mental Health Commission's task of gathering and reporting on mental health outcomes of people in rural areas.

Recommendation:

• That the National Mental Health Commission monitor the use of the Better Access and Better Access Telehealth programs as part of its task of gathering and reporting on mental health outcomes of people in rural areas. This is a practical and affordable way of utilising telehealth infrastructure to gather much needed data to shed light upon the mental health needs of regional, rural and remote Australia.

Conclusion

We welcome the opportunity to make a submission to this inquiry and discuss any of the points raised.

Level 7, 14-20 Blackwood Street
NORTH MELBOURNE VIC 3051

PO Box 2008
ROYAL MELBOURNE HOSPITAL VIC 3050

[redacted]

ACN 008 576 010
ABN 93 008 576 010

AASW
Australian Association of Social Workers

www.aasw.asn.au