

MENTAL HEALTH CARE IN RURAL AUSTRALIA

A RDAA background paper





CONTENTS	Page
1. Introduction	1
2. Background	2
3. Key Issues	3
Funding and funding cycles	3
Service provision and integration	4
Role of rural GPs	5
• Training	5
• Infrastructure	6
• Remuneration and incentives	7
• Workforce	7
• Referral pathways	8
• Community education	8

1. INTRODUCTION

In rural and remote Australia inadequate access to high quality mental health care is of major concern to people experiencing mental health disorders and their carers, and to health professionals and other individual, organisational, community and government stakeholders.

People with mental health disorders interact with many different areas within the mental health system especially if they have multi-morbid conditions or issues that increase complexity and levels of need, such as alcohol and other drug and/or violence issues. They also often interact with a range of other government and non government services, including homelessness, housing, justice, education and employment services.

Although there have been some significant advances in mental health policy and services since the 1990s, the mental health care system is still characterised by unclear lines of responsibility and is not easily navigable by people with mental health disorders or their carers. Coordination between services is rarely, if ever, seamless and fragmented care is a common experience, with some people falling through service cracks as they are “bounced” from one type of service to another.

Mechanisms for funding, organising and delivering mental health care are complex; spanning government and non government agencies and organisations and involving a web of health, social and community services providing treatment, assistance and benefit payments. These underlying systemic issues in providing mental health care are well recognised having been identified in several reviews. The *2014 National Review of Mental Health Programmes and Services* (the Review) found that

... the mental health system has fundamental structural shortcomings. This same conclusion has been reached by numerous other independent and governmental reviews.

The overall impact of a poorly planned and badly integrated system is a massive drain on peoples’ wellbeing and participation in the community—on jobs, on families, and on Australia’s productivity and economic growth.

... we lack a clear destination in mental health and suicide prevention. Our “mental health system”—which implies a planned, unitary whole—is instead a collection of often uncoordinated services introduced on an often ad hoc basis, with no clarity of roles and responsibilities or strategic approach that is reflected in practice.¹

Clearly, there has long been a need to develop a long term, strategic and proactive plan to address mental health care needs in Australia, which is mindful of the impact social, cultural and environmental determinants of health have on people experiencing mental health disorders and the complex interrelationship of mental health services with other health, social and community services.

The Australian Government’s response to the Review², released in November 2015, offers a positive agenda in relation to primary and community care. Implementation of the identified reform measures, if effectively instituted, will go some way to achieving systemic improvement.

¹ National Mental Health Commission, 2014: *The National Review of Mental Health Programmes and Services*. Sydney: NMHC. Available at <http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx>. Accessed 07 May 2015.

² Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response>

However, a number of concerns in relation to mental health care in rural and remote communities remain.

Investment targeted to groups who are at greater risk of harm from mental health disorders, including those who live in rural and remote communities and/or who are Aboriginal and/or Torres Strait Islander people, is essential to redress the inadequate, inaccessible and disjointed support and high levels of unmet needs that persist in rural and remote Australia. Specific support for rural GPs is critical to improving mental health care in rural communities.

2. BACKGROUND

Although the overall prevalence of mental health disorders is largely similar in rural and urban areas, death rates from mental illness are higher in rural areas³. The *Medical Research and Rural Health Garvan Report 2015* notes that an estimated 960,000 adults living in regional, rural and remote areas have experienced a mental disorder in the previous 12 months and that the rate of suicide is 66% higher in the country than in major cities.⁴ Farmers and farm labourers, for example, are both at a heightened suicide risk compared to the general population.⁵

This is a reflection of the unique circumstances of rural life. While it offers greater community connectedness there are a number of other factors which impact negatively on health and wellbeing. Many rural and remote areas experience socio-economic disadvantage and are increasingly impacted by the environmental extremes of adverse weather, fire and other disasters as remoteness increases. The individual and community mental health implications of significant events which cause economic and social hardship — such as the closing down of a facility which employs large numbers of local people — are rarely fully understood and little, if any, support to mitigate negative effects is provided.

Rural people are less likely to seek medical help for health issues, are more likely to delay visiting a doctor and are wary of stigma. Help seeking behaviour may also be influenced by other factors including cost, transport issues and the perceived relative importance of other events such as harvest or shearing time. Rates of risky health behaviours are also higher than in urban areas as are rates of gun ownership. Other contributing factors include greater risk of accidents and physical injury (particularly in farming and mining), uncertainty of employment and financial stressors, relationship pressures and substance misuse.

Mental illness compounds existing social disadvantage and damages chances for social and community participation. Although it can affect any person at any time, at a population level mental illness disproportionately affects those who already experience some level of disadvantage and who are often those with the least access to mental health support. Those living in rural, regional and remote communities have lower access to support for health problems compared with metropolitan areas⁶.

³ <https://www.ranzcp.org/Publications/Rural-psychiatry/Mental-health-in-rural-areas.aspx>

⁴ Available at: <http://www.garvan.org.au/news-events/news/garvan-launches-inaugural-rural-health-report>

⁵ Arnautovska U, S McPhedran, De Leo D. *Differences in characteristics between suicide cases of farm managers compared to those of farm labourers in Queensland, Australia*. Rural and Remote Health 15: 3250. (Online) 2015. Available at: <http://www.rrh.org.au>

⁶ National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services, Vol. 4, Paper 2. Sydney: NMHC. Available at <http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx> Accessed 07 May 2015.

A shortage of, and insufficient access to, appropriately trained mental health clinicians and other health professionals and to mental health treatment and support services, including crisis services, hospitals and other facilities, present significant challenges to maintaining mental wellbeing and accessing treatment for mental health disorders in rural communities. In many areas lack of access to regular, reliable and affordable transport and communication systems and other geographic and/or climatic barriers further compound the situation.

Despite some initiatives to address access issues,^{7,8} socio-economic and geographical disparities still exist.⁹ The level of investment in mental health programs is inadequate and the uncertainty of ongoing funding worsens the situation.

Primary Health Networks (PHNs) have been tasked with improving frontline service coordination of care by working with general practitioners (GPs), Local Hospital Networks (LHNs) and other health care providers and services. Six key priorities for targeted work, including mental health, have been identified. Other areas for targeted work are Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.

While the Australian Government's response to the Review acknowledges the need for resourcing and accountability measures for PHNs, these are yet to be provided. Whether the levels of resourcing, the scope of their activity and their capacity to establish meaningful partnerships with stakeholders are sufficient to meet health care needs across all these areas in rural and remote communities, particularly when "market failure" occurs, is yet to be seen.

3. KEY ISSUES

RDAA believes addressing the following issues is necessary to achieve effective mental health care reform in rural and remote Australia:

Funding and funding cycles

Cyclical, short-term funding arrangements are deleterious to the provision of mental health care and other health services. *Long term planning is unable to be realised in the absence of ongoing funding. This in turn impacts upon people's confidence in the service.*¹⁰

There is a critical need for a bipartisan, long-term strategy to provide funding certainty for mental health care providers and services in rural and remote communities where a range of geographic, climatic and demographic factors may add to the expense of delivering services.

⁷ The federal *Better Access (to Mental Health Care)* policy initiative sought to improve access to psychiatrists, psychologists and general practitioners through Medicare.

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba>

⁸ There has also been some Federal Government investment in rural and remote mental health through specific grants and policy initiatives such as Mental Health Services in Rural and Remote Australia (MHSRRA). MHSRRA provides funding to non-government health organisations to deliver mental health services by social workers, psychologists, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers in rural and remote communities.

<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-rural>

⁹ Harris MG, Burgess PM, Pirkis JE, et al. Policy initiative to improve access to psychological services for people with affective and anxiety disorders: population-level analysis. *Br J Psychiatry* 2011; 198: 99-108 in Meadows GN, Enticott JC, Inder B & Gurr R. Better access to mental health care and the failure of the Medicare principle of universality. *MJA* 202 (4) 2 March 2015. pp190-195

¹⁰ PriceWaterhouseCoopers. 2011. *The Australian Government Department of Health and Ageing: Mental Health Service in Rural and Remote Areas Program evaluation*. January 2011 version 1.3 Final Evaluation Report. p15. Available at <https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-mhsrraev>

Moves to shift funding priorities in the mental health sector away from acute services to primary care and community based services to improve mental health outcomes into the future are a positive step. However, the devolution of responsibility for the provision of mental health care services to PHNs must be aligned with appropriate and transparent accountability measures to ensure that rural and remote communities receive equitable services and to mitigate the risk of any unintended consequences.

The purchasing or provision of any services that are in direct competition with general practices operating in rural and remote areas has the potential to undermine the continuity of care provided by rural doctors, the economic viability of rural practices and consequently, the retention of rural doctors in communities where they are most needed. This could have serious consequences for the delivery of after-hours, emergency and secondary care in rural and remote communities — including for mental healthcare, which is generally provided by GPs working from rural practices — severely compromising the quality of health care and health outcomes and exacerbating rural health disadvantage.

Furthermore, it is important to recognise that the expected improvement in outcomes from the refocusing of investment will take time and that it is critical to ensure that rural doctors have access to the necessary facilities and support to provide crisis and continuing care during and after the transition phase.

Service provision and integration

Many rural areas are currently facing diminishing mental health services. Integration of care provided by the remaining services is often poor, failing to take into account multi-morbidities particularly in relation to alcohol and other drugs. 'Bouncing' people between types of services is not uncommon and communication with social services is inadequate.

In particular, longer term care is not well addressed. There are notable deficiencies in relation to referral pathways, and ongoing psychiatric, psychological and nursing services. Measures to ensure timely and appropriate intra- and inter-professional communication, including discharge letters, are required to achieve the best possible outcomes for patients.

Access disparities also exist between states and territories. People living in cross-border towns can have better access to health professionals and services on one side of the same town. This is generally not an issue with respect to acute medical services, but is problematic for all levels of mental health care.

Appropriately funded person-centred and connected stepped care as outlined in the Australian Government's response to the Review, if realised, will be a positive step to improve this situation but it is important to acknowledge and address the specific socio-economic, geographic, climatic and demographic factors impacting on the provision of this type of care in rural and remote areas. These challenges are compounded by the difficulties associated with attracting and retaining an appropriately trained health care workforce and other workforces.

To address service provision and integration issues, PHNs must work with rural general practitioners to develop local solutions. In areas where commissioning of local services may not be possible, consultative, innovative and strategic approaches to developing solutions will be essential to effectively respond to needs in the shorter term while planning and instituting longer term, more sustainable measures.

Role of rural GPs

Rural GPs have a pivotal role to play in mental health care. They are frequently the first point of contact for those seeking help and may be the only local mental health care provider. They treat not only the individual but also deal with the consequences of poor mental health on families, friends and communities. Rural GPs, together with police, ambulance and Emergency Department staff, also bear the brunt of acute mental disorder crises.

They provide episodic and ongoing treatment and support often with limited referral pathways, as concentrations of psychiatrists and psychologists decreases markedly with increasing remoteness. Only one per cent of psychiatrists, and less than one per cent of psychologists, are employed in remote and very remote areas.¹¹ This means that in some areas medical support can be infrequent or absent. This lack of access contributes to poorer conversion to specialist psychological or psychiatric treatment in rural areas, increasing the burden on rural GPs.

Although the importance of GPs in providing mental health care has been recognised to some extent by the Australian Government^{12,13}, there is a need for better understanding on the part of policy makers, bureaucrats and other health professionals about the role rural GPs play in providing mental health care. The capacity of rural doctors to effectively respond to their patient and community needs is hampered by inadequate support in a range of areas. It is essential that funding be targeted to rural and remote areas to redress this situation.

Training

Training which is appropriate to rural circumstances must be made available and accessible.

This includes acknowledging that in Aboriginal and Torres Strait Islander communities, Aboriginal and Torres Strait Islander health professionals are best placed to meet those communities' needs. While training more Aboriginal and Torres Strait Islander mental health clinicians and other health professionals should be a priority, providing appropriate training in cultural safety for non-Indigenous health professionals working in these communities, and more generally, is necessary to ensure that the specific needs of Aboriginal and Torres Strait Islander patients and communities are met.

Adequate training in mental health for medical students, junior doctors and registrars and as Continuing Professional Development (CPD) to expand or maintain the currency of mental health care skill sets is essential to ensure that rural doctors are able to manage the clinical and other complexities associated with providing mental health care in rural and remote areas.

The provision of advanced training pathways for those GPs who have the motivation, interest in and commitment to mental health care is also needed.

¹¹ University of Newcastle. Regional, rural and remote mental health services: challenges, inequities and opportunities. Technical report to accompany advice and recommendations. Prepared for the National Mental Health Commission. p 29. Available at <http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives-thriving-communities-review-of-mental-health-programmes-and-services.aspx>

¹² <http://health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-p-mono-toc~mental-pubs-p-mono-bas~mental-pubs-p-mono-bas-acc~mental-pubs-p-mono-bas-acc-pri>

¹³ "Working together for better rural mental health" media release. Senator the Hon Fiona Nash, Assistant Minister for Health, 13 November 2014. Available at <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2014-nash065.htm> Accessed 6 August 2015.

There must also be some recognition through appropriate supports of the time, effort and financial impost involved for rural GPs undertaking training. This could be achieved by providing additional funding through the current procedural grants program to provide opportunities for training in mental health.

The work of GPs in providing mental health care must be underpinned by an appropriately trained, resourced and supported broader health workforce. Mental health training must also be provided for these professionals and for other social and community sector workforces including police, employment and housing workers.

Current training arrangements for some health careers, including rural and regional training requirements for psychiatrists and psychologists, can create unhelpful perceptions about the relative status of rural to urban practice. This can impact negatively on rural areas with respect to attracting and retaining these health professionals. Training must include rural exposure to ameliorate this situation.

Infrastructure

There is a need for improvement in both physical and technological infrastructure to support mental health care in rural and remote Australia.

A greater emphasis on person-centred primary and community based care requires an accessible, appropriately trained workforce. Enhancing or expanding physical and technological infrastructure to facilitate the recruitment and retention of the necessary number of health practitioners, accommodating them and providing telehealth equipment and facilities is costly. Affordability is a key challenge especially in times of fiscal uncertainty. In addition to reestablishing an infrastructure grants program, innovative options for funding and better utilising rural health infrastructure should be explored.

Hospital-based care will also still be needed. In Australia there are no public acute psychiatric hospitals in rural or remote areas and only one such outer regional and one inner regional hospital in the private sector. There are only two outer regional and three inner regional public sub- and non-acute psychiatric hospitals.¹⁴ It is essential that rural hospitals have the facilities and resources to provide people experiencing an acute mental health episode with appropriate care and provide ongoing treatment and support for those experiencing sub- or non-acute disorders.

Australia's tiered healthcare funding means that emergency facilities and services are located within hospitals and funded by State and Territory governments. With the expected cuts to hospital health funding over the forward estimates as a result of the Federal Budget, there is a danger that the capacity of hospitals in rural and remote areas to provide services will be severely curtailed.

Many rural doctors provide a "generalist" medical service that spans general practice, hospital settings and residential facilities and often includes providing on-call and after-hours emergency services at the local hospital. Closure of these services would impact on rural general practice viability and have a far reaching and lasting impact on the provision of rural mental healthcare and other healthcare services and on rural communities more broadly.

¹⁴ Australian Institute of Health and Welfare 2015. Australian hospital peer groups. Health services series no. 66. Cat. no. HSE 170. Canberra: AIHW. Available at <http://www.aihw.gov.au/publication-detail/?id=60129553446>

Given the extent of mental health care needs in these communities, it is important to ensure that crisis and acute facilities and services are available, and that the capacity of rural doctors to provide episodic and continuing care is supported.

Remuneration and incentives

Approximately thirty per cent of Australians live outside major cities but *they do not receive anywhere near 30 per cent of funding and services for mental health*¹⁵. Only \$7 per capita is spent on Medicare funded mental health services in remote and very remote areas compared with \$43 in major cities.¹⁶ Moreover, the longer consultation time needed by GPs to provide effective mental health care is not reflected in Medicare Benefits Schedule (MBS) items. Current remuneration models for general practice services must be addressed to encourage high quality, comprehensive continuity of care and discourage throughput models. Further work to refine MBS items generally and specifically is necessary.

Realistic levels of financial and other resources are required to incentivise, recognise and appropriately remunerate rural doctors for the complexity of practice implicit in providing mental health care in rural and remote areas. Higher-level clinical decisions need to be made and greater responsibility taken when working in isolation where there are few professional supports, and limited diagnostic services and other health facilities.

Rural doctors providing this advanced level continuity of care should be recognised and recompensed appropriately. Quality indicators must be appropriate to rural practice.

Workforce

In providing for the mental health care needs of their patients, rural GPs face considerable time and other pressures including administrative impost, providing for the safety and security of their staff and themselves, and managing their practice as a business.

Some of these pressures would be alleviated by:

- providing support for team-based models of care and telehealth which would allow flexible support structures within the general practice and the capacity to utilise broader community resources. Many aspects of managed and stepped care can be undertaken by practice staff and community support staff or by mental health professionals via telehealth. It is important that these services be coordinated by the GP to ensure continuity of care.¹⁷
- developing a nationally consistent approach to clinical privileges to ensure that they are statewide rather than facility based (as is the case in some States/Territories) and transferable to other parts of Australia/ across State/Territory boundaries
- developing national safety guidelines for the management and transfer of aggressive and violent patients. Current protocols vary between States and Territories.

¹⁵ National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC. Fact Sheet 3. Available at <http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives-thriving-communities-review-of-mental-health-programmes-and-services.aspx>.

¹⁶ Ibid

¹⁷ RDAA has identified a number of key principles in relation to telehealth. Available at <http://www.rdaa.com.au/policies-submissions/policies>

While a number of initiatives have increased the overall number of doctors in Australia, maldistribution of those doctors in terms of both geography and skills is still a problem for rural and remote communities. Specific programs starting at or before the point of university course selection are necessary to attract and retain the future rural workforce.

Referral pathways

The maldistribution of doctors in Australia means that there is a critical need for proactive strategies to attract and retain both GPs with advanced skills in mental healthcare, and clinical mental health specialists, to live and work in rural communities. Support for telehealth as a mechanism to improve access to distant specialists is also needed.

Greater investment in allied health services to improve continuity of care in rural areas is also required. Measures should include providing psychology locums and outreach services.

Community education

In rural and remote Australia, where lower levels of health literacy are more likely, GPs are ideally placed to provide or support mental health promotion and prevention programs. They are the most trusted source of health information in their communities. This is especially important with the focus on strengthening the stepped care clinical service delivery approach outlined in the Australian Government's response to the Review.

Further investment to develop new, and expand existing, community education programs would be beneficial and encourage help seeking behaviour by rural Australians.

