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National Mental Health Commission

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Australian Mental Health Commissions - Submission to the accessibility and quality of mental health services in rural and remote Australia Senate Inquiry – 11 May 2018

Dear Committee Secretary

Thank you for your letter of 19 March 2018, inviting a submission to the Senate Standing Committees on Community Affairs inquiry on the accessibility and quality of mental health services in rural and remote Australia.

Please find attached the joint submission from the Australian Mental Health Commissions to the inquiry. There is no confidential material presented.

Should you require clarification, or would like to discuss this submission in further detail, please contact Catherine Brown

Yours sincerely

Dr Peggy Brown, AO
Chief Executive Officer and Commissioner
National Mental Health Commission
14 May 2018

Encl.

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EXECUTIVE SUMMARY

In this submission the Australian Mental Health Commissions (the Commissions) address the high levels of unmet mental health need in rural and regional communities. On almost any indicator, people living outside of metropolitan areas experience inequity both in terms of their health and in getting access to appropriate services. Further, this inequity compounds the mental health challenges facing the proportionally higher numbers of Aboriginal and Torres Strait Islander people living in these areas. While the prevalence of illness in rural and remote Australia is similar to that in major cities, poorer mental health outcomes are evident. Access to health services is lower with shortages of all health professions and health-related infrastructure declining markedly with increasing remoteness.

The problems facing people living in rural and remote areas of Australia in accessing quality mental health services are severe and require immediate attention. The Commissions recommend that the Senate of Community Affairs consider:

1. Enhancing the timeliness, accessibility and usability of suicide related information and data (inclusive of self-harm, suicide and suicide attempts) to support evidence-based suicide prevention strategies at the national, state and regional levels, including early identification of youth suicide clusters.

2. Ensuring that the Workforce Development Program under the *Fifth National Mental Health and Suicide Prevention Plan*, includes strategies to attract and retain mental health workers in rural and regional areas, which may include enhanced career pathways and incentives to encourage psychiatrists, psychologists, Aboriginal mental health workers to relocate from urban practice. Additionally such initiatives should include all mental health workers, including peer workers, mental health nurses, occupational therapists and social workers.

3. Expansion of the eligibility criteria for participants in the Specialist Training Program to include GPs to extend the provision of mental health services available for people living in rural and remote Australia, including training opportunities for mental health and wellbeing promotion, evidence-based interventions for early intervention and management of mild, moderate and severe mental illness within a general practice setting.

4. Expansion of the peer workforce with training and appropriate levels of clinical/ peer supervision as currently there is a lack of access to supervision. The Australian Government committed with State and Territory Governments to monitor the growth of the peer workforce and ensure that peer workforce guidelines are developed as an action under the *Fifth National Mental Health and Suicide Prevention Plan*.

5. Training local community members to provide health promotion and recovery support services in rural and remote areas. Their life experience, expertise and local knowledge could be utilised to break down stigma, promote mental health literacy, encourage the use of formal specialist services and assist with suicide prevention. This could complement the more formal peer workforce being developed in non-metropolitan communities.

6. For severe and complex mental illnesses, enable an extra six Medicare-subsidised sessions of psychological therapy as clinically determined (a total of 16 in any one year).

7. Investigate whether adding a rural and remote load for health professionals under Medicare-subsidised mental health services to determine if it would entice/retain health professionals to live and work in rural and remote Australia.

8. Ensure that there is continued effort and investment in the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing* through the Closing the Gap Framework and the Indigenous Advancement

Strategy, and that Aboriginal and Torres Strait Islander people lead the development and implementation of solutions.

9. The establishment of a national mental health consumer peak organisation to provide a united national voice for mental health consumers including rural and remote consumers.

10. Extend the *Head to Health* scope of listed services to provide greater choice and information for how people in rural and remote areas can access the right care.

11. Increase the functionality of *Head to Health* to make resource cards downloadable in the absence of adequate internet access.

12. Removal of or introduction of a caveat allowing for wavering of the face-to-face component of the Better Access Telehealth initiative where access issues are a significant barrier.

13. Ensuring communities and people with a lived experience of mental health are involved in design, development, implementation and evaluation processes advising on mental health reform.

Recommendations (1, 6 and 12) related to the Medical Benefits Schedule are also included in separate submissions to the current Medical Benefits Schedule Review.

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INTRODUCTION

This submission has been made by the Australian Mental Health Commissions (the Commissions). Mental Health Commissions have been established in the last decade – with different operating and reporting structures and responsibilities – but with a common purpose: to drive and improve the mental health and wellbeing of the Australian population through reforms.

The **Mental Health Commission of Western Australia** was the first Australian commission to be established in 2010 and provides leadership and support in a new approach to the delivery of mental health services in Western Australia. The WA Commission does not provide direct mental health services, but purchases services for the State from a range of providers including public Health Service Providers, a wide range of non-government organisations and private service providers. The WA Commission also invests in mental health illness prevention activities, including for vulnerable groups in remote communities.[1] **While it is supportive of this response it is making its own submission to the Enquiry.**

Joint submission from:

The **National Mental Health Commission** was established in 2012 and provides cross sectoral leadership on policy, programs, services and systems that support better mental health and social and emotional wellbeing in Australia. Acting as a catalyst for change, the National Commission increases accountability and transparency by leading and collaborating on key mental health initiatives, and providing independent reports and advice to the Australian Government and community.

The **Mental Health Commission of New South Wales** was also established in 2012. Responsible for monitoring, reviewing and improving the mental health system and the mental health and wellbeing of the people of NSW, the NSW Commission takes a highly collaborative approach with government agencies and the community. In 2017, it funded the Centre for Rural and Remote Mental Health to review and develop a community wellbeing collaborative model for rural and regional NSW.[2]

The **Queensland Mental Health Commission** was established in 2013 to drive ongoing reform to improve the mental health and wellbeing of all Queenslanders, with a particular focus on preventing and reducing the impact of mental illness, problematic alcohol and other drug use, and suicide. The *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019* and the *Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016-18,* developed by the Commission, articulates the Queensland Government's approach to responding to these issues.[3]

The **Mental Health Complaints Commissioner** was established in Victoria in July 2014 under the *Mental Health Act 2014* (the Act) to provide an independent, specialist body established to safeguard rights, resolve complaints about Victorian public mental health services, and recommend improvements.

The **South Australian Mental Health Commission** was established in 2015 to strengthen the mental health and wellbeing of South Australia. It recently led the development of the SA Mental Health Strategic Plan 2017–2022 which includes a strategic direction in support of diverse communities,

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[1] Mental Health Commission, Government of Western Australia (2017) 'Mental Health Commission 2016/17 Annual Report', p 119

[2] Mental Health Commission of New South Wales (2017) 'Inquiry into the Prevention of Youth Suicide: Submission to Committee on Children and Young People by the Mental Health Commission of NSW' avail https://nswmentalhealthcommission.com.au/sites/default/files/documents/submission_inquiry_into_the_pre vention_of_youth_suicide_31_august_2017_1.pdf

[3] Queensland Mental Health Commission (2014) 'Improving mental health and wellbeing: The Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019', p 20

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recognising the need for targeted solutions to provide accessible and appropriate support for those in rural and remote communities.[4]

A. The nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate

People living in rural and remote Australia make up 30 per cent of the population yet do not get anywhere near 30 per cent of funding and services for mental health.[5]

The prevalence of people experiencing mental illness in rural and remote Australia is similar with metropolitan areas, that is around 20% of this population which is approximately 960,000 people.[6] However, rural and remote Australians face greater challenges as a result, because of the difficulty in accessing the support they need, and the stigma, fear and discrimination of mental illness in small communities. Suicide and self-harm rates increase with remoteness, for those living in very remote areas, they are twice as likely to die from suicide.

The challenge of providing mental health services is complicated and magnified by geographical distance and unique community characteristics including: rapid growth due to resource and mining development, ageing population, low population density, Aboriginal and Torres Strait Islander population, limited and ageing infrastructure, and higher costs associated with health care delivery.[7] In addition to these unique community characteristics, there are other challenges that affect a remote and rural person's mental health including natural disasters, financial hardship, lack of or inaccessibility to health services, and geographical and social isolation.

People living in rural and remote Australia experience differing levels of disadvantage related to education, income and employment compared to people living in metropolitan areas. Self-harm and suicide rates are also 1.5 times higher,[8] and people are more likely to engage in behaviours associated with poorer health outcomes which may reflect a range of social, educational, economic, behavioural and physical risk factors. Aboriginal and Torres Strait islander peoples embrace a holistic consent of health, linking mental and physical health with interconnectedness of a broader concept of social and emotional wellbeing. Approaches to the social and emotional wellbeing and suicide prevention of each rural and remote community, particularly for Aboriginal and Torres Strait Islander people, needs to be considered within each communities unique cultural, historical and socio-economic contexts.

Rural and remote Australia is simply differentiated from metropolitan areas, and seen as possessing strengths in resilience and a sense of community. However, there is no single stereotypical community experience of mental health in rural and remote Australia. The diversity of small communities make the delivery of services more complex. Communities are differentially affected by many factors such as:
- specific circumstances of local Aboriginal and Torres Strait Islander communities

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[4] South Australian Mental Health Commission (2017) 'South Australian Mental Health Strategic Plan 2017–2022', p 36

[5] National Mental Health Commission (2014) 'The National Review of Mental Health Programmes and Services,' Sydney: NMHC

[6] Bishop, L., Ransom, A., Laverty, M. & Gale, L.(2017) *Mental Health in remote and rural communities* Canberra: Royal Flying Doctor Service.

[7] Queensland Health (2013) Queensland Rural and Remote Health Service Framework. Brisbane: State of Queensland cited in The Royal Australian & New Zealand College of Psychiatrists (2016) Rural and Remote Mental Health and Wellbeing Action Plan Response, avail
https://www.ranzcp.org/Files/Resources/Submissions/RANZCP-QLD-QMHC-Rural-Remote-Submission-27April20.aspx

[8] Australian Bureau of Statistics (2017) Causes of death, Australia, 2016. ABS cat. no. 3303.0. Canberra: ABS

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- social isolation, particularly for specific social, cultural and employment groups
- exposure to environmental factors and economic restructuring, particularly for farming communities
- distance from major cities and services
- economic and contributing life factors, such as access to a secure job and home, a good education and quality health and mental health care.

Mental health funding in Australia is a shared responsibility. Core service funding derives from the Commonwealth, state and territory governments, health providers and private health insurers. State and territory governments have responsibility for public mental health services, including community based services and acute hospital care for those living with severe and persistent mental illness. The Commonwealth supplements services for people with mental illness through direct funding agreements with service providers, including through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) for a rebate against the cost of privately provided medical services and prescriptions. Commonwealth, and state and territory programs and funding complement each other to ensure efficient and effective service provision and to address areas of highest need, for example, through Primary Health Networks.

In 2015-16, the Australian Government Medicare expenditure for mental health-specific services in *Remote* and *Very remote* areas comprised 0.5% of the total expenditure, whilst the population of these areas comprised 2.2% of the total.)[9] The rate of Medicare-subsidised mental health specific services was highest in *Major cities* (495.3 per 1,000 remoteness area population), with rates decreasing by remoteness. This pattern was consistent across health provider types and could be a result of the increased stigma and limited access to a mental health workforce in rural and remote areas. MBS and PBS rebates are primarily dependent on access to GPs, specialists and pharmacies.

Addressing the mental health needs of rural and remote Australia requires an understanding of the specific challenges for these areas and an innovative approach to addressing them — one which maximises available local resources and expertise, and adopts a regional or community specific approach.

The COAG Health Council endorsed the *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan)[10], with its key focus on integrated regional planning and service delivery of mental health and suicide prevention plans. Central to achieving this level of integrated mental health care and embedding stepped care approaches, is the role of Primary Health Networks in close alignment with state and territory Local Hospital Networks.

PHNs have the ability to undertake locally based gap analysis and needs assessment, regionally plan with Local Hospital Districts and commission primary mental health services which match individual and local population needs; to reduce fragmentation, and improve coordination, efficiency and effectiveness of care. Primarily, people living with severe and persistent mental illness receive the majority of their services from within the public health system. With PHNs having responsibility for the commissioning of primary mental health services, it is critical for these two sectors to be working in partnership. It is also crucial that PHNs, public health services and other sectors which provide social and welfare supports/services (including but not limited to housing and employment) work collaboratively to plan, commission and provide services.

There are 10 PHN mental health lead sites, which will document and evaluate their approaches to stepped care, regional planning and integration, and delivering low-intensity services. Of these,

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[9] Australian Institute of Health and Welfare (2018) 'Survey of Health Care: selected findings for rural and remote Australians' Canberra: AIHW avail https://www.aihw.gov.au/reports/rural-remote-australians/survey-health-care-selected-findings-rural-remote/contents/summary

[10] COAG Health Council (2017) 'Fifth National Mental Health and Suicide Prevention Plan 2017 to 2022'

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three sites are in rural and remote areas, and will demonstrate innovative approaches in preventing suicide, as well as services for both youth and adults with severe and complex mental health conditions. To support PHNs in catering for rural needs, services need be made available for them to commission. These programs may complement those provided by state and territory governments to ensure a system wide coordinated response. This requires governments (national, state and territory) to invest into community-based approaches and retention of mental health professions. Options for the Senate Inquiry's consideration are included in section c) *The nature of mental health workforce*.

B. The higher rate of suicide in rural and remote Australia

Patterns of suicide and suicide attempts differ across Australia with some population groups – including rural and remote communities – at higher risk.[11]

The Australian Bureau of Statistics (ABS) provides a breakdown of suicide incidence by two geographic categories – 'capital city' and 'rest of state.' Whilst one third of the population (7.97 million people) resided outside capital cities in 2016, the incidence of suicide in 'rest of state' areas was almost half that of capital cities (1,194 deaths in rest of state and 1,647 deaths in capital cities).This equates to a suicide rate that is 1.5 times that of people living in capital cities.[12] It is important to note that not all regions are the same. For some regions in Australia suicide rates may be higher, for example, Clarence Valley in NSW and the Kimberly in WA. The ABS can provide finer detailed information in this regard.

Aboriginal and Torres Strait Islander rates of suicide are also higher than the rest of the population with Indigenous Australians 2.1 times more likely than non-Indigenous Australians to have died as a result of suicide in 2016.[13] In the five years from 2012-2016, death by suicide was the leading cause of death for Aboriginal and Torres Strait Islander peoples between 15-34 years of age, and was the second leading cause for those 35-44 years of age.[14] Suicide is profound for anyone impacted. It is the compounding impact of multiple suicides that is of profound concern for some Aboriginal and Torres Strait Islander communities, with 20% of Aboriginal and Torres Strait Islander peoples reported living in rural areas in 2016.[15]

In recent years, rural and remote communities in Australia have been affected by increasing numbers of deaths by suicide, particularly among young people. Young males are of particular concern with reports indicating that young men aged 15-24 are up to 1.8 times more likely to die by suicide than their metropolitan counterparts.[16] There is also an increased risk of youth suicide occurring in clusters in remote areas, an incidence that is not reflected in adult suicide clusters.[17]

Certain workforces are at an increased risk of suicide, including farmers and fly-in fly-out (FIFO) workers. The evidence of farmer suicide has been well documented with individual, social, and environmental factors all playing a part in the increased risk of suicide and reduced help-seeking in

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[11] Centre for Rural & Remote Mental Health (2018) 'Rural Suicide Prevention' avail https://www.crrmh.com.au/get-help-now/self-help-resources/podcasts/rural-suicide-prevention/
[12] Australian Bureau of Statistics (2017) Population by Age and Sex, Regions of Australia, 2016. ABS cat. no. 3235.0. Canberra: ABS
[13] Australian Bureau of Statistics (2017), above n 7
[14] Australian Bureau of Statistics (2017), above n 7
[15] Australian Bureau of Statistics (2017) Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016. Cat. No. 2071.0. Canberra: ABS
[16] National Rural Health Alliance (2009) 'Suicide in rural Australia: Fact sheet' Canberra: National Rural Health Alliance
[17] Jo Robinson, Lay San Too, Jane Pirkis and Matthew J. Spittal (2016) 'Spatial suicide clusters in Australia between 2010 and 2012: a comparison of cluster and non-cluster among young people and adults' *BMC Psychiatry* 16:417

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this workforce. The rates of farmer suicide vary by age and state, with the National Rural Health Alliance indicating that farmers aged 55 years and older accounted for two-thirds of all farmer suicides.[18] There are many contributing factors to farmer suicidality which can include isolation and working alone, financial pressure and economic downturn, drought, and cultural attitudes.[19] These factors impact a person's wellbeing and resilience, and contribute to increased stress in a person's life. However, the resulting psychological and cultural impacts they present can be prevented by education and training programs, and community awareness initiatives.[20]

The prevalence of mental illness and suicidality in FIFO workers is not well evidenced. A 2015 inquiry into the impact of FIFO work practices in mental health ultimately found that there was a scarcity of reliable and comprehensive data on suicide within the FIFO work system and identified the need for further research in this area.[21] However, the demographic profile of FIFO workers (typically men aged 25-45 years) and the risk factors associated with the FIFO work system, for example isolation, long working hours, fatigue, and prolonged absences from home, do pose challenges for this workforce and increases their risk of mental ill-health and suicidality. The community has recognised the need to promote good mental health for FIFO workers, calling for work practices to be more amenable to family life and workers' mental health needs.[22] The Western Australia Mental Health Commission has developed the 'This FIFO Life' website which provides tools and resources for FIFO employees, their managers, and their families and friends.

The impact of suicide extends beyond individual families to entire communities. A recent research study *The Ripple Effect* by Suicide Prevention Australia and the University of New England identified that 89% of respondents knew someone who had attempted suicide, 85% knew someone who had died by suicide, and 80% of people had been exposed to both suicide attempt and death.[23] For rural and remote communities, where population size is lower than metropolitan areas, the impact of a suicide is even more pronounced.[24]

Although social features of rural and remote communities are protective of mental health, for example resilience and a sense of community,[25] people living in rural and remote areas can also be exposed to a variety of risk factors that contribute to mental ill-health. These are often tied to their location and include environmental adversity, geographic isolation, poorer socioeconomic circumstances, and restricted access to services.[26] For Aboriginal and Torres Strait Islander peoples, the above risk factors associated with living in rural and remote Australia are compounded by the historic and cultural experiences of intergenerational trauma and socioeconomic deprivation. Priority Area 2 of the *Fifth Plan*, Suicide Prevention, is consistent with the World Health Organization and recognises the need for access to mental health services to reduce suicidality.

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[18] Crnek-Georgeson, KT., Wilson, LA. & Page, A (2017) Factors influencing suicide in older rural males: a review of Australian studies, *Rural and Remote Health* 17: 4020

[19] Perceaval, M., Kolves, K., Reddy, P. & De Leo, D (2017) Farmer suicides: a qualitative study from Australia, *Occupational Medicine,* 67:383–388

[20] Perceaval, M., Kolves, K., Reddy, P. & De Leo, D (2017), above n 18

[21] Parliament of Western Australia (2015) The impact of FIFO work practices on mental health Final report, Report No. 5

[22] Parliament of Western Australia (2015), above n 20

[23] 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

[24] Jones, M., Ferguson, M., Walsh, S., Martinez, L., Marsh, M., Cronin, K. & Procter, N. (2018) 'Perspectives of rural health and human service practitioners following suicide prevention training programme in Australia: A thematic analysis' *Health and Social Care in the Community* 26(3):356-363, p 357

[25] Butterworth, P., Kelly, B.J., Handley, T.E., Inder, K.J. & Lewin, T.J. (2017) 'Does living in remote Australia lessen the impact of hardship on psychological distress?' *Epidemiology and Psychiatric Sciences* Apr 3:1-10, p 2

[26] Smith, K.B., Humphreys, J.S. & Wilson, M.G.A. (2008) 'Addressing the health disadvantage of rural populations: how does epidemiological evidence inform rural health policies and research?' *Australian Journal of Rural Health* 16:56-66

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Data collection and reporting

Australia's complex health system provides multiple sources of suicide related data nationally which presents challenges in obtaining accurate data that can be analysed and evaluated. Unfortunately, the geographical categories reported by the ABS are an example of the limitations in reporting on the rates of suicide in rural and remote Australia, as the 'rest of state' category includes regional, rural, and remote populations – each of which operate in different contexts and environments, and represent community groups with differing needs. Data collection and dissemination with regard to rates of suicide and self-harm therefore continues to be a challenge in the mental health sector. The publication of ABS data takes between 12 and 18 months after the year of death registration, making its use limited particularly for detecting suicide clusters in a timely manner. More rapid, accurate and comprehensive local and national data on self-harm, suicide and suicide attempts continues to be urgently needed to inform suicide prevention efforts in rural and remote Australia.

The NSW Commission is currently investigating the collection and use of data for self-harm, suicide attempts and suicide, and the utility of a data collection system in the development of the Strategic Framework for Suicide Prevention in NSW. The use of a suicide register is being assessed by NSW but it is unclear whether this is a suitable mechanism for collecting information needed in a timely manner.

There are also a range of suicide prevention trials that are being rolled out across the country, including the Australian Government Suicide Prevention Trial across 12 sites and the Blackdog Institute's LifeSpan initiative. These trials are being rolled out in rural and remote areas and whilst evaluation of the findings are not yet available, they will undoubtedly provide useful data sources and insight into the occurrence of suicide and self-harm in these areas.

> The Commissions recommend:
>
> 1. Enhancing the timeliness, accessibility and usability of suicide related information and data (inclusive of self-harm, suicide and suicide attempts) to support evidence-based suicide prevention strategies at the national, state and regional levels, including early identification of youth suicide clusters.

Examples of rural and remote experiences of suicide

Clarence Valley, NSW

The predominantly rural area of Clarence Valley in New South Wales has experienced higher than state average rates of suicide since early 2015.[27] The 2016 North Coast Primary Health Network Needs Assessment Survey identified that mental health issues and suicide were a serious concern of the community who experience long waits for GP appointments, and a lack of specialists and mental health services in the area.[28]

In response to the increased number of suicides, the community has since implemented a multi-agency mental health and wellbeing plan – Our Healthy Clarence – which aims to improve access to evidence-based suicide prevention treatments and services; improve the capacity of the workforce and the community to respond to suicide; raise community awareness; and engage the community in early intervention and prevention.[29] This is a positive example of coordinated and community-led action supported by the local Council, Local Health District, Primary Health Network, local services, organisations and schools.

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[27] Our Healthy Clarence (2016) 'Clarence Valley Mental Health & Wellbeing Plan 2016-2018', p 3
[28] North Coast Primary Health Network (2016) 'Clarence Valley Local Government Area Health Check' avail http://ncphn.org.au/needsassessment-2016
[29] North Coast Primary Health Network (2017) 'Our Healthy Clarence' avail https://ncphn.org.au/archives/programs/our-healthy-clarence

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The Kimberley, WA

The Kimberley region of Western Australia has been identified as having one of the highest rates of suicide in the world.[30] It is one of the most remote communities in Australia and one-third of the population are Aboriginal and Torres Strait Islander Australians.[31]

In 2016, the Kimberley Mental Health and Drug Service (KMHDS) undertook a retrospective audit of its internal suicide and self-harm database identifying that during the 10-year period 2005-2014, 81.6% (n = 102) of people who died by suicide in the region (n = 125) were Aboriginal and Torres Strait Islander.[32] Findings from the study indicated that the majority of people who died by suicide (70%) were not known to the KMHDS and therefore had not engaged with community mental health services.[33] Given the multiple risk factors that affect the incidence of Aboriginal and Torres Strait Islander suicide, a lack of coordination of preventative efforts and lack of engagement with mental health services is a key concern.

Last year, the suicides of 13 young people in the Kimberley, five of whom were children under the age of 13 years, prompted a coronial inquest. It has been reported that since 2007, the Western Australia Coroner's Court has stopped publishing inquests of suicides in the region.[34] This is another key concern as it contributes to the data limitations experienced in the sector and amongst other rural and remote communities more broadly.

With suicides in the Kimberley regions estimated at six times the national average,[35] there needs to be targeted action to ascertain this community's needs with respect to mental health promotion and suicide prevention. It is reflective of the need for a coordinated approach to suicide prevention based on community partnerships to ensure cultural appropriateness.

C. The nature of the mental health workforce

Mental health professionals are unevenly distributed across Australia and while some rural regions are relatively well supplied, people in other areas struggle to see psychiatrists, psychologists and even GPs. In this context, emergency hospital services are frequently used to compensate for a lack of community-based support, which may lead to inappropriate care. Noting that poor access to doctors for both non-emergency and emergency care remains a significant impediment to good health for many people living in remote and rural Australia (RFDS 2017). The evident lack of services for people in rural and remote Australia is a significant barrier to improving mental health outcomes. This issue is particularly compounded in states where there are no large towns outside of the capital city. For example, South Australia has no town with a population over 30,000 people and although well supplied with psychiatrists there are only two living and practicing outside of the greater Adelaide region.

Across Australia, access to psychiatrists is currently very limited for Aboriginal and Torres Strait Islander peoples and those living in remote and rural locations due to the maldistribution of the workforce. The World Health Organization's target for improving mental health outcomes is a workforce of 10 psychiatrists per 100,000 people.

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[30]McHugh, C., Campbell, A., Chapman, M. & Balaratnasingam, S. (2016) 'Increasing Indigenous self-harm and suicide in the Kimberley: an audit of the 2005-2014 data' *Medical Journal Australia* 205(1) p 33

[31] Campbell, A., Chapman, M., McHugh, C., Sng, Adelin. & Balaratnsingam,S. (2016) 'Rising Indigenous suicide rates in Kimberley and implications for suicide prevention' *Australian Psychiatry* 24(6):561-564, p 561

[32] McHugh, C., Campbell, A., Chapman, M. & Balaratnasingam, S. (2016), above n 29

[33] Campbell, A., Chapman, M., McHugh, C., Sng, Adelin. & Balaratnsingam,S. (2016), above n 30 p 563

[34] Campbell, A., Chapman, M., McHugh, C., Sng, Adelin. & Balaratnsingam,S. (2016), above n 30 p 563

[35] Hawthorne, M. (2016) Suicide prevention trial for Kimberley region, *Australian Medicine*, September, p 26

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It is more likely that consumers will initially seek mental health support from a generalist worker, such as a GP, a community nurse or an Aboriginal and Torres Strait Islander health worker or practitioner.[36] GPs provide a variety of services, including referral of the patient on to specialised services. For Aboriginal and Torres Strait Islander peoples strong Aboriginal community controlled health services are an important component of culturally responsive mental health system.

The Royal Flying Doctor Service is an innovative service model developed to address the large geographic and travel distances, over the years it has become a significant provider of health services, from primary care to emergency including aeromedical retrievals, to communities in rural and remote Australia. In 2016-17, the RFDS provided 24,396 mental health consultations, an increase of 72% on the previous year.[37] The RFDS research report, *Mental Health in Remote and Rural Communities*, reported that from 1 July 2013 to 30 June 2016, 2,567 aeromedical retrievals were conducted for mental disorders.[38] As restraint may be used in transit, it may be especially traumatic for the person being transport and for the workers. The Australian Government has recently announced that the RFDS is to receive additional funding in 2018 Budget to increase its mental health and suicide prevention service capacity. It will be important to ensure that people will actually be receiving services on the ground too.

Workforce Programs

The mental health workforce and its limitations – both in numbers of professionals and the scope of their practice – is one of the most significant hurdles that prevent people in rural and regional Australia having equitable access to mental health support.

In the Fifth Plan, endorsed by all governments, is an action to develop a Workforce Development Program to guide strategies to address future workforce supply requirements and drive recruitment and retention of skilled staff.[39]

> The Commissions supports:
>
> 2. Ensuring that the Workforce Development Program under the *Fifth National Mental Health and Suicide Prevention Plan*, includes strategies to attract and retain mental health workers in rural and regional areas. This may include enhanced career pathways and incentives to encourage psychiatrists, psychologists, Aboriginal mental health workers to relocate from urban practice. Additionally such initiatives should include all mental health workers, including peer workers, mental health nurses, occupational therapists and social workers.

Workforce supply issues need to be urgently addressed. Over the years, rural incentive programs for professionals have had limited success. Rural and remote areas remain unattractive for people to move to (for numerous reasons) and expansion of the current workforce mix for mental health care will require ongoing efforts.

The Royal Australian and New Zealand College of Psychiatrists recommends a suite of welfare initiatives for rural psychiatrists, including flexible work arrangements, networking opportunities and

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[36] Victorian Government Department of Health (2011) 'National Mental Health Workforce Strategy' Melbourne: Department of Health.

[37] Royal Flying Doctor Service (2017) 'Annual National Report 2016/17' Canberra: Royal Flying Doctor Service

[38] Bishop, L., Ransom, A., Laverty, M., & Gale, L. (2017) 'Mental health in remote and rural communities' Canberra: Royal Flying Doctor Service of Australia

[39] COAG Health Council (2017), above n 9

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support services, to address the undersupply of psychiatrists and improve geographical maldistribution.[40]

Other initiatives that provide opportunities to support a mental health workforce include broader workforce programs. The Australian Government's Specialist Training Program extended vocational training for specialist registrars into settings outside traditional metropolitan teaching hospitals, including rural and remote and private facilities.

Such initiatives are in need of extension to the broader mental health workforce including mental health nurses and peer workers, who both currently are excluded from the Better Access initiatives.

> The Commissions recommend:
>
> 3. The expansion of the eligibility criteria for participants in the Specialist Training Program to include GPs to extend the provision of mental health services available for people living in rural and remote Australia, including training opportunities for mental health and wellbeing promotion, evidence-based interventions for early intervention and management of mild, moderate and severe mental illness within a general practice setting.

Inclusion of GPs will increase the scope of access for people living in rural and remote locations, as GPs are often the only source of continuing care for people living with a mental illness in these areas. This in collaboration with the GP Rural Incentive Program could build community capacity, retain practitioners and increase response to people experiencing mental health problems in rural and remote areas.

Given that access to GPs in rural and remote areas is often limited, there should be expectations set about the ability and competency, support, and training for generalist staff delivering primary health services through state/territory public health services and Aboriginal Community Controlled Health Services.

The establishment of the first National Rural Health Commissioner by the Australian Government provides the opportunity for key stakeholders to engage in the process to improve rural health policies, especially with the focus on supporting a rural health workforce, including the needs of the mental health workforce. Building and maintaining mental health for people living in rural and remote locations is a critical need and should be a key focus in considering pathway options, and advising on rural health reform options.

Peer support workforce

Peer workers have a particularly important role in rural settings, where geographic isolation may be more intense and the opportunity to share personal experience more limited. There should be investment in improving the capacity of community members, especially those with a personal experience of mental illness, to provide peer and/or mental health first aid services and supports to augment the existing workforce.

> The Commissions supports:
>
> 4. Expansion of the peer workforce with training and appropriate levels of clinical/ peer supervision as currently there is a lack of access to supervision. The Australian Government committed with State and Territory Governments to monitor the growth of the peer workforce and ensure that peer workforce guidelines are developed as an action under the *Fifth National Mental Health and Suicide Prevention Plan*.

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[40] Royal Australian & New Zealand College of Psychiatrists (2017) Commonwealth Treasury 2018-19 Pre-Budget submission, avail https://www.ranzcp.org/Files/Resources/Submissions/RANZCP-Pre-Budget-Submission_FINAL.aspx

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Innovative models of providing supervision may include technological responses such as video conferencing, or fly in fly out approach that allows supervision to be provided to a range of staff in the location on the same day.

Building the strength of communities

Whilst spatial dispersion of mental health professionals is a significant concern, communities, through solidarity, can be more than a context or setting, and rather an opportunity for empowering individuals to make positive changes. However, there is no single stereotypical community experience of mental health in rural and remote Australia. The diversity of small communities make the delivery of services more complex. Yet the heterogeneity of these communities may lead to an approach more responsive to individual needs, practices and subjectiveness. This may mean accepting a wider range of support services, provided they are effective. There is growing evidence to support local community responses – where options include activities focusing on members' strengths and abilities rather than their illness; the use of peer workers; community wellbeing centres; and outreach services that do not depend on the availability of psychiatrists, psychologists or GPs[41]. In South Australia, the SA MHC visited rural and remote areas across the state to hear from local community members about their own experiences. They heard from towns pulling together programs to support people at risk or experiences mental health issues. There was growing evidence that community capacity building and using principles such as the Better Together principles and involving community stakeholders are resulting in some very well regarded programs.

Evidence suggests that stigma can be successfully impacted by promotion campaigns and training. We suggest supporting campaigns targeting awareness of mental illness specifically in rural and remote communities using the example of other effective campaigns such as the Buckle Up Princess campaign. In addition, training such as Mental Health First Aid can be provided in places where rural and remote communities gather, for example libraries and council chambers.

> The Commissions supports:
>
> 5. Training local community members to provide health promotion and recovery support services in rural and remote areas. Their life experience, expertise and local knowledge could be utilised to break down stigma, promote mental health literacy, encourage the use of formal specialist services and assist with suicide prevention. This could complement the more formal peer workforce being developed in non-metropolitan communities.

D. The challenges of delivering mental health services in the regions

The provision of quality and accessible mental health care in rural and remote locations is an ongoing challenge in Australia. Fewer mental health specialists are available when people need to access assistance for mental health concerns and people generally need to travel over greater distances to deliver or receive care. The lack of available services results in many people not accessing prevention, primary health care and early intervention services: they present late, are diagnosed late and often are at a more advanced stage of illness, with corresponding physical comorbidities.[42] The additional challenges people face in making a complaint about services in a small community where people may know each other outside the service relationship, and the issue

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[41] NSW MHC (2014) *Rural communities* Avail at https://nswmentalhealthcommission.com.au/mental-health-and/rural-communities
[42] National Mental Health Commission (2014), above n 5

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of lack of other options or choices in services.

The Better Access initiative was implemented in 2006 to improve treatment and management of mental illness within the community, providing an affordable option for people with high prevalence disorders such as depression and anxiety to access mental health services, specifically evidence-based psychological therapy. While data indicate greater utilisation of Better Access within major cities and inner regional areas (Figure A.1), often within rural and remote contexts consumers are reliant on the Better Access scheme due to specialist mental health services being unsustainable in such contexts. Therefore, ensuring a Better Access scheme that specifically meets the needs of the rural and remote context is essential.

Figure A.1: People receiving Medicare-subsidised mental health-specific services, by provider type, remoteness area, 2016-17.
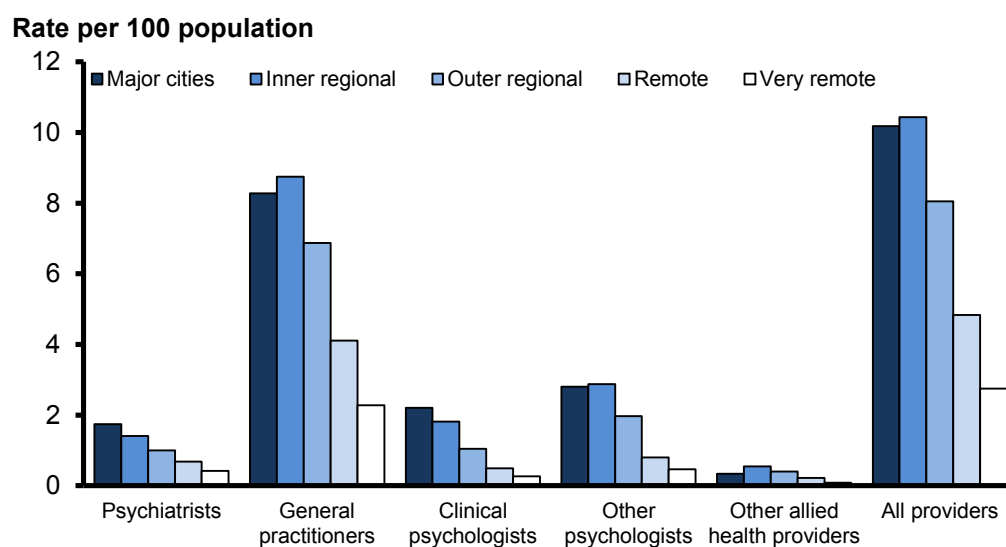
One limitation that has been identified is that Better Access no longer is sufficiently funded to treat more severe presentations of high prevalence disorders. In 2011 in order to reduce costs, sessions available through psychologists and other eligible allied health providers were reduced from 18 to 10, despite lack of clinical evidence to justify this change. However, this change has now resulted in those with more severe mental health presentations being unable to access sufficient treatment, a specific barrier in the rural and remote context where alternative government funded services are not available. Therefore, it is recommended that changes be made to Better Access with the rural and remote context in mind including, increasing the number of sessions available for severe high prevalence disorders, and increasing health professionals able to provide services in rural and remote contexts through the exploration of a rural and remote loading. Further, the introduction of Better Access Telehealth initiative has improved access but additional recommendations are discussed below (Section F).

The Commissions recommend:

6. For severe and complex mental illnesses, enable an extra six Medicare-subsidised sessions of psychological therapy as clinically determined (a total of 16 in any one year).

7. The investigation of adding a rural and remote load for health professionals under Medicare-subsidised mental health services, to determine if it would entice/retain health professionals to live and work in rural and remote Australia.

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In addition, people in rural and remote Australia are more likely to engage in behaviours associated with poorer health outcomes in general, which can also impact on mental health. This includes higher rates of daily smoking, alcohol intake, overweight and obesity, and lower levels of exercise.[43] Yet it's not only specialist mental health services that are thin on the ground in rural Australia, so are the other related issue-specific services that deal with children's mental health, relationship problems, drug and alcohol problems, domestic violence and gambling. Services that require consumers to travel long distances, pay for accommodation and possibly forgo income cannot be considered readily accessible.

Higher death rates and poorer health outcomes outside major cities, especially in remote areas, also reflect the higher proportion of the population in those areas who are Aboriginal and/or Torres Strait Islander Australians. Along with generally poorer health outcomes of Indigenous Australians, educational, economic, behavioural and cultural barriers can affect Indigenous people's access to mental health care.[44] Approaches to Aboriginal and Torres Strait Islander social and emotional wellbeing and suicide prevention within a rural and remote setting needs to be considered within each Indigenous communities unique cultural, historical and socio-economic context.

The Fifth Plan identifies as a priority "Improving Aboriginal and Torres Strait Islander mental health and suicide prevention". The Commissions consider that the current consultation, *Close the Gap Refresh*, initiated by the Council of Australian Governments, provide a real opportunity to authentically partnering with Aboriginal and Torres Strait Islander leadership and bring the priority of mental health and suicide into the new Closing the Gap framework, targets and performance indicators.

The Commissions recommends:

8. Ensuring that there is continued effort and investment in the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing* through the Closing the Gap Framework and the Indigenous Advancement Strategy, and that Aboriginal and Torres Strait Islander people lead the development and implementation of solutions.

E. Attitudes towards mental health services

Anecdotal evidence from engagement with local communities has indicated that discrimination due to mental illness is a factor which affects whether a person seeks services in their town. People living with mental illness tell us that stigma and discrimination are very common experiences for them. This acts as a barrier to people receiving the support they need, when they need it. For some, anonymity is important and they will travel to the next town or regional centre to get the support they need, if it is available and they are seeking help or know where to seek help from. We know about 46% of people don't seek help for mental health issues.[45]

A joint rural and remote survey in 2017 by National Farmers Federation and the Royal Flying Doctor Service (RFDS) found that those living in rural and remote Australia:

- identified mental health as the second most important health issue impacting rural and remote communities; and

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[43] Australian Institute of Health and Welfare (2017) Rural & remote health: Health risk factors and remoteness, avail https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/health-risk-factors-and-remoteness

[44] Australian Institute of Health and Welfare (2015) The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW

[45] National Mental Health Commission (2017) 'The 2017 Report on Mental Health and Suicide Prevention', Sydney: National Mental Health Commission

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- nominated access to medical services and mental health as the two top areas for additional funding to improve health outcomes.

The 2016 '*Survey of Health Care: selected finding for rural and remote Australians*'[46] found:

- Three in five people in *Remote/Very remote* areas said not having a specialist nearby stopped them from seeing one.
- People in *Remote/Very remote* areas were the most likely to report going to an Emergency Department because no GP was available.
- People reported decreasing information sharing between health providers as remoteness increased.

There is a significant amount of research available on attitudes towards mental illness. However, there is not a lot on the attitudes towards mental health services. Attitudes or experiences of mental health services according to those who live in major cities or rural and remote Australia is also not collected.

Interest is growing in strengthening and coordinating efforts to collect patient-reported information to benefit consumers and the health system as a whole. The ABS's Patient Experience Survey is undertaken annually to report on patient experiences of health care services (in general) in Australia. It does not report on experiences of mental health services, despite strong interest at the national level – which could support quality improvement, service evaluation and benchmarking between services. The Fifth Plan also includes a performance indicator on the proportion of consumers and carers with positive experiences of service. The development of instruments designed to measure patient experiences is ongoing and is supported by the Commissions.

The Commissions support a recent call by Community Mental Health Australia for the establishment of a national mental health consumer peak organisation which would provide a united national voice for mental health consumers. The call comes as the mental health sector undergoes a significant period of reform which is all about giving consumers choice in the care they receive and creating a system that is person-centred. The new stand-alone organisation would ensure that the design and delivery of programs, policy, and services effectively address what matters to consumers including rural and remote consumers.

> The Commissions support:
>
> 9. The establishment of a national mental health consumer peak organisation to provide a united national voice for mental health consumers including rural and remote consumers.

The mental health sector is undergoing a significant period of reform which is all about giving consumers choice in the care they receive and creating a system that is person-centred. The new stand-alone organisation would ensure that the design and delivery of programs, policy, and services effectively address what matters to consumers and carers especially in rural and remote areas.

F. Opportunities that technology presents for improved service delivery

Internet connection is a significant barrier for people living in the regions being able to access quality mental health services. Low download speeds and unreliable internet access have been raised as significant barriers through consultations undertaken by the NSW Commission. Loss of telephone land lines has also been raised as an issue, with lines not being upgraded and resulting in an increased reliance on internet access.

Technology enables communities' easy access to e-mental health such as peer support, which is a relatively untapped resource. However, there is a need to ensure that people are accessing

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[46] Australian Institute of Health and Welfare (2018), above n 8

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evidence-based online care and it is part of the broader mental health system that enables consumers and others (including clinicians) to meet the needs of the individual – and their families and support people – in the way they want them met.

Young people, in particular, have told us that technology and access to support out of hours in an anonymous way is critical. This becomes even more important for young people living in rural and remote areas where support and services availability is scarcer.

The *2014 Review*[47] recommended two solutions have been repeatedly advocated to overcome the persistent challenges to improving mental health in regional, rural and remote areas.

The first is improving access to services using technology by continued and increased investment in telehealth. It is now possible to provide much-needed assistance and interventions in real time by telephone or over the internet. The expanded use of the MBS telehealth items could help to reduce rates of hospitalisation and out-of-area hospital transfers and enable 24-hour emergency access to required services and advice. E-mental health services need to be promoted more strongly and embedded as a routine form of treatment and referral pathway.

The potential benefits for rural communities is apparent with recently launched *Head to Health*, a new consumer-friendly digital mental health gateway that is promoting and triaging available telephone and internet based mental health services in Australia. We suggest that the current service catalogue list is extended to include State and Territory services, and those of public and private organisations, not just Australian Government ones.

The Commissions support:

10. Extend the *Head to Health* scope of listed services to provide greater choice and information for how people in rural and remote areas can access the right care.

11. Increase the functionality of *Head to Health* to make resource cards downloadable in the absence of adequate internet access.

The second solution is to train local community members to provide health promotion and recovery support services in these areas. A recommendation for enhancing community engagement is provided at C, the nature of the mental health workforce.

Technology-based approaches can be applied to providing mental health services and resources in rural and remote locations in a variety of ways, including for the provision of education regarding mental health conditions and their prevention and treatment, psychological and psychiatric treatment and allied health therapy. Delivery and communication methods include websites, email, SMS, virtual reality, computer programs, blogs, social networks, online forums, telephone, video conferencing, and can also extend to computer games, instant messaging and podcasts. Key to achieving this is the quality of access to internet facilities/services.

The Fifth Plan calls for action to support an integrated approach to transitioning to digital mental health platforms, identifying and harnessing opportunities.

Better Access Program - Telehealth Measure

The uptake of video consultations has grown steadily since the introduction of Medicare rebates and incentives for eligible practitioners. The Commissions welcome the recent expansion of the Better Access initiative to include new Medicare items that allow people in Modified Monash Model[48]

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[47] National Mental Health Commission (2014), above n 5

[48] Department of Health (2016) Modified Monash Model. Canberra: DoH. avail
http://www.health.gov.au/internet/main/publishing.nsf/content/modified-monash-model

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regions 4 to 7 to access up to seven of 10 consultations through video conferencing. However, this expansion does not go far enough to really improve equity of access in rural and remote areas. A significant limitation of the telehealth measure is the requirement that one of the first four sessions is delivered face-to-face. People living in rural and remote areas of Australia may need to travel long distances or relocate to attend health services or receive specialised treatment, which places additional burden with regard to travel expenses, friends and family and employment. These expenses are variable and difficult to quantify, but increased expenditure could deter people from accessing particular services.

This barrier could be resolved through either firstly; the removal of the face-to-face requirement of telehealth, or alternatively the face-to-face session requirements could contain a caveat that allows this component to be waived subject to criteria on distance or other barriers to access at the clinician's discretion.

> The Commissions recommend:
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> 12. Removal of, or introduction of a caveat allowing for wavering of the face-to-face component of the Better Access Telehealth initiative where access issues are a significant barrier.

Additionally, mental health workers are ineligible for incentive payments which may act as a disincentive for people in rural and remote areas.

SANE – *Building Thriving Communities through Social Connection* – a national project

Social isolation is common among people with complex mental illness, especially for those who are geographically isolated, and that this has a significant impact on wellbeing, recovery and community participation. In April 2016, the National Mental Health Commission provided funding for SANE Australia to pilot the *Building Thriving Communities Through Social Connection initiative* (Thriving Communities). The aim was to enhance meaningful social connection through online peer support for Australians affected by complex mental illness, particularly those in rural and regional areas. The project demonstrated that online peer support can provide emotional support, companionship and opportunities for meaningful social engagement which have an influence on help-seeking, effective coping strategies and sense of wellbeing. It also showed this approach is effective at increasing participation of people in regional and remote areas with the advantage of being accessible in all parts of Australia where the Internet is available.

G. Any other related matters

In addition to improving access and quality of mental health services for people living in rural and remote Australia, cross-sector investment into actions which promote mental health and wellbeing and support early intervention to reduce and prevent the impact of mental illness across the life course is required. Communities and people with a lived experience of mental health are fundamental to informing mental health reform and should be involved in the design, development, implementation and evaluation of responses. This is highlighted as part of the Fifth Plan under Priority Areas 7 and 8 (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).

> The Commissions recommend:
>
> 13. Ensuring communities and people with a lived experience of mental health are involved in design, development, implementation and evaluation processes advising on mental health reform.

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