Submission to the National Mental Health Commission on the Review of Mental Health Services and Programmes

14 April 2014

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

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The National Rural Health Alliance has had a longstanding commitment to better mental health services and improved mental health outcomes for the people of rural and remote areas.

In Australia, mental illness is a serious and widespread concern. Appendix 1 contains a very brief description of the state of mental health in Australia as a whole.

Published figures suggest that, if measured by reference to psychological distress as reported by the ABS, the prevalence of mental illness in rural and remote areas is no greater than in Australia's major cities.[1] However such published data measure only the occasions when a person with a mental health condition contacts part of the health system: a doctor, a community mental health service or a hospital, for example, and when the visit is recorded as specifically related to mental health. There are likely to be all manner of reasons why people with mental health conditions do not seek or obtain mental health services, and the extent to which such reasons are prevalent in city and country areas will determine the degree to which the published data about the prevalence of mental illness are reliable.

In rural and remote areas, unlike the major cities, the reasons for non-presentation will include the fact that no appropriate mental health services are available. What this means is that serious presentations of mental illness have to be dealt with by other means, for instance through police and law enforcement agencies and/or through emergency evacuation.
Even if the prevalence of mental illness in rural and remote areas is no different from that in the major cities, the Alliance generally argues (including in this submission) that the consequences of mental illness are greater in rural and remote areas. We believe this to be true for the following three main reasons.

First, there is a quite different cultural approach to the health system and self-care among a greater proportion of people in country areas. Their approach, usually characterised as 'self-reliance' or 'resilience', is mediated by longstanding social attitudes and by the reality that it is less easy to interact with the health system in sparsely-populated areas. In general, therefore, the people of rural and remote areas are less likely to admit to a mental health problem and seek assistance for it.

Secondly, there are far fewer mental health professionals available in rural and remote areas. This means that, even given the will to do so, it is harder for rural people to know about, locate and access professional services. Therefore a person's diagnosis and intervention for a mental health condition are likely to occur later in its progression.

The third reason is a composite of the first (attitude of self-sufficiency) and the second (the 'thin' mental health system in more remote areas). The result of these two is that there is likely to be more stigma - both perceived and real - involved in seeking help for a mental health condition where the population is sparse and the health service providers few. This is even more keenly experienced by specific populations, particularly Aboriginal and culturally and linguistically diverse people. Small communities are less likely places in which confidentiality can be assured.

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[1] As is so often the case, the numbers for remote and very remote areas may not be reliable estimates .

Current access to mental health services in rural and remote areas

This submission provides new evidence, sourced from the Australian Institute of Health and Welfare (AIHW), relating to the access to mental health services funded or subsidised by Medicare. It shows clearly that people in rural and remote areas are disadvantaged in such access, almost certainly because of the maldistribution of GPs and other relevant health professionals and their shortage or absence from more remote areas.

This means that one of the standard policy responses to mental health challenges (as to other health matters) - providing Medicare rebates through targeted item numbers, largely for GPs - does not work as well in more remote areas. Another of the standard responses is to provide service through the Internet or with telephone answer lines. These may be particularly valuable for rural and remote people, especially given their greater exposure to and sensitivity towards stigma and privacy concerns. However consideration needs to be given to the reality of poor Internet connectivity and telephony in rural and remote areas. Greater certainty is also needed about which particular approaches to online and telephone services work most effectively, especially for people who are already isolated by their geographical location.

This submission deals briefly with some of the greater complexity of mental illness in rural and remote areas, caused by the fact that several of the risk factors and some of the comorbidities associated with it are more common in those areas than in major cities. Such confounding issues include smoking, risky use of alcohol and other drugs, levels of disability and ageing, prevalence of complex and chronic conditions, years of completed education and levels of income.

With respect to disability there are some particular rural and remote factors, including those that relate to the mental health of those with *intellectual* disability and the relationship between mental illness and the care to be provided under the National Disability Insurance Scheme (NDIS). (The Alliance is active in these areas and has an ongoing interest.)

> *"The lady who is 80 years of age has an intellectually disabled child, 58 years old, and is despairing as to what is going to happen to her child when she has gone and the only respite care she has access to is by putting her child in an aged care facility for a day or two. Her guilt is immense and her mental state is fragile."*
>
> *CWA correspondent*

Although the evidence is not clearly available, the Alliance believes it likely that where intervention and management are concerned, rural and remote areas are particularly deficient for people with acute and severe mental health issues, including psychotic illnesses. The fear is that many people affected by these may not be adequately recognised or supported by the health and community care systems in rural areas; the hope is that smaller community settings provide a more caring and inclusive environment for such people.

Design of effective mental health services in rural and remote areas

While it is important to emphasise the need for continued effort to establish more specialised mental health services in rural and remote areas, little change from the current workforce pattern for mental health care can be expected. Much of the initial presentation of mental health conditions and the ongoing care will continue to be managed by GPs, nurses,

midwives, psychologists and other allied health professionals, pharmacists and Aboriginal and Torres Strait Island Health workers - including for emergency presentations. The emphasis must be on education, continuing professional development and support for those health professionals who are already working in such areas.

This task should commence with all health students, particularly those heading for rural and remote areas, having sufficient training to enable them to look after their own mental health and to be prepared for the emergency mental health presentations they are sure to receive.

Recommendations

1. In efforts to design, apply and manage mental health programs that are fit-for-purpose for rural and remote areas, there must be close collaboration and communication with local health consumers, clinicians and community services.

2. A renewed and refreshed Mental Health First-Aid (MHFA) approach should be adopted with a particular eye on the agencies and individuals with whom people in rural and remote areas, including those in agriculture and mining, regularly relate and from whom they normally receive information.

3. Further development of the provision of mental health information and support by telephone and online should be a priority for people in rural and remote areas. Consideration should be given to the demonstrated efficacy of various approaches to such work, with appropriate allowance made for the realities of poor telephone and Internet connectivity in rural and remote areas. There are some new and emerging possibilities in the area relating to smart phone apps, including for Aboriginal and Torres Strait Islander people. There are already a number of valuable online mental health resources including several funded by the Australian Government, including mindhealthconnect operated by Healthdirect Australia, ANU's eHub online self help programs, and MindMatters.

4. Assuming that their efficacy and cost effectiveness can be demonstrated, programs already provided that are targeted specifically for people in rural and remote areas or are designed in such a way as to benefit them, should continue to be funded and, where appropriate, expanded. They include Mental Health Services in Rural and Remote Areas, the Mental Health Nurse Incentive Program, Access to Allied Psychological Services (ATAPS), Partners in Recovery, some targeted work relating to suicide prevention, the Personal Helpers and Mentors service (PHaMs), the Mental Health Respite: Carer Support (MHR:CS) program, the National Respite for Carers Program (NRCP), the visiting psychiatric services through the Medical Specialist Outreach Assistance Program (MSOAP) and MBS item numbers for telepsychiatry.

   Relating to this last, telehealth consultations facilitated by GPs, nurse practitioners and Aboriginal Health Workers are reimbursed through Medicare for their clients living in rural and remote areas to participate in a videoconference with a specialised psychiatry service. Consideration should be given to facilitating arrangements for mental health nurses and relevant allied health professionals to support their clients in accessing specialised telepsychiatry consultations, and to psychologists being able to bill Medicare directly in specified situations.

5. An expanded program for providing continuing professional development in mental health for rural GPs, nurses and Aboriginal Health Workers is urgently needed. It could be modelled on the successful Rural Health Continuing Education (Stream 2) (RHCE2) program managed for the Commonwealth by the Alliance. Such training and support, with a particular focus on multidisciplinary healthcare teams, should include consideration of the means by which the generalist workforce can respond to mental health emergencies.

6. Community organisations that are particularly valuable in relation to community mental health and wellbeing should be recognised, valued and, where appropriate, resourced by governments. They include bodies such as the Country Women's Association of Australia, rural local authorities, sporting bodies, Men's Sheds, and the Mental Health Professionals' Network.

7. Regional health agencies (such as Medicare Locals in some areas) will continue to have a key role to play in working with local communities, clinicians, hospital and non-government organisations to coordinate effective mental health care locally.

Introduction

The National Rural Health Alliance (NRHA) is comprised of 37 member bodies, each a national body in its own right. They include consumer groups (such as the Country Women's Association of Australia), representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses, allied health professionals, dentists, pharmacists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service and Frontier Services of the Uniting Church in Australia). (See Appendix 2). Through its broad membership, the Alliance represents the health interests of the more than 6.7 million people who live in rural and remote Australia.

People living in rural and remote Australia encounter unique challenges both in their experiences of mental illness and how they might access mental health professionals and services. Identifying and supporting effective responses to meet these challenges has long been a priority for the Alliance.

> *"I think the level of service is reasonable here for a small town but is mainly directed to the frail, the aged and those with a disability. GPs deal with mental health issues. We have a good medical centre but open only weekdays. Ambulance is available for emergencies and maybe they have a doctor on call weekends. There is a pharmacy in town, not sure of current hours but open weekends in winter. I don't know of any self-help groups but there is probably more available than I am aware of. Sorry I don't have much info. I'm a bit of a recluse and I do know that when you are feeling 'down' the last thing you feel like doing is seeking help or even talking to friends. Difficult problem."*
>
> *CWA correspondent*

While the majority of people of rural and remote Australia, like that CWA correspondent, live in communities where there are some services provided by nurses and doctors, the Alliance has always had a particular concern for the smaller number who live in remote communities in which there are no resident health professionals and where support is provided by carers, family, Aboriginal Health Workers and visiting staff. When stricter limits have to be placed on the resources available to rural and remote health and wellbeing, the 'worst first' principle should always apply.[2]

An effective mental health system is one that is equipped to recognise and serve the diverse needs of people of all ages, backgrounds, cultures, socioeconomic profiles and locations. The system needs to take account of the fact that, compared with physical illness, mental health problems are often harder to discern and describe. Also, they can have an additional layer of complexity given that co-morbidities are often characteristic of a mental health presentation. In small, tight-knit communities, the stigma and community perceptions often attached to mental illness add another dimension that must be considered in a good mental health system.

A world-class mental health system will be socially appropriate and universally accessible. It will provide integrated and cost-effective prevention, diagnosis and treatment for the full range of mental health conditions.

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[2] The point has been made that Norfolk Island provides a case study of the great difficulty people in very remote areas have in accessing more specialised health services, including for mental illness.

Such a system requires the support of legislative settings (including at State and Territory level) that help to ensure respect for the human rights and dignity of people with mental illness, and their families and carers. In day-to-day terms, this should include the provision of access to legal and advocacy services to help address the needs of mental health consumers.

The state of mental health in rural and remote Australia

The state of mental health across Australia as a whole is briefly summarised in Appendix 1. It is a matter of serious and widespread concern.

The prevalence of mental illness may be similar across all remoteness areas,[3] as suggested by figures from COAG based on the ABS's National Health Survey, 2011-12 (Table 1).

Table 1: Prevalence of psychological distress, 2011-12

	MC	IR	OR	R/VR	VR
People with very high levels of psychological distress	3.3%	3.8%	3.5%	2.9%	

Note: the combined figure for Remote and Very remote areas should be treated with caution. It will be comprised largely of numbers from larger Remote centres and may well underestimate the rate in Very remote areas.

However the personal consequences of mental illness for people in rural and remote areas are likely to be worse due to longstanding social attitudes of self-sufficiency among country people and poorer access to specialised support for those suffering from the condition, compounded by possible greater stigma.

As is well known, people in rural and especially remote areas have poorer access locally to doctors and very much less local access to psychiatrists and psychologists.

Despite these and other challenges of country life, such as lower levels of completed education and lower income, fewer employment opportunities and options for public housing, rates of self-reported life satisfaction (or, broadly speaking, 'happiness') tend to be higher in rural and remote areas than in the major cities. This is testimony to the resilience for which people in these areas are renowned. This attribute should be acknowledged and celebrated but not used as a rationale for any inaction in relation to service provision.

This personal and community resilience is partly explained by people's greater self-reliance, which can actually be a barrier to seeking help, especially among rural men. Again, factors related to stigma, combined with privacy needs, can determine people's decisions to not seek help and not take up mental health programs.[4]

Such concerns are warranted given that it has been reported that 33-49 per cent of the general population would avoid someone with a mental illness, 37 per cent would not employ someone with chronic schizophrenia, 23 per cent would not employ someone with

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[3] Throughout this submission references to remoteness areas are based on ASGC-RA, in which category 1 is Major cities, 2 is Inner regional areas, 3 Outer regional, 4 Remote and 5 Very remote. For methodological reasons (eg small numbers) Remote and Very remote are often reported jointly.

[4] Health Performance Council. Mental Health in Rural and Remote South Australian Communities. Government of South Australia, 2013.
http://www.hpcsa.com.au/files/382_mental_health_issues_in_rural_and_remote_sa.pdf

depression, [5] and about 60 per cent of the family members of people affected by mental illness report experiencing negative, hurtful and offensive attitudes from the public.[6]

It is a matter of concern that fear of discrimination not only discourages people from seeking help, but also causes them to withdraw from life and become isolated.[7]

Given the shortage of specialised mental health services and personnel in more remote areas and the prevailing attitudes to seeking help, it is often the case that diagnosis and intervention which could alleviate mental illness are hampered and delayed. This results in greater personal, family and community impacts. The seriousness of this situation should underpin consideration of the means by which greater public support is provided for specialised clinical work from psychologists and mental health nurses in selected situations of need.

Behavioural risk factors

People in rural and remote areas also experience a high prevalence of behavioural risk factors associated with poor mental health, including smoking, illicit drug use and risky alcohol consumption. The relationship between mental health and such risk factors is complex, with uncertainty about the strength and direction of causality. But the proven links are significant, and the use of alcohol and tobacco certainly increases the complexity of mental illness.

Regarding the risky use of alcohol, the Alliance has a particular concern about Fetal Alcohol Spectrum Disorder. It has developed a good working relationship with the Russell Family Fetal Alcohol Disorders Association (RFFADA) and we commend to the Commission the detailed submission to this review from that organisation.

A significantly higher proportion of people in rural and remote areas smoke: 22.4 per cent in Outer regional and Remote areas and 18.4 per cent in Inner regional areas, compared with 14.7 per cent in metropolitan areas. People living in Remote and Very remote areas are around 1.7 times more likely to smoke than those in Major cities.[8]

These are significant differences given that around 32 per cent of people with mental illness smoke, compared with just 18 per cent of the general population. The rate is far higher among people with psychotic illness such as schizophrenia, whose rates of smoking are 60-73 per cent.[9]

The proportion of people who drink at risky levels also increases with remoteness, with men, youths, and those working in farming and mining industries having particularly high rates.

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[5] Reavley N, Jorm A. National Survey of Mental Health Literacy and Stigma. Canberra: Department of Health and Ageing; 2011 as cited in as cited in the 2013 National Report Card on Mental Health and Suicide Prevention (2013), http://www.mentalhealthcommission.gov.au/media/94938/Summary%20Report.pdf

[6] Mental Health Council of Australia. Consumer and carer experiences of stigma from mental health and other health professionals. Canberra: MHCA; 2011, http://www.mentalhealthcommission.gov.au/media/94938/Summary%20Report.pdf

[7] Morgan VA, Waterreus A, Jablensky A, MacKinnon A, McGrath JJ, et al. People living with psychotic illness 2010. Report on the second Australian national survey. Canberra: Australian Government; 2011, http://www.mentalhealthcommission.gov.au/media/94938/Summary%20Report.pdf

[8] *Fact Sheet: Smoking and Rural Health* (2014), National Rural Health Alliance, http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-smoking.pdf

[9] Smoking and mental illness: A guide for health professionals, Dept. of Health and Ageing, http://www.quitnow.gov.au/internet/quitnow/publishing.nsf/Content/799BB5A8F5E8C591CA257A0D001F11DC/$File/28062012%20healthprofs%20FINAL.pdf

Among farming communities in rural Victoria, an estimated 54 per cent of men and 22 per cent of women reported drinking at high-risk levels at least once a month compared to 20 per cent of the general population.[10]

Compared with non-Indigenous people, Aboriginal and Torres Strait Islander people (two-thirds of whom live in rural and remote areas) are 1.5 times more likely to drink at risky levels, resulting in both lifetime and single-occasion harm. This is despite the fact that a higher proportion of Aboriginal and Torres Strait Islander people than non-Indigenous people do not drink alcohol at all.[11]

Around eight per cent of people in Australia aged 16–85 years have had a drug-use disorder (including harmful use/abuse and/or dependence) in their lifetime.[12] In 2007, men living outside major cities were 28 per cent more likely than those living in the cities to have a substance-use disorder at some point in their life.[13] Of concern is the fact that while rates of substance abuse a higher outside the major cities, the availability of remedial drug services is particularly limited in rural areas, including withdrawal assistance such as methadone programs and detoxification services, and needle and syringe programs that can make drug use safer. Rural and remote residents may also be more reluctant to disclose their drug use to local healthcare professionals, given the fact that there is a greater chance of them being personally known to each other.

In any given year, about 340,000 Australians grapple with the combination of a mental health difficulty and a substance (drug or alcohol) problem. Such people represent up to 70 per cent of those presenting to mental health or substance use services.[14,15]

Vulnerable population groups

A number of subgroups in rural Australia are particularly vulnerable to poor mental health and its consequences - including the most tragic. Estimates of male youth suicide in rural, regional and remote areas indicate that it occurs at almost twice the rate as it does in metropolitan areas. Factors including unemployment, greater availability of lethal means of self-harm, and barriers to mental healthcare services all contribute to this outcome. And adolescents in rural areas can be reluctant to seek help for their emotional problems. For example, a study of almost 800 high school students from the Riverina region of New South Wales reports that they do not believe they would benefit from seeking professional help.[16]

[10] *Fact Sheet: Alcohol Use in Rural Areas* (2014), National Rural Health Alliance, http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-alcohol.pdf
[11] *Fact Sheet: Alcohol Use in Rural Areas* (2014), National Rural Health Alliance, http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-alcohol.pdf
[12] *Drugs in Australia* (2010), AIHW, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737420455
[13] A snapshot of men's health in regional and remote Australia (2007), AIHW, http://www.aihw.gov.au/publication-detail/?id=6442468343
[14] Australian Bureau of Statistics. Analysis of 2007 National Survey of Mental Health and Wellbeing (Unpublished): ABS; 2013 as cited in the 2013 National Report Card on Mental Health and Suicide Prevention (2013), http://www.mentalhealthcommission.gov.au/media/94938/Summary%20Report.pdf
[15] Deady M, Teeson M, Mills K, Kay-Lambkin F, Baker A, Baillie A, et al. One person, diverse needs: living with mental health and alcohol and drug difficulties. A review of best practice. Sydney: NHMRC Centre of Research Excellence in Mental Health and Substance Use; 2013 as cited in the 2013 National Report Card on Mental Health and Suicide Prevention (2013), http://www.mentalhealthcommission.gov.au/media/94938/Summary%20Report.pdf
[16] *Media Release: Rural adolescents reluctant to seek help for emotional problems* (2011), National Rural Health Alliance, http://ruralhealth.org.au/sites/default/files/media-files/mr-2011-03-31.pdf

Rural and remote areas have higher rates of childbirth than the major cities, and women in those areas display a higher prevalence of postnatal depression.[17] Apart from that, the rates of diagnosed mental health conditions among younger women are lower in rural areas.

Despite having elevated rates of substance misuse and mental health issues, Indigenous people do not engage with mental health services at levels commensurate with need, perhaps due to the limited availability of culturally-acceptable services. Their mental health problems may go undetected and untreated until they have become severe or disruptive enough to warrant in-patient care. From 2001-2010, the overall rate of suicide for Aboriginal and Torres Strait Islander people was twice that of non-Indigenous people, with a rate ratio of 2.0 for males and 1.9 for females. The greatest difference in rates of suicide between Aboriginal and Torres Strait Islander peoples and non-Indigenous people was in the 15-19 years age group for both males and females. Suicide rates for Aboriginal and Torres Strait Islander females aged 15–19 years were 5.9 times higher than those for non-Indigenous females in this age group, while for males the corresponding rate ratio was 4.4.[18]

The Alliance hears reports from time to time of local mental health crises in various parts of the country. A recent article in The Age newspaper described the situation in Mildura.[19]

A large body of evidence shows that a lack of control over one's destiny is associated with poorer health. It is therefore significant that a larger proportion of the workforce in rural and remote communities than in the major cities find themselves in a situation in which their economic security and returns are affected by circumstances entirely beyond their control. Farm incomes and businesses linked to them are influenced by quite uncontrollable and unpredictable weather and climatic circumstances, variations in commodity and fuel prices, and exchange rate changes.

People living in rural and remote areas are likely to feel the brunt of extreme adverse weather events such as floods and bushfires. It has been estimated that one in five people affected by natural disasters is likely to develop mental health problems.

Such stressors contribute to increased levels of anxiety and depression, social isolation, the misuse of alcohol and other drugs, relationship problems and the potential risk of suicide. In 2008, the Australian Institute of Family Studies found that among farmers who were in drought, 17 per cent had mental health issues, compared with 8 per cent who had not experienced drought in the three previous years. In 2008, South Australia's Flinders University School of Social Work showed that prolonged drought and increased social isolation are linked to rates of suicide among male farmers that are almost 50 per cent higher than the average in rural communities. That study showed that 34 in every 100,000 male farmers commit suicide – significantly more than the 24 per 100,000 among rural men generally.[20]

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[17] Summary report from the Australian Longitudinal Study on Women's Health, conducted by researchers at the Universities of Newcastle and Queensland (funded by the Commonwealth Department of Health and Ageing).
[18] 3009.0 *Suicides in Australia 2001-10* (2010), ABS, http://www.abs.gov.au/ausstats/abs@.nsf/Products/3309.0~2010~Chapter~Aboriginal+and+Torres+Strait+Islander+suicide+deaths?OpenDocument
[19] Johnston, Chris and Moncrief, Marc, 'The Bush Therapist', *The Age*, 5 April 2014.
[20] *Submission to the Productivity Commission Inquiry into Drought Support* (2008), Australian General Practice Network, http://www.pc.gov.au/__data/assets/pdf_file/0018/85122/subdr170-part2.pdf

For such reasons as these the Alliance and the people of rural and remote areas welcome the earmarking of some of the funding in the recent Commonwealth drought package to help increase access to social and mental health services for families affected by drought.

Fly-in, Fly-out workers[21]

Other groups at risk in rural and remote areas include those in the mining and minerals sector, and those affected by it.

Miners tend to work longer than average hours, live away from their families, and some are in inherently dangerous jobs. The circumstances of Fly-in, Fly-out (FIFO) miners can exacerbate these lifestyle challenges. Irrespective of their trade or profession, employees in FIFO situations are often required to undertake shift work, sometimes entailing 12-hour overnight stints. This is significant given that shift workers are more likely than others to suffer from symptoms of depression and other mood disorders, and experience additional social isolation.

Workers in FIFO camps are exposed to some particular risk factors for mental illness, such as enforced separation from family, social isolation, and high levels of alcohol and/or other drug consumption. They also fall into a high-risk demographic group for health-risk factors (ie, males aged 25-44 years) and may well have poor access to health services - particularly if the workers are from culturally and linguistically diverse backgrounds.

The families of FIFO workers are also exposed to some potentially serious risk factors for mental health, with one parent - usually the father - away from home for extended periods. When the miners fly back home, they often bring their problems with them. Uniting Care, which provides pastoral care in many cities and regional centres, has reported an increased demand from FIFO workers for family support services, counselling, and financial assistance.

Frontier Services staff report that the effects of FIFO work are comparable to the mental health problems suffered by military veterans.[22] And for an organisation like Frontier Services that is providing ministry and community services to people in quite remote areas, the burgeoning minerals sector and its associated FIFO phenomenon have a range of critical impacts. It becomes almost impossible for them to compete with mining companies for staff and housing. A large influx of non-resident workers can also disrupt the social fabric and feeling of a town and have a negative impact on the safety and amenity of communities.

In its Submission to the Inquiry into the use of 'fly-in, fly-out' workforce practices in regional Australia, Centacare in Narrabri referred to the difficulties in sourcing emergency accommodation for their clients, who include people impacted by mental health and homelessness[23]:

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[21] see National Rural Health Alliance. *Use of 'fly-in, fly-out' (FIFO) workforce practices in regional Australia Submission to the Standing Committee on Regional Australia*. 11 October 2011 http://ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/submission/sub-fifo-11-oct-11.pdf

[22] *The dark side of fly-in fly-out work in remote Australia* (2013) (sourced from interview with Rosemary Young on the Religion and Ethics Report), ABC, http://www.abc.net.au/radionational/programs/religionandethicsreport/dark-side-of-fly-in-fly-out-mining/4534344

[23] http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=ra/fifodido/report/chapter3.htm

> *"Competition for such bedspace was challenging prior to the roll out of the FIFO mine workforce. Competition for such bed space has since become impossible. Bedspace is pre-booked well in advance by the mines and contracting companies."*

In its Submission to that Inquiry the Isaac Regional Council (Clermont, Dysart, Moranbah) noted:

> *Aside from visual amenity, the proportion of residents to non-residents also contributes to the sense of being 'taken over' by work camps ... Small rural towns have a strong identity and sense of community – an important part of the social capital of these towns – that is being threatened by the dominance of mining. Lack of integration between resident and non-resident workers creates a strong 'us vs them' mentality and non-resident mine workers are blamed for a disproportionate share of crime and anti-social behaviour. There are also increasing level of fear being reported.* [24]

An influx of temporary workers may also impact negatively on local residents' access to mental health and support services by increasing the demands on those services.

Given the impacts of FIFO practices on both the families and communities involved, increased family support should be provided and greater attention given to community development and sustainability in areas where the practices are common. Companies that engage in large-scale FIFO work practices should give detailed attention to the impact on the families involved and be responsive to the needs and circumstances of specific individuals and families.

Housing stress, transport

Poor housing is also associated with mental illness. Housing stress (the situation in which housing costs are 30 per cent or more of household income) is, perhaps surprisingly, more prevalent in rural and remote areas.[25]

Aboriginal and Torres Strait Islanders are particularly susceptible to housing stress and its impacts on mental health. Indigenous households are 10 times more likely to be living in overcrowded conditions than non-Indigenous households.[26] In 2008, rates of overcrowding were found to increase with remoteness, affecting 13 per cent of adults in major cities, 20 per cent in regional areas and 48 per cent of those in remote areas.[27] The rate of homelessness for Aboriginal and Torres Strait Islander people is four times that of non-Indigenous Australians.[28]

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[24] *Cancer of the bush or salvation for our cities? Fly-in, fly-out and drive-in, drive-out workforce practices in Regional Australia* (2013), House of Representatives Standing Committee on Regional Australia, http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=ra/fifodido/index.htm

[25] Australian Housing and Urban Research Institute, http://www.ahuri.edu.au/themes/housing_affordability

[26] *Housing and homelessness services: Access for Aboriginal and Torres Strait Islander people* (2011), AIHW, http://www.aihw.gov.au/publication-detail/?id=10737419006

[27] *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (2010), ABS, http://www.abs.gov.au/AUSSTATS/abs@.nsf/lookup/4704.0Chapter865Oct+2010

[28] *Housing and homelessness services: Access for Aboriginal and Torres Strait Islander people* (2011), AIHW, http://www.aihw.gov.au/publication-detail/?id=10737419006

Among homeless people, as many as 75 per cent experience mental illness.[29] Despite cheaper housing costs overall in rural areas, stocks of good housing are low, the risk of homelessness is increased due to lower incomes, and there are few emergency housing and accommodation services, all making it difficult for the homeless in rural areas to escape their predicament.

Issues relating to the access to medication and professional pharmacy services, and personal transport, may also pose particular challenges for people in more remote areas who have a mental illness.[30] The Alliance has an ongoing concern about the extent to which the States' and Territories' patient travel and accommodation assistance schemes are well enough funded and well enough known to be fair and effective, given the maldistribution of more specialised health services and the fact that public transport is limited or unavailable in many areas.[31]

Older people, people with chronic conditions and people living with disability

Overall, rural and remote communities have a larger proportion of people aged over 65 years and certain mental health conditions become more prevalent with age.

Around 10-15 per cent of older Australians experience anxiety and depression, rising to 34.7 per cent for those living in residential aged-care facilities. Conditions such as schizophrenia and related disorders are more common in older people (2.3 per cent) than in younger adults (1.3 per cent).[32] This issue may be of concern given that the National Disability Insurance Scheme (NDIS) cuts out at 65 years and mental health conditions may not manifest themselves until after a person reaches 65 years. Certainly, policies related to the application of the NDIS will also need to take account of the episodic or fluctuating nature of various mental illnesses.

Given the more rapid ageing of rural and remote areas, conditions such as dementia also pose particular concerns. In 2010, 45,400 Australians had dementia; by 2050 the number will be 1.3 million. This will pose some particular challenges for the aged care sector in rural areas which already struggles with higher running costs and staffing difficulties.[33]

> *"My chief concern is the lack of staff for the number of residents with advancing age and progressive illness, especially with dementia. Staff/resident ratios need to be increased in aged care facilities as the needs progress (often quite rapidly). They remain the same where, with people's needs continually increasing, they should be adjusted. I see staff with various levels of stress, most of it caused by far too great a work load. They are very caring and do what they can, often having to work a double shift!! when other staff become unavailable for whatever reason."*
>
> *CWA correspondent*

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[29] *Mental Health, Housing and Homelessness in Australia* (2009), Mental Health Council of Australia, https://mhca.org.au/sites/default/files/imported/component/rsfiles/publications/MHCA_Home_Truths_Layout_FINAL.pdf

[30] see http://ruralhealth.org.au/document/discussion-paper-access-medicines-and-pharmacy-services

[31] The Alliance is soon to publish a revised Fact Sheet on patients assisted travel schemes.

[32] *Older Australians Deserve a Better Deal in Mental Health*, RANZCP, https://www.ranzcp.org/Files/Resources/Older_Australians_Deserve_a_Better_Deal_in_Mental_.aspx

[33] *Older Australians Deserve a Better Deal in Mental Health*, RANZCP, https://www.ranzcp.org/Files/Resources/Older_Australians_Deserve_a_Better_Deal_in_Mental_.aspx

People with chronic pain or illness are at greater risk of suicide,[34] and an Australian Bureau of Statistics (ABS) study reports that people who live outside major cities are 23 per cent more likely to have back pain - the most commonly reported location of pain, and thus a reasonable 'proxy' for chronic pain. This figure rises to a 30 per cent increased likelihood for rural residents aged 55 to 64 years.[35]

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[34] Cavanagh JT, Carson AJ, Sharpe M, Lawrie SM. Psychological autopsy studies of suicide: a systematic review. Psychological medicine. 2003; 33(3): 395-405. as cited in the 2013 National Report Card on Mental Health and Suicide Prevention (2013),
http://www.mentalhealthcommission.gov.au/media/94938/Summary%20Report.pdf
[35] Fact Sheet: Chronic Pain - A Major Issue in Rural Australia (2013), National Rural Health Alliance,
http://ruralhealth.org.au/sites/default/files/publications//nrha-factsheet-pain.pdf

Current access to mental health services in rural and remote areas

> *"The community mental health care nurses do not do home visits in our area, requiring you to travel: more time, more money - which you don't always have. More outreach community mental health nurses could help with this problem.*
>
> *The mental health services if you can have access to them are generally helpful and can improve the outcome of mental illnesses. It is also very often that when you are unwell that you are more likely to forget, or not attend appointments."*
>
> *CWA correspondent*

Family and friends are likely to be the first to be aware of and affected by an individual's deteriorating mental health and, as discussed above, many people with a mental illness do not see a health professional for some time, if at all.

Where primary mental health care is concerned, much of the work is done by GPs and community mental health services (Table 2). The rate of use of community mental health services is encouragingly similar across remoteness areas, unlike access to GP services which falls off significantly with increasing remoteness.

Table 2: The relative role of community mental health services and GPs, by remoteness area, 2011-12[1]

	MC	IR	OR	R R/VR	VR
Community mental health encounters – per 1000 population	322.1	333.2	295.4	285.7	307.2
GP encounters for mental illness – per 1000 population	668.2	651.1	595.3	241.3	

Source: Mental Health Services Australia, AIHW, https://mhsa.aihw.gov.au/home/
GP encounters are estimated from the BEACH survey.

As the Alliance has reported,[36] the primary care deficit in rural and remote areas is partially offset by a relatively higher use of public hospitals by people in those areas. Table 3, below, shows that access by rural people to specialised psychiatric care as part of their attendance at a hospital for mental health care is at an increasingly lower rate as one moves from Major cities to Remote and Very remote areas.

> *"Priority needs to be given to mental health to ensure the wellbeing of our communities and our country, especially when you consider that mental health is a contributor to obesity and our governments and health fraternity are spending money on the outcome of mental health problems like addictions (gambling, smoking, drugs, alcohol, sex), and obesity and not the cause."*
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> *CWA correspondent*

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[36]see http://ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/position/pos-full-complementary-report-27-feb-11.pdf

Table 3: The role of hospitals in providing mental health services, by remoteness area, 2010-11

	MC	IR	OR	R	VR
				R/VR	
Mental health separations per 1000 population - with specialised psychiatric care	6.2	5.8	4.7	3.1	
Mental health separations per 1000 population - without specialised psychiatric care	3.5	4.4	5.5	8.0	
Ambulatory-equivalent mental health related separations with specialised psychiatric care, per 1000 population	6.5	2.3	0.7	0.3	0.2
Mental health related emergency department attendances	not published				

Source: Mental Health Services Australia, AIHW, https://mhsa.aihw.gov.au/home/

> *"I can speak from two perspectives here. Firstly from a family point of view and then work point of view. They both have a common denominator: when an episode or incident occurs, where do I go and who should I ring? There needs to be more mental health primary care responsibilities through Medicare incentives and/or rebates. This would need to include training of Medical Centre staff, to be able to recognise mental health issues and crisis, and know where to get appropriate intervention promptly.*
>
> *This will enable people to access services in the community rather than having to present to ED. If you have mental health issues, the last place you want to be is ED."*
>
> *CWA correspondent*

The pattern of mental health care by primary and acute care sectors is, like so much else, heavily influenced by the local availability of relevant health professionals. Table 4 and Figure 1 show that mental health professionals become scarce in more remote areas. (There is a separate section below on the services of psychologists to people in rural and remote areas.)

Almost nine out of 10 FTE psychiatrists (87.7 per cent) were employed in Major cities in 2011. There were 16.4 FTE per 100,000 population in the Major cities, 5.8 for Inner regional, 3.4 for Outer regional and 4.6 for Remote and Very remote areas (Table 4).

The bulk of general practice care is underwritten by Medicare and, as is the case for so many other conditions, it is GPs and Medicare to which so many of the expectations for mental health care are attached. The Alliance regularly makes the point that such an approach is inoperable or deficient where doctors are either absent or in short supply.

Table 4: Absolute numbers and prevalence (per 100,000 population) of psychiatrists, mental health nurses and psychologists, by remoteness area

	MC	IR	OR	R/VR
Psychiatrists	2,464	259	66	21
Mental health nurses	13,154	3,577	984	199
Psychologists	17,689	2,629	1,005	185
	FTE/100,000 population			
Psychiatrists	16.4	5.8	3.4	4.6
Mental health nurses	81.7	78.6	47.8	38.8
Psychologists	98.3	56.2	45.3	32.9

Source: Mental Health Services Australia, AIHW, https://mhsa.aihw.gov.au/home/

In terms of the geographic distribution of benefits, a distinction may be drawn between the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative (Better Access), and the much smaller Access to Allied Psychological Services (ATAPS).[37]

The overall distribution of mental health services subsidised by Medicare, on the basis of a proportion of the population, is graphically illustrated in Figure 1.

Figure 1: Mental health related services subsidised by Medicare, per 100,000 people, by remoteness area (2011-2012)

Source: Mental Health Services Australia, AIHW, https://mhsa.aihw.gov.au/home/

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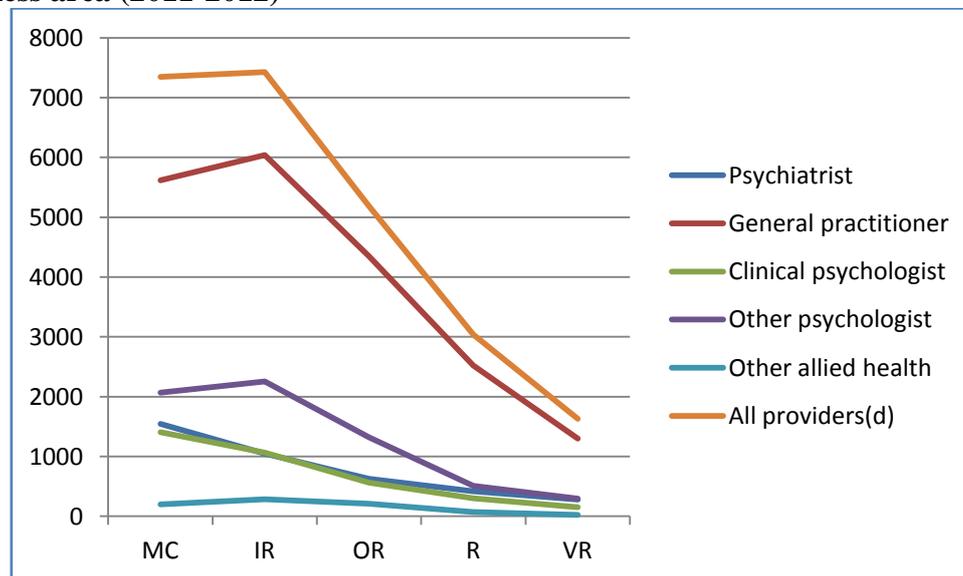
[37] Better Access had an allocation of some $2.8 billion, 2006-13, compared with some $150 million for ATAPS, 2001-10.

A report from the Mental Health Council of Australia (MHCA) showed that in regional areas the rate of access to mental health services funded by the MBS was 40-90 per cent of that in Major cities, while in remote areas it was 10-30 per cent of the rate in Major cities.[38]

As would be expected from the evidence shown above on the distribution and availability of the mental health workforce, the proportion of people who receive a mental health service funded or subsidised by Medicare falls off dramatically as one moves from Major cities to Remote and Very remote areas. In Major cities, over 75 per 1,000 benefit from an MBS-subsidised consultation with a mental health provider, compared with 18 per 1,000 in Very remote areas (Table 5).

These data are reflected in the number of services provided per 1,000 (Table 6).

People from Major cities who receive such care seem to have five consultations each, compared with three each for the much lower proportion from Very remote areas (Table 7).

Table 5: Number of people per 1,000 population receiving Medicare-subsidised mental health services, by provider, by remoteness area, 2011-12

	MC	IR	OR	R	VR
MBS Psychiatrist	15.7	10.3	6.4	4.1	3.2
MBS General practitioners	57.9	61.2	45.9	24.8	14.2
MBS Clinical psychologist	14.6	10.8	5.9	2.9	1.6
MBS Other psychologist	21.5	23.0	14.0	5.0	3.2
MBS Other allied health	2.1	2.9	2.2	0.7	0.2
MBS All Medicare providers	75.7	74.9	54.5	29.9	18.1

Source: Mental Health Services Australia, AIHW, https://mhsa.aihw.gov.au/home/

Table 6: Mental health services subsidised by Medicare, per 1000 population, by provider, by remoteness area, 2011-12

	MC	IR	OR	R	VR
MBS Psychiatrist	111.2	56.5	27.9	16.8	12.8
MBS General practitioners	102.8	104.4	74.5	37.7	23.0
MBS Clinical psychologist	72.8	48.7	25.7	11.6	5.7
MBS Other psychologist	100.8	97.5	57.1	19.2	12.5
MBS Other allied health	10.8	12.0	8.9	2.5	0.9
MBS All providers	398.3	319.2	194.1	87.9	54.9

Source: Mental Health Services Australia, AIHW, https://mhsa.aihw.gov.au/home/

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[38] *Mental Health and the new Medicare Services*: 2nd Report November 2006 – August 2008 (2008), Mental Health Council of Australia, http://mhca.org.au/sites/default/files/imported/component/rsfiles/mental-health-services/COAG_MBS_2nd_Report_Sept_2008.pdf

Table 7: Mental health services funded by Medicare, per patient per year, by provider, by remoteness area, 2011-12

	MC	IR	OR	R	VR
MBS Psychiatrist	7.1	5.6	4.4	4.1	3.8
MBS General practitioner	1.8	1.7	1.6	1.5	1.6
MBS Clinical psychologist	5.0	4.5	4.4	4.0	3.5
MBS Other psychologist	4.7	4.3	4.1	3.9	4.0
MBS Other allied health	5.1	4.2	4.1	3.7	3.6
MBS All providers	5.3	4.3	3.6	3.0	3.0

Source: Mental Health Services Australia, AIHW, https://mhsa.aihw.gov.au/home/

These numbers translate to dollar figures per head of population per year of $42 in Major cities and $9.00 in remote areas (Table 8).

> *"There have been several places opening mental health services for 12-25 yr olds, which is great, but the greater community need to have access as well. There need to be places like headspace that cater for all age groups. I have a sister who has a multitude of problems; other than the community mental health team (overworked) there is nowhere to go except her GP, mind you costs $75. Mental health needs to follow the same primary health care model: accessible, affordable, timely, quality. It also depends on where you're located, sadly."*
>
> *CWA correspondent*

Table 8: Medicare expenditure on mental health services per head of population, by remoteness area, 2011-12, dollars

	MC	IR	OR	R/VR
MBS Psychiatrist	15.06	7.38	3.66	2.15
MBS General practitioner	8.96	9.24	6.32	3.43
MBS Clinical psychologist	8.70	5.81	2.97	1.43
MBS Other psychologist	8.37	8.10	4.58	1.68
MBS Other allied health	0.81	0.89	0.64	0.19
MBS All providers	41.91	31.43	18.18	8.89

Source: Mental Health Services Australia, AIHW, https://mhsa.aihw.gov.au/home/

These consistent gradients in access to and use of mental health services would be less concerning if it was the case that the need for mental health care was less in rural and remote areas than the Major cities. But as the evidence described earlier shows, this is not the case, with the consequences of mental illness arguably being greater in rural and remote areas.

The services of psychologists to people in rural and remote areas

Many of the services currently delivered by psychologists to people in rural areas are funded through the Better Access and ATAPS programs. GPs can initiate sessions under both schemes and a shortage or absence of GPs can therefore be a block on psychological services.

Obviously if a rural patient could have a limited number of sessions with a psychologist reimbursed by Medicare before requiring the referral from the GP, this barrier would disappear. The psychologist could assist the patient to access the best type of funding to go on with their treatment and in time link in to a GP to talk them through the referral options.

It is already the case that some Better Access clients also have funding from Medicare Locals for ATAPS Child Mental Health Focused Services (CMHS) for children from birth to 11 years, which allows for a Provisional Referral from School Counsellors and Principals. This means that psychologists can provide up to three sessions to the child before requiring a Mental Health Care Plan (MHCP) from their GP, as they are in a remote location.

Overall, psychologists value the GP gateway and involvement from GPs with more complex clients, especially when working with children, as some rural areas do not have child services. ATAPS funding certainly does allow for greater flexibility in service delivery with children.

Some of the available evidence about the provision of psychological services to Aboriginal and Torres Strait Islander people in more remote areas through ATAPS may include the travel and accommodation costs for the psychologists involved. This is a reminder of the distinction that must be made between the cost of remote health services and the volume of services provided. Higher unit costs are an unavoidable reality for remote area health services and must be recognised in funding streams.

In some areas (eg parts of the Hunter Region) ATAPS is used to fund services delivered by private practitioners.

The rural and remote mental health workforce could be augmented through supported placements for students of psychology, with some sort of incentive for them to return to rural and remote practice. Supported placements would give clients access to training psychologists and encourage students to work in rural and remote areas.
Even where new mental health facilities have been opened in regional centres, there has still been under-servicing due to inadequate funding for full staffing levels. Some of the professional shortages could be overcome if barriers were reduced for rural psychologists to undertake Masters in Clinical Psychology. There is currently a distinct disadvantage for rural psychologists, with only one university nationally able to offer a Master of Clinical Psychology by Distance Education - with enrolment numbers limited.

An increased supply of the services of psychologists to people in rural and remote areas would have great benefits, including through reducing the return of patients through 'the revolving door' as a result of unfinished treatment.

> *"Standardise hospital admission forms (eg in emergency departments) so that 'mental health' questions are included (ie in same way as eg all women are asked 'are you pregnant?') – each hospital apparently has a different form and not all canvass mental health."*
>
> *CWA correspondent*

Design of effective mental health services in rural and remote Australia

There are a number of approaches to mental health service delivery that have the potential to contribute towards some of the local mental health needs of people in smaller towns and communities. Some of the principles that relate to these approaches are discussed below.

Consumer and community engagement

Close collaboration between and with local health consumers, clinicians and other relevant community members is critical to the effective design, delivery and management of mental health programs that are fit-for-purpose in rural and remote areas. Local people will know who is available in their area and the resources that can be drawn together for the program. They will also be critical to building local awareness about the programs and encouraging people to use them.

Research studies indicate that consumers who understand their health conditions and are actively involved in decisions about their own care are more likely to value treatment programs and to have better health outcomes.[39]

A renewed emphasis on Mental Health First-Aid

Mental Health First-Aid (MHFA) is an important way to raise awareness of mental health issues in the broader community and to facilitate and support early intervention.

Members of the community such as police officers, teachers, aged-care workers, school nurses, building and mining foremen and others whose work brings them into contact with people who could have mental illness should be encouraged to gain additional MHFA know-how. Their learning would provide them with greater confidence and the ability to observe early symptoms and signs of mental health issues, and be alerted to particular actions that might be taken.

Providing MHFA training to bank personnel, financial counsellors, agribusiness officers, veterinarians, stock-and-station agents and other people who interact with people in agriculture on a day-to-day basis has been shown to improve the their ability to recognise a mental disorder, increase their confidence level in providing help to someone with a mental health problem, decrease social distances and positively change their beliefs about treatment.[40] Such training should be available to those in the mining and resources sector and can be delivered by a range of means, including via eLearning.

This renewed and refreshed approach to MHFA should be adopted with a particular eye on the agencies and individuals with whom people in rural and remote areas, including those in agriculture and mining, regularly relate and from whom they receive information.

eMental health care: Mental health services online and by telephone

> *"Personally in relation to the remote aspect, the basic access to the services provided is the biggest barrier. For me to see a psychiatrist there is a very long waiting list to*

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[39] *Consumer participation in health care decision making in community based settings and its relationship to health outcomes* (2009), State Govt. VIC, http://www.health.vic.gov.au/mentalhealth/publications/cons-part.pdf
[40] Enhancing the Knowledge and Skills of Advisory and Extension Agents in Mental Health Issues of Farmers (2010), Centre for Rural and Remote Area Health, University of Southern Queensland, Toowoomba, QLD, Australia, http://www.rrh.org.au/publishedarticles/article_print_1593.pdf

start with unless in crisis, but who wants to go there! Then it takes a four-hour drive (round trip). So it you cannot make your appointment for unforeseeable circumstances, flood etc, you have to then wait another six months for appointment. This gap of a year between appointments does not enable continuity of care and proper assessment and management to maintain good mental health.

It is frustrating that all the technology has been around for a while now and all this could be avoided by the use of teleconference with your doctor, saving time and money. Thus giving the fundamental right of primary health care in the form of mental health care being accessible to people who live in the bush."

CWA correspondent

eMental health programs offer treatment and support to people with mental health disorders through telephone, mobile phone, computer and online applications, ranging from the provision of health information to real-time interaction with clinicians trained to assist people experiencing mental health issues.

Telehealth consultations facilitated by GPs, nurse practitioners and Aboriginal Health Workers are reimbursed through Medicare for their clients living in rural and remote areas to participate in a videoconference with a specialised psychiatry service. Consideration should be given to facilitating arrangements for mental health nurses and relevant allied health professionals to support their clients in accessing specialised telepsychiatry consultations, including from Aboriginal Community Controlled Health Organisations (ACCHOs) and in a mentoring and support role - as well as to provide direct client services.

Considerable use is made in Australia of telephone counselling services such as Lifeline, Kids Helpline and beyondblue. These can be of particular use to people living in areas where few or no mental health professionals are available. This of course assumes that their particular area has good telephony connections.

However, many parts of country areas have poor telephone services, and dial-up, satellite or ADSL Internet connections are not necessarily available, let alone high speed broadband. For many people in such areas the internet is slow and unreliable, with drop-out common. Skype may provide an avenue for people to talk or videoconference with a clinician or support worker, but interpersonal interactions about sensitive mental health discussions may require better security to ensure confidentiality, and better picture quality to provide sufficient visual cues of facial expressions. Although specialised equipment, such as may be available through schools and health services, may give a better quality of videoconference, privacy in a school or hospital setting may be poor if there are other people around.

As was demonstrated recently across Gippsland, power outages can happen, with large sections of a region being left without power for prolonged periods, including after fires or other extreme weather events.

The Indigenous Communications Program supports access by providing and maintaining community phones in remote communities with baseline populations of less than 50 people. Community phones provide access to emergency and other medical and support services as well as to family and friends. In 2013–2014, up to 545 phones in remote communities will be

monitored and maintained and 63 satellite mobile phones have been provided to eligible remote Indigenous communities.[41]

While not all areas of Australia have mobile phone coverage, the smartphone has nevertheless become a useful platform for information access and communication in many Indigenous communities. Research suggests that, in some areas, Aboriginal and Torres Strait Islander people are enthusiastic users of the technology.

An example of such an initiative is the I-bobbly app specifically for Aboriginal people living in remote communities. The app's graphics have been designed by Kimberley Indigenous artists, and young Indigenous people have provided the voice-overs. The app delivers a treatment based on mindfulness and values-based action and draws on stories and imagery and traditional activities such as drawing, painting, storytelling and fishing.[42]

The mental health needs of resident and outreach health professionals themselves in rural and remote areas must not be forgotten. The challenges of working in an isolated community where demand for mental health services is high and support for health professionals is often unavailable can cause high occupational stress. Not surprisingly, the mental health workforce faces high turnover and burnout rates, often disrupting continuity of care for patients.

> *"Sometimes regions are huge and workers travel large distances just to cover their normal service areas - not only in health either. There are safety and OH&S issues: the more people travel, the more fatigue is a problem. This can have a detrimental effect on health care provision: it is hard to treat someone properly after a long drive. In rural areas you have the added issues of wildlife on the roads, especially at night. All too often rural workers are just out of University which sets a different set of pressures, and flying or driving in and out puts huge amounts of stress on them and the system - not to mention families."*
>
> *NRHA Submission to the Standing Committee on Regional Australia on the Use of 'fly-in, fly-out' (FIFO) workforce practices in regional Australia[43]*

The CRANAplus Bush Support Services is a fine example of an experienced and effective telephone support service, providing valuable support for isolated health professionals and their family members. A confidential, free, 24-hour, nationwide telephone service, it is staffed by eight registered psychologists experienced in working in remote and rural areas. The service offered is tailored to the individual and their situation, with the capacity for repeat callers to speak to the same psychologist. Caller confidentiality is guaranteed and they can remain anonymous if they wish.

Research presented at the 12th National Rural Health Conference identified lack of awareness of telephone support services (79 per cent) and confusion regarding the different types of

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[41] *Fact Sheet: Connectivity for Rural and Remote Health* (2013), National Rural Health Alliance, http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-connectivity.pdf

[42] Hilary Smale (2013), *Getting mobile mental health into Indigenous communities*, ABC Kimberly (13 June 2013), http://www.abc.net.au/local/audio/2013/06/13/3780802.htm

[43] see http://ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/submission/sub-fifo-11-oct-11.pdf

support services available (71 per cent) as major barriers to accessing mental health telephone support for rural and remote communities.[44]

To overcome these barriers, effective promotion of mental health telephone support was deemed to be important, with television (58 per cent), referral from a GP (52 per cent) and radio (43 per cent) selected as the best three options for promotion.

Figure2 Sources of information for mental health telephone support[45]
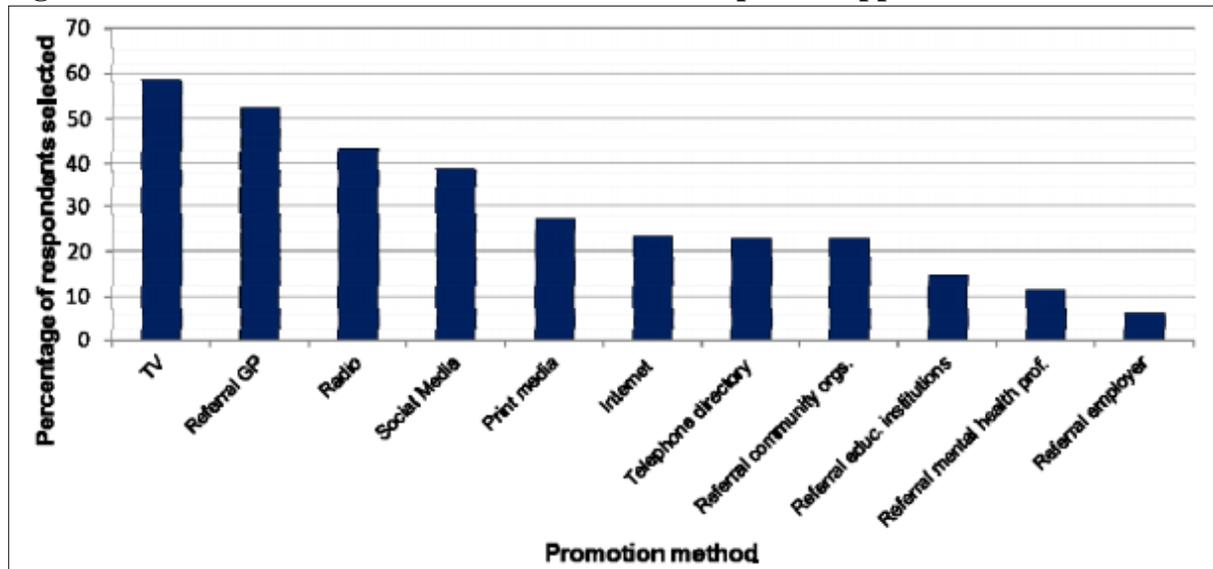
The Australian Government's mindhealth**connect** website aggregates mental health resources and content from the leading health focused organisations in Australia. It simplifies access to a range of mental health resources including online programs, fact sheets, audio and video, and online communities provided by the website's partners.

Internet-based therapy programs may well be effective in delivering mental health services to those with depression and anxiety. Studies of internet-based programs have shown that over 20 per cent of spontaneous users are from rural or remote areas, indicating a strong demand. The benefits of such internet programs include that they can be undertaken around rural work schedules, do not require lengthy travel to consultations, provide a means for rural residents to manage their own health and users can remain anonymous.[46]

Centre-based services such as Early Psychosis Prevention and Intervention Centre (EPPIC) and headspace are supplemented by eheadspace (eheadspace.org.au) - a telephone, email and online counselling service. The anonymity this offers is particularly valuable for adolescents in small communities who may not want to seek help in person for fear of the attached stigma.

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[44] Le Gresley, H., Darling, C., Reddy, P. (2013), *New South Wales rural and remote communities' perception of mental health telephone support services*, presented at the 12th National Rural Health Conference, http://nrha.org.au/12nrhc/wp-content/uploads/2013/06/Le-Gresley-Helen_ppr.pdf

[45] Le Gresley, Helen. (2013), *New South Wales rural and remote communities' perception of mental health telephone support services*, presented at the 12th NRHC, http://nrha.org.au/12nrhc/wp-content/uploads/2013/06/Le-Gresley-Helen_ppr.pdf

[46] Partyline (October 2013), NRHA, http://ruralhealth.org.au/sites/default/files/publications/partyline-48-nov2013.pdf

The ANU's eHub: eMental Health and Development is a suite of online self-help services based on the best available evidence and evaluated through high-quality research.

MindMatters provides online professional development for school staff around promoting mental health, preventing problems and intervening early.

Further development of the provision of mental health information and support by telephone and online should be a priority for people in rural and remote areas. Consideration should be given to the demonstrated efficacy of various approaches to such work, and appropriate allowance must always be made for the realities of poor telephone and Internet connectivity in rural and remote areas.

At the same time there remains an ongoing concern that phone and Internet access to mental health support should not be seen as a completely sufficient and desirable replacement for face-to-face interactions with mental health professionals for people who are already isolated by where they live.

Existing programs that may work well for rural and remote people

A small number of mental health programs are directed specifically to patients in rural and remote areas, and there are a few others which - although not rural programs - have design features that suit people in the Bush.

The Mental Health Services in Rural and Remote Areas (MHSRRA) program provides funding to non-government health organisations such as Medicare Locals, Aboriginal Medical Services and the Royal Flying Doctor Service (RFDS) for social workers, psychologists, occupational therapists, mental health nurses, Aboriginal Health Workers and Aboriginal Mental Health Workers. The program supports the engagement of such professionals with people with a mental disorder of mild to moderate severity in more than 200 communities.

The Alliance is aware that the RFDS's *Social and Emotional Wellbeing Program: Covering Central West* provides counselling, information and support services across drought-affected areas around Longreach in Queensland. The region has experienced declining rural industries as a result of the drought which has placed added strain on its communities. Teams of mental health professionals have been assisting with broad-ranging issues related to anxiety, depression, grief and loss, substance-misuse, unemployment, ongoing illness and family relationships as well as providing Mental Health First-Aid Training for local communities. Working in conjunction with appropriate local support, these confidential and non-judgmental services are helping to prevent, identify and resolve difficulties.

Nurses are the best distributed health professionals in rural and remote Australia and therefore critical in a response to mental illness. Nevertheless there are shortages of specialist mental health nurses in such areas and targeted programs such as the Mental Health Nurse Incentive Program are highly valued.[47] An expansion of the program would be very useful if it had a particular focus on rural and remote Australia.

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[47] It is understood that there is as yet no guarantee of funding for the MHNIP beyond 2013-2014.

"In several local areas the only access to Health Services is by a Remote Area Nurse. We have spoken with these ladies and they advise that they can take clients to the (mental health) services but they need to be referred by a GP which they do not have - only Registered Nurses are employed. How can we access the Mental Health Nurse Incentive Programme in rural areas - is the course available to be done by correspondence?"

CWA correspondent

The Medical Specialist Outreach Assistance Program (MSOAP) improves access to psychiatrists (and other medical specialists) in rural and remote communities.[48] The Program has proven to be most successful when implemented in consultation with local communities and with local health professionals working in the area.

As already discussed, telehealth consultations with more specialised mental health clinicians have an important role to play and, so as not to be restrictive, MBS subsidies should allow for a range of professionals to be the ones with the patient, and should permit an appropriate range of telehealth activity (including mentoring and support) and settings, including Aboriginal Community Controlled Health Organisations.

Both the relatively small Access to Allied Psychological Services program (ATAPS) and the very much larger MBS-funded Better Access scheme provide for psychologists as well as doctors to contribute to mental health care. Better Access has had limited application in more remote areas, mainly because of the shortage of GPs and psychologists there.

The expansion of ATAPS would be welcomed by people in rural and remote areas but it must include flexible funding and straightforward guidelines that enable appropriate programs to be tailored to meet the needs of a particular community or individual.

The Personal Helpers and Mentors (PHaMs) service provides practical assistance to people with severe mental illness to help them achieve their personal goals, develop better relationships with family and friends, and manage their everyday tasks. One-to-one and ongoing support ensures the individual needs of the PHaMs participants can be addressed. They are assisted to access services and participate economically and socially in the community, increasing their opportunities for recovery.

The Alliance is concerned that much of any new government financial allocations for mental health over recent years have been for centre-based services such as Early Psychosis Prevention and Intervention Centre (EPPIC) and headspace. These investments are no doubt of benefit to the target population in cities and large regional centres where they exist, but are unlikely to benefit people in smaller towns. There are more than 1,400 towns of 200 to 5,000 people and about 140 in the range 5,000-18,000.

The Alliance is therefore very interested in the extent to which these centre-based programs are resourced to undertake outreach to smaller centres nearby and to support health generalists in those catchment areas. It remains of concern that programs which target teenagers and young adults may leave other demographic groups such as young children,

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[48]Australian government Department of Health and Ageing. Medical Specialist Outreach Assistance Program Guidelines. June 2011.

older adults and the elderly without support. It is important that when such services outreach to rural and remote areas they are equipped to provide some sort of support or gateway service for those in need, no matter what their age.

The Department of Veterans' Affairs provides a suite of successful and effective mental health programs for eligible people, including in rural and remote areas. This targeted and comprehensive approach could perhaps be used as a model for mental health services for other unique target groups.

The Housing and Accommodation Support Initiative (HASI) between NSW Health, Housing NSW and various non-government organisations (NGOs) provides people with mental health problems with vital access to supported accommodation linked to clinical and psychosocial rehabilitation services.

Assuming that their efficacy and cost effectiveness can be demonstrated, funding for such programs as described in this section should continue, including for the growth and expansion which is justified in terms of cost-effectiveness.

Supporting and up-skilling the existing rural and remote health workforce
There needs to be significantly increased capacity in the primary care system to provide mental health care for people with mild to moderate mental health concerns and to address their range of health needs - including co-morbidities - and act as an entry point to consultations with people with more specialised mental health skills.

This means building on the existing capacity and skills of health professionals already working in rural and remote areas. A range of workforce recruitment, retention and support programs used for many years in rural general practice should be scrutinised for their potential benefit if applied to the mental healthcare capacities of all existing health professionals who might usefully and safely be involved.[49]

This supportive and upskilling work should begin with undergraduate education for health professionals for mental health, including the need to deal with mental health emergencies. The Alliance notes the significant priority given to mental health by the National Rural Health Students' Network and the rural and remote health clubs within it. This work with early career health professionals should be just the start of care for the mental health of the health professionals themselves.

> *"My view about mental health training is that it needs to be done on site. Practical skills can be learned while students are working toward their degree."*
>
> *CWA correspondent*

An expanded program to provide continuing professional development in mental health for rural GPs, nurses and Aboriginal Health Workers is urgently needed. It could be modelled on the successful Rural Health Continuing Education Stream 2 (RHCE2) program managed for the Commonwealth by the Alliance, which has been consistently oversubscribed and which

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[49] The Professional Development element of the MBS-funded Better Access to Psychiatrists, Psychologists and GPs already provides such training for doctors.

has been very positively reviewed.[50] Such training and support should include a focus on the means by which the generalist workforce can respond to mental health emergencies.

Providing such support to existing health professionals in a rural area can be the means by which local communities can in effect 'grow their own' mental health care network. This will provide the local healthcare team with stronger capacity to understand patients' needs and be able to provide more continuity of care locally for at least some of those with mental health problems.

Local health professionals who are specifically trained to provide mental health care must be cognisant of local needs for culturally-appropriate care for Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds. The use of eHealth to deliver professional education and support should continue to be evaluated and, as appropriate, expanded.

Supporting community organisations

Country Women's Association branches are invaluable networks which, among other work, support positive mental health of older people, women and families in rural and remote communities. Where they exist, Men's Sheds also play a valuable role. Such organisations help older people in particular to overcome social isolation and increase their confidence and self-esteem. They also open up channels to health information and help them navigate a path to and through the health system.

The Mental Health Professionals' Network (MHPN) is a good example of a local community development approach to building mental health care teams. It supports mental health practitioners to form networks in which relationships can be built, knowledge exchanged and professional development undertaken. The initiative currently supports over 450 networks, 43 per cent of which are located in rural and remote communities. The MHPN aims to increase interdisciplinary collaboration by fostering local networks across Australia where GPs, psychiatrists, psychologists, mental health nurses, occupational therapists, social workers and any other practitioners working in primary mental health care can meet regularly.

As an effective and expanding model useful networking and teambuilding, the MHPN deserves substantial ongoing support.

Community organisations including those described above should be recognised, valued and, where appropriate, resourced by governments.

Local coordination

Given the extent of the burden of disease attributable to mental illness,[51] it goes without saying that finding better ways to focus on prevention, early intervention and management will play a significant part in reducing health care costs and improving the status of health. Local work to bring together consumers and clinicians with the hospital and primary care system will be very valuable.

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[50] see http://ruralhealth.org.au/rhce

[51] Mental illness accounts for an estimated 13 per cent of the burden of disease; 11.1 per cent of GP encounters involve the management of a psychological condition.

People with limited networks and poor mental health may not want to engage with the mental health system. Family and carers, too, may feel overwhelmed and powerless by the processes involved.

Close coordination is required to develop flexible pathways for the needs of individual patients which, among other things, can reduce the incidence of avoidable hospitalisation and ensure well-managed discharge of acute patients back into community and primary care.

With their good local knowledge and contacts, Medicare Locals in some areas are well-placed to provide more effective local solutions for rural communities than is possible through national systems alone, ensuring that optimum use is made of the expertise of all health professionals available locally. Medicare Locals have inherited a key role in leading local collaboration with consumers, the local health or hospital networks and non-government organisations. They should be specifically tasked to work with Local Hospital Networks to develop integrated patient pathways for people with more acute mental health needs.

Local health agencies such as Medicare Locals will continue to have critical roles to play in coordinating the local community, clinicians, hospital and non-government organisations working in mental health.

Conclusion

The Alliance welcomes the opportunity to make this submission to the Mental Health Commission and looks forward to ongoing communications with the Commission and other agencies on this challenging and critical matter.

There is no single or simple solution where better mental health in rural and remote areas is concerned. What is required is a focus on enhancing and supporting the capacity of those health professionals already engaged in those areas, innovative uses of new technology, continued efforts to have a better distribution of the services of mental health specialists (including psychologists), and a renewed emphasis on Mental Health First-Aid capacities for those who, like it or not, will be the family, carers and work colleagues of people who develop symptoms of mental illness.

> *"Mental health services are many and varied, all targeting specific types and demographics, this being evidenced when you consider the service provider such as: Open gates, LifeLine, Anglicare, OzCare, Salvation Army, beyond blue, Aussie Helpers, Black Dog, plus institutions, aged facilities, religious organisations.*
>
> *Add to this the list of practitioners, therapists, counsellors etc. and there is an impression that this is a well serviced sector. This could not be further from the truth.*
>
> *First-hand experience and working and talking to many people says there is a real deficit and this in reality is because of the fractured services available.*
>
> *If you are physically sick you go to the hospital or the emergency centre and whatever the problem you are looked at then and there. With mental health you have to know where to contact and have done research into your needs before you go.*
>
> *The provision of training courses to up-skill the farmers and to help the women on the land has been a good initiative but when things are really bad and there is no money food or petrol the last thing you want is someone suggesting you learn something new, why would you, you can't manage what you're doing now."*
>
> *CWA correspondent*

Appendix 1: The state of mental health across Australia

The most common forms of mental illness are depression, anxiety and substance use disorders, which can often occur in combination. Other mental health conditions include schizophrenia and those of a serious psychotic nature which may require hospitalisation.

In any one year, one in five Australians aged 16-85 years will experience a mental illness, and almost half of all Australians will experience a mental illness at some time in their lifetime. Of those with a mental illness, 65 per cent do not access any treatment.[52]

Seventy-five per cent of mental health disorders begin before the age of 25 years, their onset typically occurring in mid-to-late adolescence. Over one in four young Australians experience a mental illness every year, with people aged 18-24 years having a higher prevalence of mental illness than any other age group. Seventy per cent of young people who experience mental health and substance use problems do not seek help.[53] Men are estimated to access mental health services provided by GPs at only 50 per cent of the rate of women.[54]

Daily, at least six Australians die from suicide and a further 30 will attempt to take their own life. Suicide is the leading cause of death among people aged 15-24 years.

One in seven Australians will experience depression at some time in their lifetime, with the condition being responsible for 13.3 per cent of the burden of disease in Australia. This makes depression the third most significant condition where disease burden is concerned.[55]

The annual cost of mental illness in Australia has been estimated at $20 billion.[56] In 2007-2008, outlays by governments and health insurers on mental health services totaled $5.32 billion, representing 7.5 per cent of all government health spending. An additional $4.63 billion was spent by the Australian Government in providing other support services for people with mental illness, including income support, housing assistance, community and domiciliary care, and employment and training opportunities.[57]

Mental disorders also have large economic impacts in other areas including on out-of-pocket healthcare costs, carer/family costs, lost productivity and costs to other non-government organisations. These costs are at least equal to, if not more than, government expenditures on mental health.[58]

[52] Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: Summary of Results, 2007. Cat. no. 4326.0. Canberra: ABS; 2008.

[53] Youth Mental Health, Bupa, http://www.bupa.com.au/health-and-wellness/health-information/healthy-living/healthy-mind/mind/youth-mental-health

[54] *Mental Health Service in Rural and Remote Areas Program evaluation* (2011), DOHA, http://www.health.gov.au/internet/main/publishing.nsf/Content/3E902EE0AE59B800CA257BF0001ACE0B/$File/mhsrraev.pdf

[55] *Facts and Figures about mental health and mood disorders*, Black Dog Institute, http://www.blackdoginstitute.org.au/docs/Factsandfiguresaboutmentalhealthandmooddisorders.pdf

[56] Mental Health, ABS, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features30March%202009

[57] *The evidence on the costs and impacts on the economy and productivity due to mental ill health: a rapid review* (2013), An Evidence Check review brokered by the Sax Institute for the Mental Health Commission of NSW https://www.saxinstitute.org.au/wp-content/uploads/The-evidence-on-the-costs-and-impacts-on-the-economy-and-productivity-due-to-mental-ill-health-a-rapid-review.pdf

[58] *The evidence on the costs and impacts on the economy and productivity due to mental ill health: a rapid review* (2013), An Evidence Check review brokered by the Sax Institute for the Mental Health Commission of

The *Suicide and Suicide Prevention in Australia: Breaking the Silence* report (2010) put the annual cost to the nation as a result of suicide and suicidal behaviour at $17.5 billion (in 2007-08 dollars), representing 1.5 per cent of Gross Domestic Product, or $795 per person, per year.[59]

Mental illness also significantly influences individual and national economic productivity. Australia loses more than nine million working days - or 9.5 days per person - each year due to mental illness. The cost to business has been estimated at $237 million a year due to extra leave taken.[60] Not surprisingly, when mental illness is averted or successfully treated, it is estimated to have a significant positive impact on labour force participation.[61]

NSW https://www.saxinstitute.org.au/wp-content/uploads/The-evidence-on-the-costs-and-impacts-on-the-economy-and-productivity-due-to-mental-ill-health-a-rapid-review.pdf

[59] Mendoza J., Rosenberg S. (2010) *Suicide and suicide prevention in Australia: breaking the silence*, http://www.healthinfonet.ecu.edu.au/key-resources/bibliography?lid=19560

[60] *Counting the Cost: The Impact of Young Men's Mental Health on the Australian Economy* (2012), Ernst and Young, http://www.youngandwellcrc.org.au/wp-content/uploads/2014/02/Counting-the-Cost-Inspire-Foundation-2012.pdf

[61] *Mental Health and the NSW Minerals Industry* (2012), Prepared for the NSW Minerals Council by University of Newcastle and Hunter Institute of Mental Health, http://www.himh.org.au/__data/assets/pdf_file/0004/4945/Mental-Health-in-Mining.pdf

Appendix 2: Member Bodies of the National Rural Health Alliance

ACEM (RRRC)	Australasian College of Emergency Medicine (Rural, Regional and Remote Committee)
ACHSM	Australasian College of Health Service Management
ACM (RRAC)	Australian College of Midwives (Rural and Remote Advisory Committee)
ACN (RNMCI)	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (NRRC)	Exercise and Sports Science Australia (National Rural and Remote Committee)
FRAME	Federation of Rural Australian Medical Educators
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Royal Flying Doctor Service
RHWA	Rural Health Workforce Australia
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health
SPA (RRMC)	Speech Pathology Australia (Rural and Remote Member Community)