Senate Enquiry on Access to Mental Health Services in Rural and Remote Australia

Introduction

The Centre for Rural and Remote Mental Health (CRRMH) is based in Orange NSW and receives a major grant from the NSW Health Mental Health Branch. It addresses three key objectives: the promotion of good mental health, improving rural mental health services, and working with rural communities to prevent suicide. The CRRMH is a leader in rural and remote mental health expertise and research in Australia. It has an exceptional track record of conducting high quality research and delivering exceptional evidence-based programs and services that improve mental health and wellbeing.

The Centre has a small research team that works collaboratively with University of Newcastle colleagues and others in Australia and overseas. The CRRMH publishes widely in local and international journals, and presents regularly at conferences and in 2017, the CRRMH brought in more than $700,000 in new direct research funding. Our research focus areas map to our priorities and include community wellbeing collaboratives, low intensity mental health services, integrated care and understanding and preventing rural suicide. The programs we run are based on the best available research and evaluated to determine their effectiveness. For more information see www.crrmh.com.au

The CRRMH provides two major programs: the Rural Adversity Mental Health Program (RAMHP) and Good SPACE, a rural Suicide Prevention Program. These programs are unique, developed in response to rural needs and are evidence-based. The aim of RAMHP is to support rural and remote communities in a number of ways: linking people to mental health services and resources; training workplace and community members to recognise and provide support to someone who they think may be experiencing a mental health problem; informing and raising awareness around mental health and wellbeing; responding in times of severe adversity, such as drought; and partnering with services and organisations in rural NSW to increase RAMHP's impact in rural communities.

RAMHP has an extensive geographic reach across all NSW Local Health Districts, with 14 RAMHP coordinators based across the state. In 2017, RAMHP linked 1,947 people to mental health support services and resources, and 419 different training courses were delivered to 8,542 people. RAMHP has also built strong partnerships with various government bodies and non-government organisations including the Department of Primary Industries, Country Women's Association, The Land, NSW Farmers and Local Land Services.

Good SPACE is an evidence-based suicide prevention project that aims to prevent suicide through community and clinical education. It offers workshops and training sessions, including an Aboriginal Suicide Prevention Workshop (We-Yarn) and a suicide prevention community workshop. The overarching goal of the Good SPACE Suicide Prevention Program is to help community members recognise suicidal behaviour and provide practical help in their communities and workplaces.

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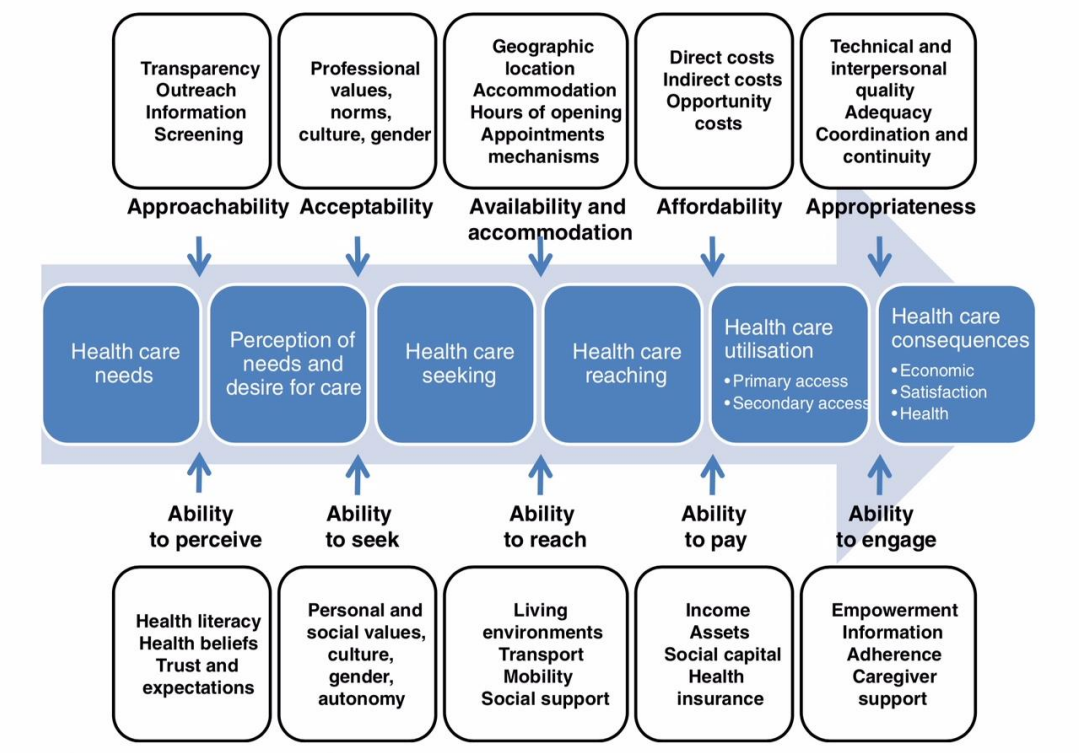
This submission does NOT represent the views of the New South Wales Government, who provide an operating grant to the CRRMH.

Our key messages address the key enquiry questions:

1. Lower access to services

- Rural and remote areas vary according to social, demographic and economic factors. Some rural communities are relatively wealthy and well served, others are struggling and have major challenges of access to mental and physical health care. One size or solution will not fit all and the logic of regional planning in the Fifth National Mental Health Plan makes sense.
- Mental health needs include high prevalence (e.g. anxiety, depression, substance abuse) and low prevalence conditions (schizophrenia, psychosis etc). Many individuals with mental health problems will also have physical health problems. The state government focus is on low prevalence and Commonwealth primary health services largely address high prevalence conditions.
- It is not clear which, if any agency, is responsible or funded for the prevention of mental illness and the promotion of mental wellbeing.
- Rural communities face access challenges for all sorts of specialist and expert services due to demand factors whether for publicly provided, market based or subsidised services. This inequity of access cannot be left to market mechanisms or to incremental policy decisions and investments, it requires a holistic approach.
- Access to mental health services is a complex matter. There are a series of steps required to access health care which are influenced by supply-side and demand-side factors. These factors are well known and are illustrated in Figure 1.[1]

Figure 1 - A conceptual framework of access to health care (From Levesque et al, 2013).[1]



- The normal response to rural access problems has been to implement new services in public, private and voluntary sectors such as Headspace, ATAPS, Early Psychosis Centres, Better Access, Royal Flying Doctor Service Mental Health, New Access, online and many other services. This has created a very complex and fragmented service model which is difficult for funders, service providers such as GPs, patients and carers to navigate.

2. Higher rates of suicide

- In April 2017, the CRRMH hosted a Rural Suicide Prevention Forum at the Royal Sydney Easter Show, where 60 key stakeholders met to discuss rural suicide prevention. These stakeholders included politicians, policy makers, industry representatives and non-government and government organisations. These stakeholders were given the opportunity to discuss their thoughts and voice their concerns regarding the higher rates of suicide among those living outside of capital cities, and even more so in rural and remote areas.
- During the forum there was a series of short presentations that offered various different perspectives on the issue. Attendees identified the key issues that should be considered when planning and implementing suicide prevention strategies in rural and remote areas.
- From this Forum and informed by the literature, the CRRMH developed a Position Paper on Rural Suicide and its Prevention. The paper addresses the key issues of higher rates of suicide in rural and remote areas of Australia.[2]
- Drawing from data from 2016, the number of suicides in rural and remote areas per 100, 000 people, was 50% higher than that in city areas. [2]
- Additionally, data from 2012 to 2016, found the rate of suicide for the Indigenous population was 23.7 per 100,000 people; more than twice that of non-indigenous Australians over the same period, 11.6 per 100,000 people.[3]
- It is a complex question, aggregate figures for rural suicide are higher than in major capital cities but numbers vary over time and between communities. It appears that the metropolitan strategies are not working in rural and remote communities. The rates of death by suicide have been coming down in greater Sydney and greater Melbourne but not in rural Australia. Our analysis suggests that we must focus on both short and medium-term strategies to prevent rural suicide. We have made the following suggestions in our position paper based on evidence and consultation.

CRRMH Rural Suicide Prevention Strategies	
Short term strategies:	1. Prevent people who are suicidal from taking their own lives
	2. Help those who are affected by suicide
Medium term strategies:	3. Provide support to vulnerable groups in rural communities
	4. Build protective factors in children and young people
	5. Build healthy and resilient communities

3. Challenges in delivering mental health services in rural areas

- These challenges are well known. The MBS schedule provides reimbursement for part of the cost of health services and the rates favour short interventions provided by medical practitioners and not extended consultations for patients with mental health problems.
- Similarly, the introduction of activity based service funding and the structure of private health insurance schedules do not favour comprehensive care for rural residents with mental health problems.

4. The mental health workforce

We conducted a major review of workforce issues for the National Mental Health Commission in 2014.[4] We do not believe that the numbers have changed significantly.

- Our broad recommendations were as follows:

Recommendations for the mental health workforce
1. Retrain general nurses as mental health nurses
2. Undertake a study of the psychologist workforce
3. Build the capacity of primary care services to increase access to mental health care and promote prevention and early intervention
4. Co-locate a proportion of Community Mental Health Staff within Primary Care
5. Support the development of the peer support mental health workforce
6. Establish the infrastructure for competency-based workforce planning and development for mental health services.

- This approach focusses on building mental health capabilities within GP and community health services and emphasising prevention and early intervention.

5. Attitudes towards mental health services

- Attitudes towards mental health services which contribute towards restricted access and poor outcomes include those held by funders, providers, clients/community.
- Funding of rural mental health services is rising but it is much less than that available for physical conditions with a similar burden. Funding is often rationed to a limited number of sessions in a way that is not the case for physical illness. The funding of mental health services is often opaque, and reporting of expenditure and outcomes is not transparent. This has resulted in what might be called structural inequality for those with mental health problems in which poorer treatment is embedded within service systems.
- While modern epidemiology recognises the prevalence of co-morbidity and the co-occurrence of mental and physical conditions, many health services fragment treatment, usually focussing on physical conditions. Thus, this is a missed opportunity as mental health problems may inhibit a person's ability to self-manage their chronic, physical illnesses. Furthermore, when people are treated solely for mental illness, their physical needs may be neglected; such as for those who are treated with anti-psychotic medication and develop metabolic syndrome as a result of treatment.

6. Opportunities for technology

- Australia has been a pioneer in research and development of IT platforms for the delivery of online care often based on Cognitive Behavioural Therapy (CBT)-based interventions. These interventions, whilst having good clinical evidence of effectiveness, have not been widely adopted or promoted in rural communities.
- Effective marketing and promotion of e-Mental Health interventions are recommended and the Commonwealth Government's Head to Health Digital Gateway (https://headtohealth.gov.au/) represents a great first step, but needs better promotion.
- Similarly, Australia has been a pioneer in the use of tele-psychiatry but while MBS reimbursement items for clinicians and latterly for psychologists have been introduced, their use is not widespread nor is it part of integrated rural health service models in most parts of Australia.
- Services delivered via technological platforms have much to offer when part of a coherent rural service model.

7. Opportunities in effective data collection, linkage and reporting

- A broader issue in mental health is the inability to measure the ongoing impact of investments in one area of mental health on other areas, for example, primary care on tertiary hospitalisations. This is a lost opportunity to

fully understand the impact of service developments on the health system, the provision of transparency and allowing the prioritisation of resourcing based on evidence.

- This recommendation is echoed in the recent *Investing to Save* economic analysis of investing in mental health reform by Mental Health Australia and KPMG.[5]
- The establishment of the Primary Mental Health Care Data Set (PMHC-MDS) is a positive step and the opportunity should be taken to widen its linkage to other health and social care data sets.
- There are a number of challenges to achieving this including a lack of expertise (data literacy, data entry and collection capacity, database architecture and analytic capacity), cultural aversion to data sharing (even where legislation permits, jurisdictional/political complications of Commonwealth, State/Territory and private practice) and the cost.
- It is important to improve the resolution of population health data including that of mental health, and the resourcing to oversample in rural areas for effective sample sizes.
- An update of the National Mental Health and Wellbeing Survey 2007, should be considered.

8. Recommendations

- Australian governments, funders and providers should adopt the policy and practice of **parity of esteem for mental health problems** and practices which means 'valuing mental health equally with physical health'.[6]

Parity of esteem:
Implications of valuing mental health equally with physical health

- Equal access to the most effective and safest care and treatment
- Equal efforts to improve the quality of care
- The allocation of time, effort and resources on a basis commensurate with need
- Equal status within healthcare education and practice
- Equally high aspirations for service users
- Equal status in the measurement of health outcomes[5]

- Primary Health Network (PHN) and local mental health service commissioning arrangements are immature. Many rural PHNs have found it difficult to recruit the skills needed to lead regional mental health planning and this is not made easier by short term funding which impacts on the duration of contracts with mental health service providers. This, in turn, weakens rural service providers who face particular challenges in building and retaining a skilled workforce. Thus PHNs need time and support to mature, and to work with local services to commission effective mental health services fit for the needs of rural communities.

*The combination of **local mental health service planning/service commissioning** and **parity of esteem for mental health problems** has much to offer rural communities but it will require agreement from all levels of government, health service funders and providers. This will have implorations for legislation, regulation of health insurance providers, the education and training of clinicians, and the measurement and reporting of health service performance and population health more broadly.*

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