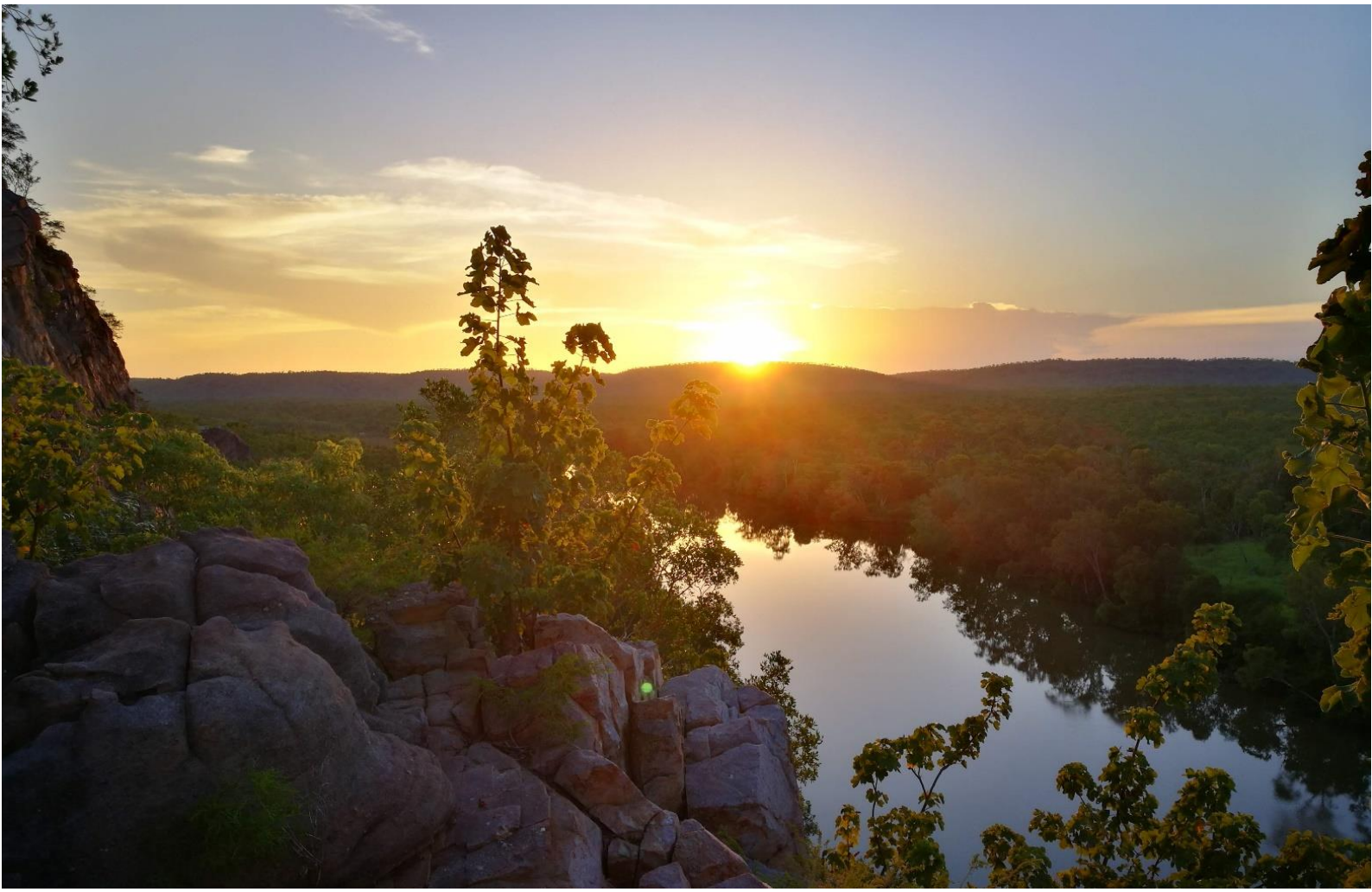
National Rural Health Alliance

House Select Committee on Mental Health and Suicide Prevention

March 24th 2021



… healthy and sustainable rural, regional and remote communities

National Rural Health Alliance

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House Select Committee on Mental Health and Suicide Prevention

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Introduction

The National Rural Health Alliance (the Alliance) welcomes the opportunity to provide a perspective on mental health and suicide in rural, regional and remote (hereafter rural) Australia to inform the House of Representatives Select Committee. The Alliance comprises 44 national member organisations and is focused on improving the health and wellbeing of the 7 million people residing outside our major cities. Our members include health consumers, health care professionals, service providers, health educators, students, and the Indigenous health sector. Well-rounded representation of the rural health sector enables us to work toward our vision of 'healthy and sustainable rural, regional and remote communities'.

Though the reported prevalence of mental health conditions in rural Australia is similar to major cities, rates of suicide and intentional self-harm are higher, as are rates of substance abuse. The burden attributable to mental and substance use disorders is also comparable across geographical regions, yet the burden attributable to injury, particularly suicide and self-inflicted injuries, increases dramatically with remoteness. The anomalous statistics for prevalence of mental health conditions in rural Australia may mask significant under-reporting.

The livelihood of many rural people relies on the land and associated industries, making them more exposed to the effects of extreme weather events and climate change, including drought, bushfires and floods. In the broader context of lower incomes, lower educational attainment and higher rates of unemployment, rural people face the challenge of cumulative and ongoing adversity, with its subsequent impact on mental health and wellbeing. When combined with inadequate health workforce to meet population need and barriers to accessing services – geographical distance, costs, waiting times, privacy concerns, attitudinal factors and digital barriers – it is evident that there is significant unmet need.

Aboriginal and Torres Strait Islander (Aboriginal) people, who make up a higher proportion of the population with increasing remoteness, have unique mental health and social and emotional wellbeing needs and their experience contributes significantly to the overall experience in rural Australia.

Rural lives are being lost due to lack of available and appropriate mental health support and people are not being enabled to achieve a state of optimal mental health and wellbeing - allowing them to live fulfilling lives and contribute fully to society - and this is a strong imperative for change.

This submission will expand on the key data that illuminates the current state of rural mental health and wellbeing and paint a picture of the various contemporary issues impacting mental health and wellbeing for rural people. It will develop the issues of workforce and access to services and discuss how the system needs to change to better meet the needs of rural people and communities in the context of recently published reports (as per the terms of reference of this committee). Recommendations for action will be presented.

Epidemiology

Diagnosable mental illness and other states on the spectrum of wellness to illness

Mental health and wellbeing is experienced along a continuum. A person does not need to meet the criteria for diagnosis of a mental disorder or condition to be negatively affected by their mental health. The proportion of the population with self-reported mental and behavioural conditions,

according to the National Health Survey 2017-18, was similar across geographical regions: 19.5% in major cities, 22.9% in inner regional areas and 19.6% in outer regional and remote Australia.[1] The National Mental Health Survey, reported in 2007, provides similar, albeit older and less granular results: 20.4% of people living in major urban areas had a mental disorder within a 12-month period according to diagnostic criteria, compared with 19.2% of people in other urban areas and 19.2% of people in the balance of the state/territory.[2]

Suicide and intentional self-harm

Throughout the period 2012 to 2019, the rate of **intentional self-harm hospitalisations** across all age groups was closely correlated with remoteness. Rates of intentional self-harm hospitalisation in very remote areas between 2012-13 and 2018-19 were between 1.5 and 2 times higher than in major cities. Rates in rural areas have been increasing over time and there is a widening gap in under 25-year-olds which is concerning. Trends in rates of intentional self-harm hospitalisation over time are consistently higher in Indigenous Australians and the gap is widening in every age group.[3]

Suicide rates also show strong regional trends, with rates consistently higher in areas of greater remoteness during the period 2010 to 2018. In inner regional areas suicide rates were at least 1.2 times higher than in major cities, in outer regional areas at least 1.4 times higher and in remote and very remote areas suicide rates were at least 1.7 times higher than in major cities. Mirroring patterns in intentional self-harm hospitalisations, rates of suicide among Indigenous Australians were consistently higher than rates for non-Indigenous Australians throughout the period 2001 to 2018. In all years, rates of suicide were at least 1.4 and up to 2.3 times higher in Indigenous compared with non-Indigenous Australians.[4]

People who experience suicidality are more likely than the general population to have a mental health disorder or condition, though not all people with mental health disorders or conditions experience suicidality.[5]

It has been suggested that the comparable rates of mental illness in rural areas and major cities, juxtaposed with comparatively high rates of suicide and intentional self-harm, mask a high prevalence of psychological distress and untreated (or undiagnosed) mental illness.[6]

Substance abuse

Rates of **lifetime risky drinking** (more than two standard drinks per day on average) show a strong regional dependence, with rates increasing with increasing remoteness throughout the period 2010 to 2019. People living in remote and very remote areas have been found to be 1.6 and 2.1 times more likely to engage in lifetime risky drinking than people living in other regions during the period 2010 to 2019. Rates of **single occasion risky drinking** (more than 4 drinks on one occasion at least once per month), like lifetime risky drinking, show a strong regional dependence, with rates increasing with greater remoteness throughout the period 2010 to 2019. While rates of lifetime risky drinking have declined over time, Indigenous rates remain higher than those for Australians overall. In 2019, Aboriginal Australians were 1.5 times more likely to engage in single occasion risky drinking than Australians overall.[7] Indigenous Australians living in remote communities are less likely than Indigenous Australians living in non-remote areas or non-Indigenous Australians to have consumed alcohol in the previous 12 months. This might reflect a portion of “dry” communities within the sample population and might not reflect broader patterns.[8]

Illicit drug use was higher in remote and very remote areas compared to all other regions, throughout the period 2010 to 2019.[9] Indigenous Australians living in remote communities were significantly (two to three times) more likely to have consumed **illicit drugs** within the past 12

months than Indigenous Australians living outside of remote communities and non-Indigenous Australians.[10] Most illicit drug use by Indigenous Australians living in remote communities was of cannabis. In 2019, rates of **painkiller and opioid** use for non-medical purposes in remote and very remote areas was 1.5 times that of major cities. In outer regional areas, use was 1.4-fold that of major cities. This was a reduction, in all remoteness categories, compared with 2016. Rates of **non-medical pharmaceutical** use in remote and very remote areas was substantially (at least 1.5-fold) higher than in all other regions in 2016. This regional disparity had resolved somewhat by 2019. This may be due to recent changes in government policy which have implemented restriction on prescription rates of these pain-relief medications. While non-medical pharmaceutical usage remained higher in remote and very remote areas in 2019, inter-regional differences were lower.[11]

There is a complex relationship between illicit drug use and mental health and wellbeing, with those who reported using an illicit drug in the previous 12 months more likely that those who did not to have a self-reported mental health condition.[12] Comorbidity of substance use and mental illness is widely accepted.[13]

Burden of disease

The burden (measured in disability adjusted life years (DALYs)) attributable to mental and substance use disorders, while similar across geographical regions, is high: 12% of the total burden of disease in 2015 and third highest after cardiovascular disease and musculoskeletal conditions.[14] Alarmingly, the burden attributable to injury, particularly suicide and self-inflicted injuries, increases dramatically with remoteness.[15] In outer regional areas, suicide and self-inflicted injuries are the fourth leading cause of total disease burden and in remote and very remote areas they are the second leading cause of total disease burden – the rate in both regions is at least 50% greater than the national average.[16]

These differences in health outcomes based on location of residence highlight significant inequity and deficiencies within our health care and social support systems that must be addressed urgently.

Contemporary issues and their impact on mental health and wellbeing in rural people

It is generally understood that a person's experience of mental health and wellbeing is influenced by multiple social and economic factors[17] and that different population groups have different experiences.[18] This can be explained further by looking at the risk and protective factors that interact to contribute to mental health and wellbeing and suicidality (plans, attempts and ideation),[19] taking account of the interplay between mental health and wellbeing, suicidality and substance abuse.

Risk and protective factors for mental health and wellbeing and suicidality

Factors protective of mental health are suggested to include: social capital (social support and community participation), physical and other lifestyle factors (physical activity, sleep quality, good diet), individual factors (optimism, orientation to happiness, humour, perceived restorativeness, sense of purpose, proactive coping, perceived wellness, self-efficacy) and creative arts (engaging in music and art and craft activities).[20] Many interventions have been developed in recent times based on building protective factors and have enabled targeting of populations often resistant to traditional approaches to mental health treatment. Employment, lower levels of alcohol consumption and access to green space have also been found to be protective.[21] Risk factors for poor mental health and wellbeing include: social isolation and loneliness, physical health conditions, stress, caregiving, insecure employment and unemployment, unsupportive work environment, economic inequality, homelessness, migration, and being in a sexual minority group.[22]

Suicide attempts are often linked to stressful life events, and associated feelings of helplessness and overwhelm, with causes including social isolation, relationship problems, loss of a job or income and financial or housing stress.[23]

Stress, psychological distress and trauma

According to the Australian Institute of Health and Welfare, "any event that involves exposure to actual or threatened death, serious injury, or sexual violence has the potential to be traumatic"[24 p2]. The experience of trauma can contribute to the development of mental illness[25] and is common amongst those utilising mental health services.[26] The risk of mental illness is increased due to the experience of childhood trauma.[27]

Stress is a related concept and refers to "a physical, mental, or emotional factor that causes bodily or mental tension" [28 p1], triggering a complex physiological reaction. Prolonged stress can lead to distress and can cause or influence mental health conditions.[29]

By the nature of their geographic location and the industries that contribute to the economy in rural areas, rural people are more exposed to the effects of extreme weather events and climate change (both direct and indirect), including drought, bushfires and floods. There is potential for trauma to occur as a result acute events such as bushfires and floods[30] and evidence to suggest that chronic stress and distress can result from exposure to more prolonged extreme weather events such as drought.[31]

COVID-19 pandemic

Research performed in Australia during the first period of lockdown due to the COVID-19 pandemic found 78% of respondents (predominantly female and a high proportion with pre-existing mental health conditions) reported their mental health had worsened since the outbreak, with a higher level of symptoms in those with self-reported pre-existing conditions.[32] Though this research was not rural-specific, and rural people have had less exposure to the most severe lockdown policies than their metropolitan counterparts, it illustrates the significant impact of the pandemic on mental health and wellbeing in the short term. Research findings on the longer-term impacts will continue to emerge.

Given the previously described influence of social relationships, employment and financial factors and stress on mental health and wellbeing and suicidality, and the background levels of reduced income and higher unemployment in rural Australia,[33] it is likely that we will see the COVID-19 pandemic influence mental health outcomes now and into the future. The impact is likely to amplify existing inequity.

Rural adversity

Lawrence-Bourne, Dalton and Perkins et al. (2020) present a model of "rural adversity" to describe the impact of hardship on mental health outcomes for rural people and communities, according to an ecosystem approach.[34] They describe adverse events as occurring at multiple levels: life-course adversity at the individual and family level (eg. bereavement, serious illness, relationship problems and financial difficulty), rural adversity at the community level (eg. drought, fire, flood) and universal adversity at the societal level (eg. pandemic, recession). Events might be rapid onset (eg. flood) or long-term (eg. drought) and can be combined, sequential or cumulative. This model essentially integrates the concepts of mental health and wellbeing and suicidality risk and protection, with the impact of stress and trauma, and background issues of social and economic disadvantage in rural areas. It provides a holistic underpinning to the experience of mental health and wellbeing in rural

Australia and can be used to help us understand how our systems are failing rural people and where we might best intervene to enable rural people and communities to flourish.

Rural mental health workforce

Overview

General practitioners are often the first point of entry to the primary mental health care system, providing assessment, treatment, referral and treatment plans. They have a key role in initiating multi-disciplinary, collaborative and integrated care. Psychiatrists, psychologists, mental health social workers, occupational therapists and mental health nurses are integral to the functioning of this Medicare Benefits Schedule (MBS) funded system, along with paediatricians, Aboriginal and Torres Strait Islander health workers and Aboriginal and Torres Strait Islander health practitioners. Many other health professionals, health workers and people with non-clinical expertise contribute to mental health care - including pharmacists, paramedics, emergency physicians, intensivists, emergency and critical care nurses, peer workers and gate-keepers, among others.

In general, the health workforce reduces with increasing remoteness and is disproportionate to increasing need. Table 1 below shows the prevalence of selected mental health professions by remoteness: [35]

Health practitioner (FTE per 100 000 population)			
	Psychiatrists	**Psychologists**	**Mental health nurses**
Major cities	16.0	106.5	93.2
Inner regional	6.9	62.5	85.6
Outer regional	5.7	45.6	54.1
Remote	6.7	38.3	56.1
Very remote	3.1	25.5	36.1

Table 1: Prevalence of mental health practitioners by remoteness, 2018. Available from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce

Medical workforce

The overall medical practitioner workforce declines with increasing remoteness, with rates from highest to lowest as follows: major cities; remote; inner regional; outer regional; very remote.[36] For specialist medical practitioners, prevalence reduces progressively with remoteness, from 162.1 FTE per 100 000 in major cities to 34.2 FTE per 100 000 in remote and very remote areas.[37]

The number of **general practitioners (GPs)** generally decreases with remoteness, except that there appear to be more GPs in remote and very remote areas than in major cities.[38] Care is needed when interpreting this data as these differences may reflect different models of service,[39] skewed data due to small numbers, and the higher need for primary care with increasing remoteness.[40]

Psychiatrists have an important role in supporting mental health and suicide prevention in Australia. Across the country, there are only 3,441 psychiatrists in total, comprising just 9.8% of all specialist medical practitioners.[41] Their distribution is skewed heavily towards major cities (16 FTE per 100 000) as opposed to regional and remote areas (6.9 in inner regional; 5.7 in outer regional; 6.7 in remote; and 3.1 in very remote).[42] Psychiatrists working in major cities work an average of 38.7 hours per week, whereas those in remote areas work an average of 43.3 hours per week.[43] This data exposes

potential for risk of burnout in psychiatrists in rural Australia, as well as the greater demand for psychiatric services.

In addition to general practitioners and psychiatrists, **intensive care specialists (intensivists)** are relied upon to provide acute services for patients who have attempted suicide or other self-harm. These patients may require invasive ventilators, dialysis machines and other life support alongside continuous clinical monitoring.

The equitable distribution of intensivists, and other members of the acute care workforce such as paramedics and emergency/intensive care unit (ICU) nurses, is essential in rural Australia. Members of the Alliance are calling for an increase in the number of visiting medical officers and locum specialists, junior ICU doctors and ICU nurses in rural hospitals. This distribution issue leaves rural communities vulnerable, and this is magnified by their higher risk of suicide and self-harm.

Allied health workforce

The prevalence of registered allied health professionals as a FTE per 100 000 population decreases with remoteness – this group includes **psychologists, occupational therapists, Aboriginal and Torres Strait Islander health workers and Aboriginal and Torres Strait Islander health practitioners**.[44] The prevalence of self-regulated allied health professionals (including **mental health social workers**), as a full time equivalent per 100 000 population, is less in all rural areas compared with major cities.[45]

The allied health professionals with the greatest direct role in supporting mental health in Australia are **psychologists**, with 27,027 employed psychologists across the country.[46] The number of psychologists decreases progressively with remoteness, as shown in Table 1 above.

Nursing workforce

In broad terms, nurses have a pivotal role in the provision of health care services in remote and very remote areas, particularly where access to other health professionals is reduced. The overall supply of registered nurses varies across remoteness areas. Fewer nurses work in outer regional areas, whilst the greatest number work in very remote areas (1012 FTE per 100 000 population).[47] As a whole, nurses stand out as the most well distributed of all the health professions in rural Australia. However, generic training may not include specific expertise in mental health issues, and a shortfall is projected in the future due to an older age structure outside of major cities.[48]

Mental health nurses are health professionals who provide clinical services to support the mental wellbeing of patients, primarily working in hospitals and community health settings. Their geographic distribution is shown in Table 1 – supply reduces with increasing remoteness.

Pharmacists

The Alliance acknowledges that community pharmacists are part of the multidisciplinary mental health workforce who support the mental health and wellbeing of patients. They can play a particularly important role for patients with a mental illness who have been prescribed medication for management and treatment. Pharmacists can help in promoting medication adherence and education about drug interactions, side effects and related information. They can also signpost patients to other health professionals and mental health services.

The Australian Government is providing $5 million for the ‘Bridging the Gap between Physical and Mental Illness in Community Pharmacy’ (PharMIbridge) trial.[49] This trial is currently studying the effectiveness of an individualised, pharmacist-led support service for patients with severe and persistent mental illness. This trial is being conducted across 48 pharmacies across four Australian

regions are participating, with a total of 380 participants. The evaluation of this trial has not yet concluded.

Summary

There is a shortage of appropriately trained and experienced mental health professionals in rural Australia. This is part of a broader problem in rural communities, in that they frequently face poorer access to health services, the inability to receive services within a reasonable travel distance, prolonged waiting lists and less timely service provision, reduced individual choice and increased out-of-pocket costs.

Access to care

Overview

Mental health care services are provided via the MBS-subsidised system, by state or territory delivered community mental health services, by non-government organisations (sometimes with federal government funding through Primary Health Networks (PHNs)) and by state or territory delivered public hospitals and facilities, and private hospitals and facilities. The predominantly fee-for-service nature of the MBS system means that gap fees for GP, medical specialist and allied health consultations in primary care may be prohibitive for clients. Primary mental health care funding mechanisms also often mean that medical and allied health professionals are less likely to practice outside of major cities, where it is more sustainable for them to run a private practice. PHNs have a role in providing affordable primary mental health care to vulnerable populations in accordance with local needs and in improving integration and coordination of care. State or territory government delivered community mental health and hospital services are generally free for those eligible for Medicare but are limited to acute and/severe and complex mental illness.

Service provision

Table 2 below summarises the provision of MBS-subsidised mental health care services in primary health care, by remoteness category.[50] It should be noted that the rate of service reduces with increasing remoteness in each category and only a small rate of services are provided by allied health professionals outside of psychologists. The highest rate of service in each remoteness category is provided by GPs, yet GP mental health specific services reduce significantly in remote and very remote areas: from 15.5 in major cities to 7.3 and 3.5 respectively. Services provided by a psychiatrist reduce dramatically once outside of major cities, from 11.2 to 1.8 in very remote areas. More services are provided by other psychologists than clinical psychologists in all remoteness categories, but they reduce to 1.2 and 1.7 in remote and very remote areas respectively.

MBS-subsidised primary mental health services (claims/100 population)					
Remoteness Category	**GP**	**Psychiatrist**	**Clinical psychologist**	**Other psychologist**	**Other allied health**
Major cities	15.5	11.2	10.8	13.0	1.7
Inner regional	15.2	7.5	8.5	11.7	2.6
Outer regional	12.1	4.6	4.8	7.7	1.8
Remote	7.3	3.4	2.6	3.9	0.8
Very remote	3.5	1.8	1.2	1.7	0.2

Table 2: MBS subsidised primary mental health specific services, 2018-19. Available from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

Primary mental health services are also provided by community mental health care services delivered by state or territory governments, though eligibility criteria for these services are usually limited to those with acute or severe and complex illness. Table 3 below illustrates that the rate of utilisation of community mental health care services generally increases with remoteness, as well as the much higher rates in Indigenous people.[51] Increased utilisation of this system in rural areas might indicate presentation later in the course of an illness or disorder.

Community mental health care utilisation (service contacts/1,000 population)						
Major cities	**Inner regional**	**Outer regional**	**Remote**	**Very remote**	**Indigenous**	**Non-Indigenous**
351.0	389.1	411.7	463.0	412.0	53.8	16.1

Table 3: Community mental health care services, 2018-19. Available from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

Table 4 below summarises mental health-related emergency department presentations by remoteness category and Indigenous status.[52] Mental health emergency department presentations increase with remoteness such that the rate in remote and very remote areas is almost twice that in major cities. The rate of emergency department presentations for mental health issues in Indigenous people is more than 4 times higher than in non-Indigenous people. This regional disparity in utilisation of emergency departments for mental health-related conditions might be used as an argument for the inadequacy of access to primary mental health care services in rural Australia relative to population need.

Mental health emergency department services (presentations/10,000 population)						
Major cities	**Inner regional**	**Outer regional**	**Remote**	**Very remote**	**Indigenous**	**Non-Indigenous**
104.1	140.5	144.3	202.6		449.4	108.0

Table 4: Mental health-related emergency department presentations, 2018-19. Available from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

State and territory governments deliver hospital-based mental health care services. Table 5 presents several hospital services by remoteness category, including hospital admissions data both with and

without specialised psychiatric care. [53,54] This data illustrates the trend of reduced specialised and increased non-specialised mental health care, with remoteness, for same day admitted patients in public hospitals. The same trend is evident for overnight admitted separations: specialised mental health care services reduce with remoteness and non-specialised mental health care services increase with remoteness. Utilisation of hospital-based mental health care services is much higher for Indigenous people than non-Indigenous people in all categories presented.

	State or territory mental health care services (separations/10,000 population)			
	Same day admitted public hospitals		Overnight admitted public and private hospitals	
	With specialist services	Without specialist services	With specialist services	Without specialist services
Major cities	8.6	14.3	68.0	37.0
Inner regional	4.4	16.2	67.5	38.3
Outer regional	3.7	23.7	55.8	48.5
Remote	1.4	40.0	37.2	73.5
Very remote				
Indigenous	11.7	58.4	153.6	105.2
Non-Indigenous	6.1	14.0	63.4	31.4

Table 5: State or territory delivery mental health care services, 2018-19. Available from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia

Rural Australians are less likely to access MBS funded primary mental health care services than their city counterparts, yet more likely to utilise the state and territory government delivered community mental health care sector. They are also more likely to present to an emergency department with a mental health concern. When rural Australians access hospital based mental health care, they are less likely to receive the specialised psychiatric services they need.

The Alliance believes this data illustrates the lack of alignment between population need and access to primary mental healthcare outside of major cities and a resultant shifting of care to more acute parts of the health system, where people are likely to present later in the trajectory of their illness or condition with more severe symptoms. A lack of utilisation of primary mental health care not only costs the health system more but is likely to contribute to poorer outcomes for rural people. A lack of access to specialised psychiatric services when admitted to hospital also has the potential to result in poorer outcomes for rural Australians.

Barriers to access

Various issues influence access to mental health and wellbeing services and support from the demand side in rural Australia, including attitudinal factors, privacy concerns, travel, cost and digital access, among others. Some sections of the rural population face unique challenges. Within rural communities, farmers have been found to be less likely to access healthcare generally and mental health care specifically, with a "need for control and self-reliance" [55 p351] and communication difficulties with health professionals identified more strongly as barriers to help-seeking in farmers than non-farming rural residents. The following attitudes were prevalent among a sample of rural people: preference for self-management, lack of confidence that anything will help and concerns

about privacy.[56] Stigma related to mental health perpetuates privacy concerns for rural people, where health professionals are embedded within local communities and might be known to individuals.

Structural barriers such as the need to travel vast distances to access care, and costs related to travel, accommodation and time away from work are also a significant concern. While access to digital care and support services may ameliorate some of these barriers, reduced digital literacy in consumers and health professionals, lack of access to digital infrastructure (including reliable and affordable internet and mobile phone connectivity, hardware and interoperable software), presents challenges to equitable access outside of major cities, where the potential for benefit is large.

How does the system need to change? Policy reflections and recommendations

The evidence and discussion presented to this point has attempted to build a picture of a population group that is not being well served by the mental health and wellbeing and suicide prevention systems as they currently exist. There is significant unmet population need for services and supports, challenges to the provision of a suitable and sustainable workforce and multiple barriers to access. In order to improve outcomes for rural people, major system adjustments need to occur to manage these shortcomings.

Prevention and early intervention orientation

The Alliance supports the reorientation of the system towards prevention and early intervention, in line with the recommendations of *the Productivity Commission Inquiry Report Mental Health Volume 1* (Productivity Commission report),[57] *Royal Commission into Victoria's Mental Health System Final Report* (Victorian Royal Commission),[58,59,60] and the *Prime Minister's National Suicide Prevention Advisor - Summary of Interim Advice* (Suicide Prevention Advisor's Advice).[61] Given the workforce and access constraints previously discussed, it is imperative mental health and wellbeing and suicide prevention services, supports and interventions are carefully aligned to consumer and community need. This will support person-centred, integrated, evidence-based care across the continuum of care needs, including clinical and non-clinical services, with best of use of limited resources (including workforce): the right care in the right place at the right time. The *Stepped Model of Mental Health Care*[62] promotes the provision of a range of services – a hierarchy of intervention – according to differing levels of population need, with the least intensive option provided that meets an individual's needs. A prevention and early intervention reorientation would allow the provision of population level interventions to promote individual and community resilience and wellbeing, address risk factors for ill-health, and also allow those with early-stage illness to be identified and provided with appropriate support. Thus, the need (at a population level) for more intensive, specialised clinical and non-clinical services would be reduced.

The Productivity Commission report advocates for the broadening of access to low-intensity services delivered online and an increase in the intensity of services provided to the "missing middle" via changes to the Better Access scheme funded through the MBS (an increase in the number of funded consultations per year, incentives to increase group service provision and a review of the program more broadly). Though these changes to the intensity of the Better Access program and their redirection to those who, in theory, need the services more, makes sense, it will still be limited in rural areas by the lack of access to allied mental health mental and psychiatric specialist medical services in primary care and waiting lists for the services that do exist. Hence, such changes must be implemented concurrently with actions to address workforce disparities.

The increased focus on low-intensity services delivered online, some of which would be clinician supported, needs to be taken with care and not seen as a stand-alone solution to face-to-face care. Though digital health care reduces barriers due to geographical distance, might be more accessible for people who lack flexibility in their work and family commitments, and provides the benefit of privacy for those living in smaller communities where this is a concern, its uptake might be limited by reduced digital literacy and lack of universal access to a reliable, affordable internet connection**.** There is also the risk that a generic online program, or one supported by a clinician from another geographic location, will miss the contextual nuances a clinician embedded within a community would be aware of. Though there are many potential benefits, it may also be that people who have overcome barriers to seek help need human connection, particularly in the context of the COVID-19 pandemic. Hence, we continue to advocate for improved provision of appropriate face-to-face services in local communities, in addition to increased access to high quality, on-line services.

The Alliance wishes to highlight the importance of primordial prevention – action on the broader determinant of health at a population level - to reduce the incidence of mental illness and states of distress that might lead to suicidality, particularly for rural people who experience greater social and economic disadvantage. The Suicide Prevention Advisor's Advice, under recommendation 8 and 9, refers to the urgent need for this type of activity. We believe there is also huge potential for benefit to rural people in the wide-spread training of gate-keepers - individuals who come into contact with people who are at risk of or are experiencing challenges to their mental health and wellbeing eg. Financial councillors, veterinarians, pharmacists – in suicide prevention, enabling them to provide support and guidance. 'Mental First-Aid' is an example of this type of initiative. This and similar strategies are recommended by a number of contemporary reports.[63,64] The Productivity Commission report refers to current suicide prevention activities and the need to assess their evaluations and share the learnings. Given there is plenty of good work being done in this space, including in rural Australia, we are positive about this reform but note the call of the Orange Declaration[65] that policy solutions in mental health and wellbeing are relevant to the local context and not rolled out based on assumptions that may not be fit for purpose. We also wish to draw attention to the role of community-based interventions, such as the "Community Collectives" proposed by the Victorian Royal Commission,[66] in improving mental health and wellbeing, at a community level.

Recommendation

1. **Reorientation of the mental health and wellbeing and suicide prevention system towards prevention and early intervention is essential - given the workforce and access constraints in rural Australia – to allow efficient use of limited resources. This requires alignment of services, supports and interventions with consumer and community need.**
2. **Changes to the Better Access scheme to increase the intensity of treatment offered to the "missing middle" should acknowledge the ongoing limitation posed by reduced access to psychiatrists and allied mental health professionals in rural areas and be implemented concurrently with actions to address workforce disparities.**
3. **A decision to broaden access to low-intensity online services should be taken with care and not seen as a stand-alone alternative to face-to-face treatment. We continue to advocate for improved provision of face-to-face individual and group services in local communities.**
4. **Primordial prevention, gate-keeper training and community level prevention activities all have an important place in a prevention-oriented system in rural Australia.**

Workforce

There are multiple targets for activity to improve the size and distribution of the mental health workforce in rural Australia. We appreciate the acknowledgement of the inadequacy of the workforce in rural Australia in the Productivity Commission report and by the Victorian Royal Commission.[67]

Equitable access to **GPs**, as the first point of entry to the primary mental health care system, and key to delivery of multi-disciplinary, collaborative and integrated care, must be prioritised in rural areas. Due to their broadened scope of practice with increased remoteness, and reduced access to more specialised mental health services, it is essential GPs have good skills and training in mental health and wellbeing and suicide prevention. Rural generalist pathways have potential to increase the capacity of rural practitioners to provide care to people with mental health concerns and suicidality, where specialised services are not available. Linkage of such rural generalist practitioners, both within primary and secondary care, with more specialised services via clear, integrated pathways is imperative to ensure best outcomes for rural people.

The Productivity Commission report asserts that in order to counter the reduced prevalence of specialist **psychiatrists** with increasing remoteness, more are needed overall and action is required, as a priority, to increase recruitment and retention of psychiatrists in rural areas. Increasing the ease of completing specialist training in psychiatry outside of metropolitan centres would reduce the likelihood that medical professionals put down roots in major cities at a formative time in their life and that of their families, making it more likely they would choose to stay rural on completion. More innovative approaches to accessing specialist care where it is not available in person need to be trialled and rigorously evaluated, with the learnings of successful models shared widely.

The Productivity Commission report proposes that a new curriculum be developed for a three-year direct-entry undergraduate degree in **mental health nursing** and that a unit on mental health be included in all nurse training courses. To enhance equity of access to graduates, provision of such a course at rural university campuses should be considered. The Alliance believes the benefit of this new cohort of mental health nurses might be limited in rural areas as their narrow scope of practice (by the nature of direct entry, rather than being general nurses with additional training in mental health) might make them less employable in areas requiring generalist nursing practice. Conversely, improving the knowledge and skill of all graduate nurses in mental health and wellbeing, would have broad benefits.

The Productivity Commission report emphasises the potential for occupational substitution and looking for new ways of utilising workforce to meet consumer needs, including prioritising access to care coordination services to improve service navigation. The Suicide Prevention Advisor's Advice recommends a focus on the peer workforce to support new models of care. Both the Suicide Prevention Advisor's Advice and the Victorian Royal Commission assert the importance of building a gate-keeper workforce.

Considering the entirety of the mental health workforce, including those who are not currently eligible for MBS funding via the Better Access scheme, it is important that all health practitioners (and non-clinical workers) are utilised according to their scope of practice. This includes medical specialists, psychologists and other allied health professionals, nurses, pharmacists and paramedics.

In addition to having the mental health workforce performing at top-of-scope, we recognise that certain health professionals are unable to be replaced by others through occupational substitution. This includes psychologists and psychiatrists, whose professional training and scope of practice give them unique roles int eh care of patients interacting with the mental health system.

Removing barriers to recruitment and retention of mental health professionals is particularly important in rural Australia, given the constraints of the system. Options for local vocational education and training of components of the workforce merits consideration in rural areas.

Strategies to improve the distribution of the health workforce as a whole in rural Australia are important:

- Entry-to-practice university training in rural areas – targeting the whole student cohort, not just rural students
- Funding and infrastructure for post-entry-to-practice training programs with more time spent in rural areas, removing the need for (particularly doctors) to continue to return to metropolitan centres; and alteration to the training requirements of medical colleges to increase the ability to complete specialist training rurally
- Approaches to ensure professional development, support and mentoring and opportunities for career progression for rural health professionals
- Use of proven recruitment and retention strategies to support rural health professionals to become embedded in their community, find employment for partners and schooling for their children
- Work to improve the perception of rural health professional practice.

Recommendation

5. **The Alliance supports strategies to ensure equitable access to GPs as an essential source of primary mental health care in rural areas and full implementation of rural generalist pathways to increase the capacity of rural practitioners to provide care to people with mental health concerns and suicidality, where specialised services are not available.**
6. **There is a strong imperative to implement strategies to increase access to psychiatrists and psychologists in rural Australia.**
7. **Improving the knowledge and skill of all graduate nurses in mental health and wellbeing would have broad benefits for rural people.**
8. **Occupational substitution strategies that look at new ways to meet consumer needs, ensure all appropriately qualified and experience professionals are utilised and working to full scope and prioritise access to care coordination, the peer workforce and gate-keepers is essential to reform of the sector in rural Australia.**
9. **Universal workforce strategies with impact across professions must continue to focus on rural training (both pre and post entry to practice), ensure professionals support structures are in place and enable professionals and their families to integrate into rural communities.**

State and territory delivered mental health services and emergency department care

Both the Productivity Commission report and the Victorian Royal Commission[68] highlight the gap between state or territory run community-based mental health services and population need. They contend that funding be increased over time to meet demand. The Victorian Royal Commission proposes a reorientation of their system to centre around community based ambulatory care services. State or territory delivered community based mental health services are likely to be less cost prohibitive for rural people, improving their accessibility compared to some services delivered via the MBS. The location of bolstered state and territory delivered community mental health

services must be well considered and adequately distributed to ensure access to people living outside of major cities and major regional centres. Innovative outreach models should be developed and technology used as required, to ensure their benefit is delivered equitably.

Given emergency department presentations for mental health-related conditions are much higher outside of major cities and suicide is a significant problem, the way first responders and emergency department staff manage patients is pertinent to outcomes in rural areas. The Suicide Prevention Advisor's Advice recommends training for these personnel to improve their response to people in suicidal crisis and broadened access to aftercare after an attempted suicide. The Victorian Royal Commission has a similar focus on the provision of aftercare programs,[69] as does the Productivity Commission report.

Recommendation

10. **Increasing the capacity and acceptability of state or territory run community-based and hospital mental health services to meet consumer needs, with a particular focus on the provision of integrated suicide aftercare services, has the potential to improve outcomes in rural areas.**

Additional policy proposal

There is a strong focus on regional planning and governance in primary mental health and wellbeing and suicide prevention in the Productivity Commission report. This is supported to some degree by the concept of Local and Area Mental Health and Wellbeing Services with regional boards, proposed by the Victorian Royal Commission.[70] The Productivity Commission Report proposes Primary Health Networks (PHNs) work more closely with Local Hospital Networks (LHNs) to jointly plan and commission services, with state and territory governments establishing new Regional Commissioning Authorities (RCAs) as an alternative when these partnerships are not performing well.

The Alliance has been calling for many years for alternative models of primary care that can specifically meet the needs of rural communities that are:

- locally tailored
- provide the employment conditions necessary to attract and retain the full spectrum of primary health care providers, including general practitioners, nurses and midwives, pharmacists and a range of allied health professionals and
- provide a range of services to communities, including both health and social services.

We acknowledge Aboriginal Community Controlled Health Services (ACCHSs) as an example of how a system can be tailored to meet the needs of an identified population group and note the recommendation by the Productivity Commission report that ACCHS be the preferred provider of mental health and wellbeing and suicide prevention services and supports for Aboriginal people. We propose Rural Area Community Controlled Health Services (RACCHOs) as a solution to tailoring the system to meet the needs of rural Australians.

In rural areas, we suggest that capacity might not exist to have dedicated mental health and wellbeing governance structures and that RACCHOs provide a mechanism for efficient sharing of limited funding, workforce and infrastructure. RACCHOs would be broadly modelled on the ACCHS, with modifications to meet the needs of rural communities. They would focus on Modified Monash Model[71] categories 3-7 to ensure a genuine emphasis on the most disadvantaged rural areas (in terms of access to care and health outcomes), utilise existing infrastructure, and require

collaboration between PHNs and LHNs to develop models in alignment with community need. A key feature of this proposed service model is the combination of fee for service funding models with block, blended and shared funding arrangement as appropriate, streamlining funding from multiple sources. This would assist the attraction and retention of primary health care professionals by providing secure, ongoing employment, financial viability, a multidisciplinary team environment, professional and social support networks and the opportunity to work to full scope of practice. We anticipate these measures would make rural practice more attractive for all health professionals, but especially allied health professionals who currently do not have access to the levels of support available to medical staff to practice rurally.

RACCHOs build on trials currently underway to explore innovative models of care for rural Australia and have the potential to reduce the over-representation of rural people in the public hospital system. They would enable a focus on prevention and early intervention, incorporate strategies to improve workforce availability and increase equitable access to care.

Recommendation

11. **We urge the Committee to consider the Alliance's model of RACCHOs as a tailored solution to health care (including mental health care) provision in rural areas.**

Conclusion

This submission has provided an overview of the disparities in mental health and wellbeing and suicide experienced by people living outside our major cities. Though the prevalence of mental health conditions in rural Australia is similar to major cities, rates of suicide and intentional self-harm are much higher, as are rates of substance abuse, and the burden attributable to suicide and self-inflicted injuries increases dramatically with remoteness. Rural living, when analysed from an eco-systems perspective, presents the challenge of cumulative and ongoing adversity on many levels (from the individual and family to the community and societal level). This adversity takes into account the impact of extreme weather events and climatic changes, along with broader social and economic challenges and has a subsequent impact on mental health and wellbeing. Differences in access to and utilisation of services and supports on the background of this adversity results in a greater impact on the lives of rural people. Change needs to occur at multiple levels and points in the system, as advocated in various contemporary reports, to positively effect outcomes for rural people. We urge the Committee to thoroughly consider the Alliance's recommendations to this end.

National Rural Health Alliance – member organisations

Allied Health Professions Australia Rural and Remote
Australasian College for Emergency Medicine
Australasian College of Health Service Management (Regional, Rural and Remote Special Interest Group)
Australasian College of Paramedicine
Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine
Australian Chiropractors Association (Aboriginal and Torres Strait Islander Rural and Remote Practitioner Network)
Australian College of Midwives (Rural and Remote Advisory Committee)
Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
Australian College of Rural and Remote Medicine
Australian Dental Association (Rural Dentists' Network)
Australian General Practice Accreditation Limited
Australian Healthcare and Hospitals Association
Australian Indigenous Doctors' Association
Australian Nursing and Midwifery Federation (rural members)
Australian Paediatric Society
Australian Physiotherapy Association (Rural Advisory Council)
Australian Psychological Society (Rural and Remote Psychology Interest Group)
Australian Rural Health Education Network
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
Council of Ambulance Authorities
Country Women's Association of Australia
CRANAplus
Exercise and Sports Science Australia
Federation of Rural Australian Medical Educators
Isolated Children's Parents' Association
National Aboriginal Community Controlled Health Organisation
National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
National Rural Health Student Network
Optometry Australia (Rural Optometry Group)
Pharmaceutical Society of Australia (Rural Special Interest Group)
Regional Medical Specialists Association
Royal Australasian College of Medical Administrators
Royal Australasian College of Surgeons (Rural Surgery Section)
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners Rural Faculty
Royal Far West
Royal Flying Doctor Service
Rural Doctors Association of Australia
Rural Health Workforce Australia
Rural Pharmacists Australia
Services for Australian Rural and Remote Allied Health
Society of Hospital Pharmacists of Australia
Speech Pathology Australia

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