MentalHealth Victoria

Collaboration • Knowledge • Leadership

Submission on

Accessibility and quality of mental health services in rural and remote Australia

May 2018

Contact details

Simon Tatz

Policy Manager

T: 03 9519 7000
E: s.tatz@mhvic.org.au

KEY POINTS

- **Low access rates in rural and remote areas exist because there is a lack of available primary health and mental health services. Lack of affordability and a failure to adequately subsidise travel further disadvantages people living in these areas.**
- **Underinvestment, particularly in Victoria, has led to a fragmented and confusing mental health service system. Long term, sustained investment, planning and oversight is required.**
- **Addressing the lack of mental health services is crucial to reducing the suicide rate in rural and remote communities, especially early intervention and community-based support.**
- **Urgent action is needed to address the exodus of community mental health workers from the mental health system. The loss of skills and expertise will be particularly felt in rural and remote communities where these are in short supply.**
- **The National Mental Health Commission should be tasked with developing a national rural and remote mental health strategy and overseeing its implementation.**
- **A comprehensive national mental health workforce strategy is needed which accounts for the community mental health, peer and primary health workforce.**
- **Without adequately resourced strategies and plans, low access rates and poor mental health outcomes will persist.**

INTRODUCTION

Mental Health Victoria (formerly Psychiatric Disability Services of Victoria (VICSERV)) is the peak body representing mental health services in Victoria. Mental Health Victoria is a champion of mental health system reform, offering stakeholders the opportunity to share their ideas and experiences to shape best practice in the field. Mental Health Victoria also provides professional development to the mental health workforce.

This submission outlines concerns raised in consultation with Mental Health Victoria's members and other stakeholders with an interest in the mental health system. It covers the following terms of reference of the inquiry:

> (a) the nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate;
> (b) the higher rate of suicide in rural and remote Australia;
> (c) the nature of the mental health workforce;
> (d) the challenges of delivering mental health services in the regions;
> (e) attitudes towards mental health services;
> (f) opportunities that technology presents for improved service delivery; and
> (g) any other related matters.

Mental Health Victoria supports the work of other organisation specialising in the provision of mental health services in rural, remote and Aboriginal communities. We would like to draw attention to the work of the following organisations and their submissions to this inquiry:

- The Centre for Rural & Remote Mental Health
- Suicide Prevention Australia
- Community Mental Health Australia

- Royal Australian and New Zealand College of Psychiatrists
- The National Mental Health Commission
- Mental Health Australia
- The Australian College of Mental Health Nurses
- The Royal Flying Doctors Service

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

The causes of low access rates to mental health services in rural and remote areas are multiple and complex. Barriers exist on both the supply (service delivery) and the demand side (service use) of the service system. However, these difficulties are surmountable with adequate long-term investment, planning and coordination.

Mental Health Victoria supports the work of the **Centre for Rural & Remote Mental Health**. We draw attention to their submission to this inquiry and their expertise in this area. In particular, they have referenced the following diagram (from Levesque et al, 2013[1]), which demonstrates some of the barriers/facilitators of access to health care.

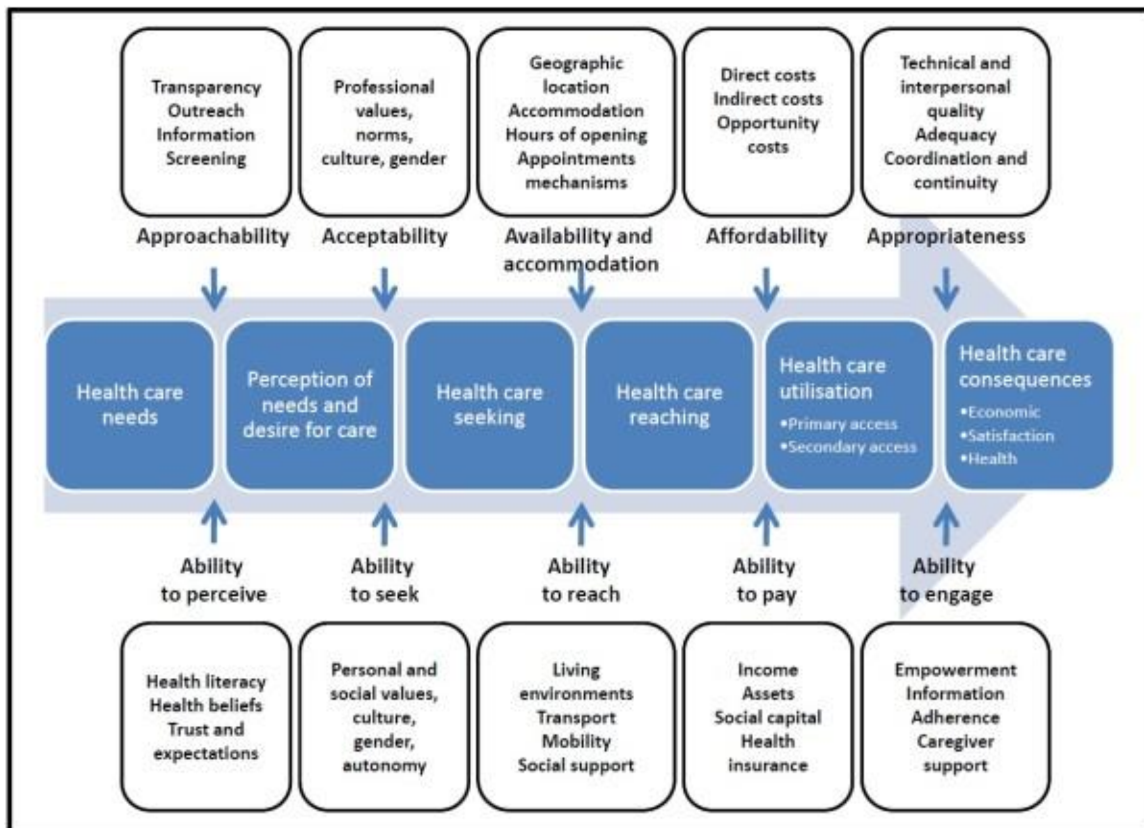

Figure 1. A conceptual Framework of access to health care [2]

We also highlight to the following specific barriers to access:

Disproportionate spread of services

---

[1] Levesque, J., Harris, M. & Russell, G., (2013), 'Patient-centred access to health care: conceptualising access at the interface of health systems and populations', *International Journal for Equity in Health*, vol. 12:18.

[2] ibid.

Mental health services and expertise tend to be skewed toward cities and communities with a higher socio-economic status. For example, in one year, there were 68 consultations with a clinical psychologist for every 1,000 people in the highest socio-economic status areas compared to 40 and 23 in the middle and lowest status areas. And; over a 1 year period GPs billed for eight mental health items for every 1,000 people in remote areas compared with 79 in cities and 25 in rural areas (Meadows et al. 2015).

Although all rural and remote communities differ in terms of socio-economic and population factors, those communities with a lower socio-economic status indicators will be doubly disadvantaged and will likely demonstrate higher levels of need.

Disadvantage and lack of affordability

Although all rural and remote communities differ in terms of socio-economic and population factors, communities and individuals who are socio-economically disadvantaged or have complex or multiple health issues and disabilities will face additional barriers to access.

Lack of access to affordable health services, such as bulk billing GPs, is likely to be an especially significant barrier to accessing mental health services for such communities and individuals.

Lack of transport

Lack of funding to compensate for geographic isolation limits service users' access to services.

For instance, the current NDIS pricing structure does not adequately allow for travel. Despite the McKinsey Independent Pricing Review adjusting the allowance to 45 minutes, this is still inadequate for some of the distances travelled by participants or providers.

Lack of access to public transport and lack of outreach services are also concerns.

Limited available services across the system

Health professionals such as GPs, psychologists and psychiatrists may not be available in all locations and outreach or visiting service may be limited. There has been an observed decline in outreach services in Victoria over the past 10 years.

Mental health services across Victoria are limited to provide the support needed to prevent the acute stage of mental illness. There is a lack of services available to provide support over the full trajectory of an experience of mental illness. There is an obvious lack of prevention, early intervention and community based support to prevent crises and acute episodes of illness. More community based services are also required to assist people to recover and return to life in the community after an acute episode of illness.

Community knowledge of services

It is difficult for service users and those referring to services (such as GPs, carers/family) to navigate and to know what individuals are eligible for and who is responsible for what.

The service system is fragmented and confusing.

RECOMMENDATIONS

Mental Health Victoria support the recommendations of Mental Health Australia and others, that the government:

- **Task the National Mental Health Commission (the Commission) (on behalf of the COAG Health Council) with developing a rural mental health strategy;**

- **Ensure the strategy is informed by a service mapping project undertaken by the Commission and informed by Primary Health Network (PHN) service mapping data and other key data; and**
- **Task the Commission with monitoring and overseeing the implementation of the strategy and reporting back directly to the COAG Health Council.**

Successful implementation of this strategy requires long-term, sustained investment. Without adequate resourcing low access rates and poor mental health outcomes will persist.

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

Mental Health Victoria supports the work of organisations specialising in addressing suicidality in rural and remote Australia, in particular Suicide Prevention Australia, the Centre for Rural and Remote Mental Health, the Royal Flying Doctors Service and the Royal Australian and New Zealand College of Psychiatrists.

Of particular relevance to this Inquiry is the **Centre for Rural and Remote Mental Health's** position Paper ***Rural Suicide and its Prevention***[3].

Although mental illness is just one of the many risk factors associated with suicidality, Mental Health Victoria believes addressing inequality of access to mental health services is a crucial component of a broader suicide prevention strategy.

A well planned and executed mental health service system will increase opportunities for intervention in suicidality amongst people with mental illness, one of the most at risk groups. Effective mental health support (from preventative to acute care) in the community and in specialist settings, will reduce the vulnerability of this group to suicidality.

RECOMMENDATIONS

Mental Health Victoria supports the recommendations of the Centre for Rural and Remote Health (NSW) and Suicide Prevention Australia in relation to suicide prevention. In particular, we recommend the government:

- **Sufficiently fund the full suite of mental health services, including prevention and early intervention, community support, acute and crisis services;**
- **Work collaboratively with communities to provide services that are tailored to local needs, ideally via existing networks, such as PHNs;**
- **Provide long-term follow-up care for people who make a suicide attempt or are thinking of suicide;**
- **Provide follow-up social support programs for people who attempt suicide or who self-harm;**
- **Provide professional development for all rural GPs; and**
- **Fund programs that provide social support by lay people. In particular, the trial of existing community-based interventions and peer work models, such as those provided by the Victorian Government funded *Mutual Support and Self Help Program*.**

C. The nature of the mental health workforce

---

[3] Hazell, T., Dalton, H., Caton, T. & Perkins, D. (2017) 'Rural Suicide and its Prevention: a CRRMH position paper'. *Centre for Rural and Remote Mental Health*, University of Newcastle, Australia. https://www.crrmh.com.au/content/uploads/RuralSuicidePreventionPaper_2017_WEB_FINAL.pdf

The cessation of state and federally funded mental health programs (such as Mental Health Community Support Services (MHCSS), and the Personal Helpers and Mentors Service (PHaMs)) and the transfer of funds to the NDIS, is having a considerable impact on the mental health workforce and on the communities they work with.

Workforce-wide data is not yet available but a considerable and growing body of evidence indicates that large numbers of qualified and experienced mental health staff will exit the sector in 2018 through redundancy and worker dissatisfaction.

In Victoria, at least 1000 qualified and experienced mental health workers will exit the system as the Victorian Government and the Commonwealth decommissions community mental health services to fund the NDIS..

In addition to redundancy, we are advised that the qualified worker exit from the sector is being driven by worker dissatisfaction. The inability of workers to implement recovery orientated practice within the NDIS context and worker safely are key issues for the workforce. The NDIS environment encourages a highly mobile workforce with limited supervision, opportunities for professional development and collegial contact. These issues are causing great concern to service providers, workers and the unions.

Community mental health service providers are employing a range of strategies to ensure they remain financially viable, however several large organisations that provide services across the state are poised to leave the market. This is particularly concerning in rural and remote areas where the choice of service provider is already limited. Closures will leave participants without support and consequently place them at risk. It will also impact local employment opportunities and therefore local economies.

RECOMMENDATIONS

Mental Health Victoria urges the Victorian Government and the Commonwealth to take urgent action to prevent further large-scale job losses. In particular:

- **The Workforce Development Program, as part of the Implementation Plan for the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), urgently needs to address the role of the community mental health workforce;**
- **Mental Health Victoria emphatically supports the call by Community Mental Health Australia (CMHA) for a national mental health workforce strategy. It must be comprehensive and specifically include:**
    - **the role of the community mental health sector, the mental health peer workforce and the primary health workforce;**
    - **strategies for rural and remote areas; and**
- **Consider retrospective reports in future workforce planning, including:**
    - **Community Managed Mental Health Sector Mapping Report[4];**
    - **Review of Australian Government Health Workforce Programs[5].**

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

The Victorian situation: underinvestment

[4] Mental Health Coordinating Council (2010). 'The NSW Community Managed Mental Health Sector Mapping Report'. NSW, Australia.

[5] Appendix ii: Health Workforce 2025 summary, Review of Australian Government Health Workforce Programs, Australian Government Department of Health, http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~appendices~appendix-ii-health-workforce-2025-summary

Victorian expenditure per capita on specialist mental health services is the lowest in the country. For many years there has been unmet demand for services due to underinvestment in the mental health system. Historically, the majority of investment has been in acute and crisis interventions, rather than community-based services and early intervention that prevents people reaching the acute stage. Because of this underinvestment people living in rural and remote areas may have little or no access to mental health services. They are also disadvantaged because existing resources and workforce capacity tend to be skewed toward city areas.

In some regional areas there is an absence of hospital beds and crisis services for people who are acutely mentally unwell. In other areas, these services are extremely limited. For example, there may be a maximum stay of a couple of days before an individual is transferred to a larger regional hospital. The distance from home, family and community supports can be of great concern and cost to those people.

The transition to the NDIS, and decommissioning of Victorian Government and Commonwealth community mental health programs has extended the gap in mental health services and support. The loss of these services is impacting the capacity and capability of the system to provide much needed early intervention and step-down support for people returning to the community from hospital. This type of community support is vital to people living in rural and remote communities where flexibility, supportive relationships and links with existing social ties are valued over formalisation and bureaucratisation (Henderson et al. 2017, p. 5[6]).

E. Attitudes towards mental health services

As previously discussed, service users in rural and remote areas have very limited choice of mental health services. This lack of choice along with 'sticky' negative community perceptions about individuals and services can lead to low access rates. Examples of this include:

- An individual not seeking help because of the community's negative impression of a clinician/service;
- An individual not seeking help because of perceived negative judgement by the community (stigma); and
- Service providers not referring to other services because of negative perceptions about a clinician or a service more generally.

It is less relevant whether there is merit to such attitudes. Rather, it is entirely relevant that adequate **attention and funding is available to foster and strengthen collaborative relationships**.

F. Opportunities that technology presents for improved service delivery

It is well known that technology can improve mental health service provision, especially in rural and remote communities. However, implementation is sporadic and unsupported. The use of technology to benefit people in rural and remote communities incudes but is not limited to:

---

[6] Henderson, J., Dawson, S., Fuller, J., O'Kane, Gerace, A., Oster, C., & Cochrane, M. (2017), 'Rural responses to the challenge of delivering integrated care to older people with mental health problems in rural Australia', *Aging and Mental Health*, https://doi.org/10.1080/14607863.2017.1320702

- Improving access to services (especially specialised/expert care) that aren't available in the local area;
- Facilitating integrated care;
- Facilitating shared care/care coordination amongst disciplines; and
- Improving access to supervision, mentoring, support and training of mental health workers.

> 'Where they are skilfully used, and where staff are trained and supported to use them effectively and efficiently, they can also provide powerful retention tools in isolated settings away from major teaching services. This may encourage redistribution of the workforce, because people are more likely to work in underserved areas if they feel that it will not limit their career progression and that they will be well supported.
>
> An ongoing investment in e-learning, training and system use would support workers and managers to maximise benefits from e-health developments. Many service providers said they had access to a reasonable standard of e-health technology, but were not using it owing to lack of support and confidence.
>
> Where possible, successful local initiatives should be shared and embedded across the mental health service system.' **Victorian Government Department of Health**[7]

RECOMMENDATIONS

- **Long-term strategy and investment in technology are required to ensure that the implementation is not solely reliant on individual clinicians in their current capacity.**
- **Successful local initiatives should be shared and embedded across the mental health service system.**

G. Other related issues

Mental Health Victoria strongly recommends the Committee **consider the specific needs of Aboriginal and Torres Strait Islander and other culturally and linguistically diverse community groups** living in rural and remote areas. We urge the Committee to closely examine the submissions and recommendations of those organisations who represent the interests of these communities.

[7] 'National Mental Health Workforce Strategy' (2011), Victorian Government Department of Health, Melbourne, Victoria. https://www.aihw.gov.au/getmedia/f7a2eaf1-1e9e-43f8-8f03-b705ce38f272/National-mental-health-workforce-strategy-2011.pdf.aspx