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Mental Health Services Rural Remote Areas (MHSRRA)

Medicare Locals gratefully acknowledge the financial and other support from the Australian Government Department of Health

About the Northern Territory

- Population: Total 231,862
  - Aboriginal Population: 72,625 (30% of total population)
  - NT Dept. of Treasury and Finance predicts NT pop will grow to 304,269 by 2031 with the Indigenous population to increase to 89,456 (currently 72,625).
- 1/3 of the population below the poverty line, while 30% more than $1000 per week (higher than Australian Average).
- The Rural, Remote and Metropolitan Areas (RRMA) index classifies the NTML region as Very Remote, exception of Alice Springs (Small Rural Centre) and Darwin (Urban centre = 56% of the NT population).
- Very remote definition includes locational disadvantaged with very little access to goods and services such as education, retail, and social services.
- The NTML records 22.4% of the population living in very remote areas and 21.6% in remote areas.

About MHSRRA

The MHSRRA program is delivered by mental health professionals via Aboriginal Medical Services / NGOs or sole contractors through NTMLs commission framework.

- MHSRRA is delivered across 3 NT regions
  - East Arnhem
  - Katherine region
  - Central Australian remote communities

- Approximately 16 employed staff contracted through NTML MHSRRA program, this includes
  - Aboriginal Mental Health Workers,
  - Aboriginal Health Practitioners,
  - Mental Health Nurses (MHN),
  - Psychologists
  - Social Workers

- Wider aims of MHSRRA are to develop and support NT rural and remote mental health workforce, including Aboriginal Mental Health Worker models.

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<u>The nature of small, rural and remote communities and MH needs</u>

- Fear of others finding out / confidentiality being compromised
- Clients face greater visibility and stigma attached to mental health.
- Higher prevalence of mental health problems due to;
  - socioeconomic disadvantage,
  - harsher natural and social environment,
  - loneliness and isolation, and
  - fewer available health services (Morrissey & Reser 2007).
- Remote MH programs are established for short periods of time and frequently do not continue

Service delivery models

There are three service delivery models that are currently in place;

1. Outer Rural Darwin - Sole Contractor – Psychologist Model

2. Katherine - Aboriginal health service - Social Worker Model

3. East Arnhem – Aboriginal Health Service – Aboriginal Mental Health Worker Model

Key challenges and constraints

- Infrastructure and Resources
- Staff attraction and recruitment
- Extreme health needs
- Substance Abuse, Gambling and Family Violence

practically define work of MH professionals Inclusively across social-emotional distress to diagnosed mental illness

- Challenge to develop pathways and protocols that are embedded in systems rather than dependent on individual relationships.

MHSRRA data

Total new MHSRRA referrals 2013 / 2014 = 667
Total MHSRRA clients across NT = 4532
Total MHSRRA service contacts 2013 / 2014 across NT = 9474

Examples of populations in community compared to service contacts being delivered for 2013/14:

- Galiwinku pop. 1100 / Service contacts 2446
- Laynhapuy Homelands pop. 1500 / Service contacts 795
- Angurugu pop. 882 / Service contacts 865
- Katherine East Communities pop. 3500 / Service contacts 287 (1 community out of 9)
- S.W. Central Australian Communities pop. 4000 / Service contacts 4090

All examples of MHSRRA service delivery display a very high proportion of population accessing services.

Conclusion

- MHSRRA is the most preferred and effective remote option
- High degree of cultural understanding essential to delivery of these services.
- Working conditions within this funding approach are able to also support traditional and cultural obligations.
- MHSRRA provides much needed local employment
- Communication between Psychologists, Aboriginal Mental Health Workers (AMHWs), GPs and Clinic staff has developed via MHSRRA in to a well supported clinical service.
- Psychologists that are funded are also able to debrief and educate GPs and staff as well as supervise AMHWs as a delivery model option.
- Flexible MH access to forgotten pops. / structure can address the particulars of each site
- MHSRRA Funds support the NT Aboriginal Mental Health Worker Program that was formalised in 2002.
- Workforce models into the future, such as support workers and internships would allow a more substantial service.