CARPA oral submission for Senate Community Affairs Reference committee
Inquiry into rural and remote mental health services
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Opening Statement:
Central Australian Rural Practitioners Association (CARPA) was formed in the late 1980s by health care providers who saw a need to support remote health practitioners in the delivery of quality health care in unique and challenging settings. CARPA is a loosely structured, voluntary organisation with members from across Australia. Members join because they are passionate about remote health and bring this passion and their expertise in different areas to the organisation.

CARPA core activities include:

- Supporting education and professional development – through sponsorship of forums such as the AMSANT leadership forum, Chronic Disease NT, SARRAH & CRANA+ conference.

- Developing resources such as the "Orientation to Remote Primary Health Care manuals" video, which are freely available to all via its website.

- Playing a key role in the governance and production of the Remote Primary Health Care Manuals, a suite of clinical guidelines for primary health care practitioners in remote and Indigenous health services, which guide clinical practice in many areas of rural and remote Australia.

Inquiry Scope & Terms of Reference:

The accessibility and quality of mental health services in rural and remote Australia, with specific reference to:

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

    - Covered in detail in others submissions, notably NRHA and CRANA+
    - Maslow hierarchy of needs
    - Stigma, fear – welfare involvement, DFV, jail
    - Lack of services, child and youth, perinatal, AOD, psychological, counselling, trauma, cognitive assessment, services for intellectual impairment, clients bounce between
    - Medicare billing
    - Cultural appropriate, interpreters, enmeshed/contextually appropriate services
    - Point of access; usually via acute/crisis,
    - Sustainability ie what is in place post crisis or prevention,
    - Respite services
    - Preventative services – social welfare
    - Lack of public transport

PATS
Lack of access to counselling and other psychological services (CBT), leads to use of medication as first line treatment even for mild mental health conditions. This leads to over-medicalisation with risk of medication side effects including sedation, weight gain and risks of drug interactions.

One partial solution to this issue is related to Patient Assisted Travel Schemes. These are funded through the Commonwealth so are similar nation-wide, which is strength because of the mobility of health professionals so we don't need to learn of different rules in each locality. However PATS is limited to referrals from a medical doctor to a medical specialist. Often neither of these is essential, with non-medical practitioners capable of making many of the referrals, and allied health staff being the appropriate specialist service particularly for mental health issues requiring psychological treatment. As a result remote doctors may tend towards medical referrals with limited usefulness in order to access allied health. Common examples are chest and dental x-ray and pelvic, renal and liver ultrasound http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-pats.pdf.

Recommendation: PATS be allowed for non-medical services including psychologist, social work, mental health nurse and others in the mental health team.

b. the higher rate of suicide in rural and remote Australia;

- Impulsivity
- Main stream teachings how to manage not necessarily applicable
- Suicide story program: https://mhaca.org.au/education-and-community-awareness/aboriginal-suicide-prevention/
- Aboriginal Youth Suicide in Central Australia: developing a consistent data system and referral pathway, 2013, http://www.flinders.edu.au/medicine/fms/sites/poche-alicesprings/documents/MHACAReport%20Youth%20Suicide.pdf

c. the nature of the mental health workforce;

- Generalist nurses, some with training or understanding in mental health, limited child and youth, perinatal
- Need more Aboriginal Health Practitioners mental health with understanding of two systems, traditional and medical
- Need programs like NPY Uti Kulintjaku to build up capacity in communities https://www.npywc.org.au/ngangkari/uti-kulintjaku/
- Scott Truemans thesis, 2016: RN caring for mental health clients in remote Australia
- https://researchonline.jcu.edu.au/46135/1/46135-trueman-2016-thesis.pdf
- Youth workers/services, education pick up much of load
- Need support services similar to CRANA+ Bush Support Service https://crana.org.au/workforce-support/bush-support-services/ for remote youth workers, teachers, police, women centre, art centre workers

d. the challenges of delivering mental health services in the regions;

- Costs
- Technology
- Safety
- Economies of scale
- Recruitment and retention – little incentive in very remote Australia, housing, safety, working conditions, costs, continuing professional development, acute care,
- Sustainability – short term grants
- Cross border issues – different mental health acts in each state and Territory

- Silo services
- Cross service communications – acknowledged positions – understanding of each services strengths and weaknesses, scope
- Cultural understanding
    - Growing up our way: the first year of life in remote Aboriginal Australia 2012, http://journals.sagepub.com/doi/10.1177/1049732311432717
    - Hear our stories: child rearing practices of a remote Australian Aboriginal community 2012, https://espace.library.uq.edu.au/view/UQ:330940

e. attitudes towards mental health services;
- Stigma
- Understanding of services
- Cultural context
- Lived context vs FIFO/DIDO

f. opportunities that technology presents for improved service delivery;

Telehealth Medicare requirements

Aboriginal health services depend on Medicare because they are under-funded to work autonomously. In effect they are not community controlled but controlled by the demands of funding, Many invest resources to increase billing Medicare of whenever possible for services even though Medicare requirements are based on the mainstream GP model rather than collaborative model that is the strongest feature of Aboriginal community controlled organisations. ACCHOs often have a team of staff whose entire role is to optimise Medicare billing.

Mental health services would intuitively seem to be ideal for telehealth, because they depend on oral and visual communication, and there is little requirement for the mental health specialist to touch or be in the same room as the patient, particularly if there is a health professional with the patient.

However for ACCHOs to bill Medicare for specialist services, including psychiatry, the specialist must also bill Medicare. Since most psychiatrists who provide services for ACCHOs are salaried doctors, they do not bill Medicare. As a result, the ACCHO cannot bill Medicare. This is a significant reduction in income for the ACCHO and acts as barrier to Telehealth and high quality mental health services.

As per MBS online: “Patient end services can only be claimed where a Medicare eligible specialist service is claimed”.

http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/connectinghealthservices-patients-QA

Recommendation: ACCHOs and other rural primary care services can bill Medicare for patient–end at specialist consultations whether or not the telehealth psychiatrist bills Medicare.

- big focus on technology in many submissions
- has its place, but doesn’t substitute for face to face interaction
- “therapeutic relationship” crucial
- Underlying infrastructure needs to be in place
- Dangers – Cyber Safety in Remote Aboriginal Communities, 2018, http://apo.org.au/system/files/172076/apo-nid172076-789941.pdf

g. any other related matters.

Strengths-based approach

While prevalence of almost every health condition increases as remoteness increases this is not the case for mental health issues, as identified in many submissions. We need research to explain this, as results could be used in health promotion and disease prevention initiatives.

What are the features of rural and remote life that protect against mental illness? Exposure to nature, relationships with the natural environment, stronger and more close-knit communities where people interact with those they know, reduced commuting time. While it would be ironic to take health leadership from rural to urban areas, it is important to focus on strengths and qualities of rural life rather than its perceived costs and deficits compared to urban life.

Recommendation: Target strengths-based approaches to research for rural and remote health, rather than focus on deficits and costs.