

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.



The nature of small, rural and remote communities and MH needs

- 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

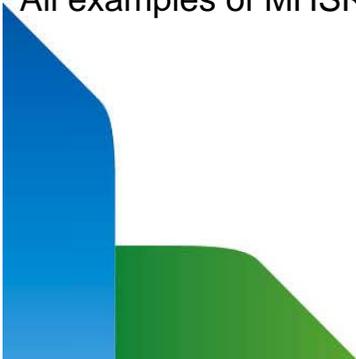
Total MHSRRA clients across NT = 4532

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.

