NORTHERN TERRITORY MENTAL HEALTH COALITION

Queensland Alliance FOR MENTAL HEALTH

Joint Submission to Senate Standing Committee on Community Affairs

Accessibility and Quality of Mental Health Services in Rural and Remote Australia

May 2018

Dear Senate Standing Committee Members,

The Queensland Alliance for Mental Health (QAMH) and the Northern Territory Mental Health Coalition (the Coalition) make this joint submission regarding the sustainability and quality of adequate mental health services in rural and remote communities throughout Queensland and the Northern Territory.

To address the issues identified throughout this submission we call on the Committee to recommend the formation of an independent Queensland and Northern Territory rural and remote mental health taskforce. This taskforce will measure established mental health services in regional areas, look at these services' ability to improve mental health in their communities and identify gaps against the National Disability Insurance Scheme (NDIS) and the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan). This independent taskforce will provide recommendations to government on ways to address service gaps and make mental health services more accessible in rural and remote locations.

The QAMH is the peak organisation for the community managed mental health sector in Queensland. Representing more than 140 organisations and stakeholders across the State, the QAMH works with our members to build capacity, promote professionalism in the sector, facilitate innovative partnerships and advocate on behalf of people experiencing mental health issues.

The Coalition is the equivalent peak for the community managed mental health sector in the Northern Territory. The Coalition has a network of 200 individuals, organisations and stakeholders, including 35-member organisations across the Northern Territory.

Both organisations are members of Community Mental Health Australia (CMHA) – a coalition of eight peak community mental health organisations representing all states and territories across the nation.

The information contained in the submission is a collection of anecdotal and qualitative submissions from mental health providers and professionals with experience living and working in regional and remote communities.

This joint submission reflects many of the shared issues and challenges faced in Queensland and the Northern Territory in rural and remote communities. Queensland is the most decentralised state in Australia, with approximately half the population living outside of the Greater Brisbane area. Queensland has the highest proportion of Aboriginal and Torres Strait Islander people of any mainland state, with a significant proportion living in rural areas. Similarly, the Northern Territory has a comparatively small and sparsely distributed population and a high percentage of Aboriginal and Torres Strait Islander people living in remote and very remote communities. Our regional economies were built on the agricultural industry, and they continue to rely on the services provided to that industry.

The tyranny of distance is also a very real challenge for a large proportion of our respective populations. The distance between Brisbane and Mount Isa is almost 2,000 kilometres, while it's almost 1,500 kilometres between Darwin and Alice Springs. This poses significant service delivery challenges. People living in regional communities deserve access to the same services as Australians living in metropolitan areas, however ongoing evidence shows regional Australians are being left behind.

Why are rural and remote Australians accessing mental health services at a much lower rate?

Queensland

This is a complex situation with many variables impacting on quality mental health services in rural and remote areas. The issue of stigma was one that was constantly raised in our discussions with members regarding this inquiry. Rural communities have a culture of self-sufficiency and self-reliance[1] which does not lend itself to openly seeking treatment when it might be required. The lack of anonymity in small rural settings often creates barriers to access due to stigma and privacy. This is demonstrated through examples sent by our members located in rural and remote regions. Some of the issues identified include:

- The need for privacy when everyone is known to each other
- The difficulty in recruiting health professionals to rural areas. Where they are living in the community they are not able to separate their personal life from their rural setting
- People put running their business (such as a farm) before their own personal health

It's important to highlight a few members reported a reduction in stigma towards accessing mental health in rural settings. There are a variety of organisations doing fantastic work in regional areas to raise awareness about these important issues, however, the stigma still exists.

The changing nature of the mental health workforce in regional areas can also be a barrier to people accessing services. Young professionals often do placements in country areas as part of their professional development, only to return to metropolitan areas to continue their career advancement. The lack of mature-aged professionals can act as a disincentive to seeking treatment. If the staff are just out of training and viewed as inexperienced it means people might not have confidence in them.

Accessibility to services is also a critical part of the problem. Despite about a third of Australians living in regional Australia, around 90 per cent of psychiatrists and two-thirds of mental health practitioners work in major cities[2]. The Fifth Plan also highlights

that the rates of mental health professionals decline markedly with remoteness, with only three psychiatrists per 100,000 of population and 30 psychologists per 100,000 of population employed in remote and very remote areas.

General practitioners (GPs) are often the first point of call for people seeking help with a mental illness, however there are barely half the GP services per person in very remote areas as there are in major cities[3]. A Grattan Institute report found there were less GP services provided outside traditional hours in rural, regional and remote areas, meaning country people were having to wait longer to see a GP[4]. Evidence from the Australian Institute of Health and Welfare (AIHW) shows mental health-related GP encounters in outer regional and remote and very remote communities is occurring at a far lower level than in more populated centres[5]. That same dataset also shows Medicare-subsidised mental health-specific GP services in remote areas are occurring at less than half the rate of major cities. Medicare subsidised mental-health related GP services in very remote areas are happening at nearly one fifth the rate of major cities. This data backs up the anecdotal evidence provided by organisations citing the delays in getting appointments, the challenges posed in travelling significant distances to access health services, juggling these types of appointments with ongoing work commitments (such as running a primary production business) and the cost of accessing these services. There is also a lack of GPs that bulk bill in many communities, which limits the access of low income workers to mental health care plans. The level of mental health awareness and training among GPs is another contributing factor.

Another issue is the lack of options available to people in regional communities. We know that the NDIS, which is being rolled out across Australia, is about choice and control for participants, however there is little to no choice and control for rural and remote communities accessing mental health services. If there is only one provider or mental health support service and that service does not work for the individual (for example, it is targeted at a different demographic) then people are left with no other

options. This can stop individuals from seeking treatment for a mental health problem and can reduce the likelihood of ongoing engagement with the service.

Northern Territory

As in Queensland, there is a range of complex, interrelated factors that impact on the accessibility and quality of mental health services in rural and remote communities in the Northern Territory. However, the accessibility and quality of mental health services cannot be considered in isolation from the significant socio-economic disadvantage and intergenerational trauma experienced by many Aboriginal and Torres Strait Islander communities in the Northern Territory.

Social Determinants of Health

Upstream social determinants, such as poverty, unemployment, drug and alcohol use, family violence, chronic disease and ongoing grief and loss due to higher rates of mortality and imprisonment, are central to the disproportionately high rates of suicide and psychological distress experienced by Aboriginal and Torres Strait Islander people in the NT. These issues heighten the need for accessible and high quality mental health services, and also for whole-of-government strategies to address entrenched socio-economic disadvantage.

Service Mix

In terms of service provision, the widely dispersed and comparatively small rural and remote population of the NT is supported by a mental health system that is skewed towards high-intensity services, which are often under-resourced and tasked with providing mental health care across vast, isolated regions[6]. It is notable that the Barkly region alone is larger in size than the state of Victoria, yet its many remote communities are serviced primarily by a small number of Northern Territory Department of Health and non-government mental health practitioners based in the hub town of Tennant Creek.

In many remote communities across the NT, low-intensity prevention and early intervention services are largely unavailable, with child and adolescent services being particularly under-resourced across the NT.

To this end, the scarcity of services across the spectrum of low to high intensity, is a significant cause of low access rates amongst rural and remote communities in the NT.

Mental Health Training

Training in mental health assessment varies greatly amongst GPs in the NT, as does the level of awareness amongst GPs of the broader mental health sector, which is

reported by some stakeholders to reduce GP capacity to refer to community-based mental health services.

Recruitment and Retention

Where funding for rural and remote mental health services is available, the recruitment and retention of mental health professionals - with requisite cultural competencies, is a significant challenge to maintaining continuity in service provision. Multiple service providers in remote areas report that the recruitment, induction and development of cultural competency of new mental health practitioners can take months.

NDIS

The costs of delivering remote mental health services can be significant and the current price points under the NDIS have been prohibitive for many providers in the NT. As a consequence, the NDIS does not appear to be producing a wider choice of service options for people with psychiatric disability.

Aboriginal and Torres Strait Islander Social and Emotional Wellbeing

Our organisations would specifically like to highlight the access issues and cultural challenges that exist in Aboriginal and Torres Strait Islander communities. As outlined in the Fifth Plan, Aboriginal and Torres Strait Islander peoples have higher rates of mental illness, suicide, substance abuse and psychological distress[7]. One of the biggest challenges is that mainstream mental health services do not meet the differing cultural needs of Aboriginal and Torres Strait Islander people[8], who view social and emotional wellbeing differently to non-Indigenous concepts of mental illness and mental health and well-being[9]. It also takes time to earn the trust of the people living in these communities before they feel more comfortable talking to mental health professionals.

One provider who offered their insights for this submission said it took a period of up to three years to build up trust and understanding in the communities they operated in.

Another provider highlighted that when providing a new mental health service in a community there is an unrealistic expectation to deliver outcomes within a short timeframe but that it “takes time to gain the trust of the community and develop those relationships that are needed to deliver a service efficiently and effectively”.

The Northern Territory perspective is that a well-trained, well supported and well-resourced Aboriginal mental health workforce is widely seen to be critical to the delivery of equitable, culturally engaged mental health care for Aboriginal people in the Northern Territory.

The Higher Rate of Suicide in Rural and Remote Australia

Sadly, evidence shows suicide rates in remote and very remote areas occur at a much higher rate than major cities[10]. Heartbreakingly, there are particular groups that are acutely impacted:

Men

Australian males between 15 and 45 years of age are in the highest risk category for suicide. Across the country, men are approximately 3 times more likely to take their own life than women, and male farmers are dying by suicide at rates significantly higher than non-farming rural males – the further you move from the coast into regional, rural, and remote Australia, the more that figure climbs

- Queensland Farmers' Federation[11]

Young Men

The rate of suicide among men aged 15-29 years who live outside major cities is almost twice as high as it is in major cities.

- National Rural Health Alliance[12]

Primary Producers

In Australia, it has been found that farmers have suicide rates around 1.5 to 2 times higher than the national average.

- Queensland Mental Health Commission[13]

LGBTIQ

As in many parts of Australia, Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people continue to experience stigma and discrimination in the community, including in accessing health services in the NT. Service providers and governments have an important responsibility to improve understanding and responsiveness to the needs of LGBTI people.

- Northern Territory Mental Health Coalition[14]

Aboriginal and Torres Strait Islander Peoples

Suicide accounted for over 1 in 20 Aboriginal and Torres Strait Islander deaths in 2015 compared to just under 1 in 50 non-Indigenous deaths.

- Australian Government[15]

It's clear that a complex range of factors contribute to these higher rates of suicide, including the ability to access services, easier access to lethal means in country areas and the greater pressures faced by primary producers (such as weather conditions, government policy intervention and external factors impacting profitability).

For young people, the lack of employment prospects and economic independence are an issue. The youth unemployment rate in Queensland Outback was 59.1 per cent (at March 2018), while youth unemployment in Northern Territory – Outback is far higher than the Greater Darwin region. The socioeconomic issues faced in rural and regional locations cannot be discounted.

Research suggests LGBTIQ people in rural areas face heightened discrimination and abuse and have less access to inclusive mental health services[16]. This leads to higher risks of suicide attempts and suicides.

There are also significant risk factors for Aboriginal and Torres Strait Islander peoples, including discrimination based on race or culture, economic and social disadvantage, physical health, alcohol and substance misuse and interactions with the criminal justice system.

It's clear the low rates of people accessing mental health services is a contributing factor to the high rates of suicide amongst these cohorts living in regional communities. To address issues in relation to rural suicide the provision of adequate health services should be addressed[17].

There is no one-size-fits-all approach to reducing suicide rates in regional communities. A prevention strategy that works in one community, may have very little impact in another.

For example, there are a range of unique factors when considering Aboriginal and Torres Strait Islander communities. These include: limited access to suitably trained mental health professionals, a lack of culturally sensitive services that incorporate a holistic conceptualisation of mental health and the impact of alcohol and other substances[18].

We note the considerable work that is happening regarding regional mental health and suicide prevention plans as a result of the Fifth Plan (particularly Priority Area 4, in relation to the Aboriginal and Torres Strait Islander community). However, we believe to truly address all of these issues an independent rural and regional mental health taskforce focusing on Queensland and the Northern Territory is required.

The Nature of The Mental Health Workforce

This is arguably the biggest challenge in providing mental health services to regional communities. Earlier in this submission we identified the low number of GPs, psychologists, psychiatrists and mental health nurses living and working in regional communities. This illustrates the significant challenges in attracting and retaining suitably qualified staff in rural and remote communities. Like all other parts of delivering mental health services in regional communities, there are a complex range of factors that add to the difficulty of retaining suitably trained professionals, including:

- The difficulty in attracting people with the right skills
- The cost of attracting and retaining staff in rural locations
- The inability to keep staff in regional locations for a prolonged period of time
- The need for better professional development programs
- The uncertainty of short-term contracts
- Staff burnout

Anecdotal evidence shows many older health professionals have made their careers living and working in rural communities, but that the vast majority of younger tertiary-qualified professionals coming through the system are moving to regional communities as a way of gaining experience to enable a move back to coastal towns and cities. A range of factors contribute to this churn, particularly the lack of a support network (both personally and professionally), that opportunities for career advancement are not available in rural communities and the burden of extra time and travel to reach patients.

Many non-government organisations providing mental health programs in regional communities highlighted the significant costs in attracting and retaining staff, particularly in remote locations. Uncertainty around government funding contracts only adds to this challenge. A number of providers identified difficulties in keeping trained and experienced staff in a regional location when there was significant uncertainty over the renewal of funding. These delays can force employees to look for more employment certainty, which can lead to the loss of staff and provide an additional cost to the provider in replacing an employee that has left the organisation. While many government programs may respond to specific community needs (such as the impacts of drought) by investing in additional staff, without ongoing funding it is not possible to embed these professionals in those regions. One submitter particularly noted the challenges in attracting suitably trained staff, especially to remote locations, and that fund providers (for example, government) needed to understand these challenges and the importance of identifying the right person for the role.

Staff burnout is another challenge. According to the Australian Medical Association, rural GPs tend to work longer hours and take on broader tasks[19]. Similarly, the Royal Australian and New Zealand College of Psychiatrists has identified the vulnerability of staff to burnout, identifying the need for appropriate professional support[20].

The Northern Territory perspective is that a well-trained, well supported and well-resourced Aboriginal mental health workforce is widely seen to be critical to the delivery of equitable, culturally engaged mental health care for Aboriginal people in the Northern Territory.

In some rural and remote regions, the size of the Aboriginal mental health workforce appears to be in decline. There are also a lack of Registered Training Organisations currently delivering culturally appropriate, accessible, accredited mental health training and education in the Northern Territory.

Priority areas to address workforce development and training challenges in the NT include:

- Appropriate cultural competency training
- Training in trauma-informed practice
- Dual diagnosis skills across mental health, alcohol and other drugs sectors
- Increasing sector awareness amongst GPs
- Providing better training and support to enhance the Aboriginal and Torres Strait Islander workforce.

The Challenges of Delivering Mental Health Services in The Regions

There are many challenges to delivering health services in rural and remote parts of Australia, which have been identified above. These challenges are interrelated. For example – the lack of available staff can cause burnout, which in turn contributes high turnover of health professionals in regional communities.

The limited services in smaller communities can lead to longer wait times to access services. Some organisations reported a wait period of at least 10 weeks to access youth counselling services. The delays in being able to access these services can lead to crisis for those individuals seeking treatment and support.

The lack of services in rural and remote areas can also mean individuals have no choice but to travel to larger regional centres to access professional support or for hospitalisation. This requires additional financial and human services. It also means the person is separated from their family and support networks, so appropriate post-vention support is compromised.

Attitudes Towards Mental Health Services

This is another complex issue and is a key theme of our submission, with many examples highlighted above.

If a person is unable to access a service when they need it, or if a person has a poor experience dealing with mental health services, this can lead to a lack of trust and an indifferent view. The constant turnover of young (and seemingly inexperienced staff) can also impact attitudes.

To really encourage people to access mental health services we need to make sure they are affordable, available and responsive. Currently, accessing mental health services in the regions is more difficult, takes longer and can be more expensive (particularly in those regional communities with a lower socio-economic position).

There are also less beds available (if any at all) in acute services. This can lead to more aggressive patients being placed alongside non-aggressive patients – which can again damage the view of mental health services.

To put it simply, to improve attitudes towards mental health services there needs to be an improvement in services in rural and remote communities. If there are more available and responsive services, delivered by experienced staff with a demonstrated commitment to the community, then attitudes will improve and more people will seek treatment. This will improve positive mental health across regional Australia.

Opportunities That Technology Presents for Improved Service Delivery

Amongst our members in Queensland there is strong support for the role of technology in improving service delivery.

As highlighted by the Royal Australian and New Zealand College of Psychiatrists a number of studies have illustrated that telepsychiatry can be as effective as face-to-face consultations[21].

Some organisations we consulted as part of this submission highlighted the benefits of telehealth services as:

- Removing the concern in regional communities that someone will see you walking into a clinic
- Eliminating the concern that the physician you get treatment from knows your friends/family

- It links people directly to experienced professionals who are also linked to other services (GPs, pharmacists)
- Provides access to a service that a person might not have had access to, or had to travel significant distances for.

However, our members also highlighted the importance of having people who were properly trained and experienced in delivering these types of services. As one member said, “I think the use of appropriate and skilled support workers would be beneficial in this area”.

The way in which these services are delivered is critical to ensuring their increased usage into the future. As these services are rolled out they need to be delivered by trained professionals with experience engaging with patients through the use of technology.

Internet access is another critically important part of telehealth services. It’s no good providing these services if internet accessibility is so bad that it doesn’t allow a continuous connection, or if it becomes too expensive for people to get access to adequate internet services. There is also a lack of internet access for most Aboriginal and Torres Strait Islander people living in remote communities. Any strategy for delivering more telehealth services would need to address the challenge of providing these services in remote Aboriginal and Torres Strait Islander and other isolated communities.

If individuals have bad first-up experiences with telehealth or telepsychiatry services, it will damage the attitudes towards these services. There is great potential for these services to improve access to mental health services in regional locations, but they must be delivered in a measured way.

In the Northern Territory the expansion of digital therapies represents a welcome boost to the service mix, however, many service providers have warned against over-estimating the efficacy of digital mental health therapies in remote areas.

Cultural and linguistic diversity, coupled with limited access and uptake of web-based services, limits the potential of widespread use of digital therapies in much of the NT. Continued investment in locally developed, low-intensity treatment options that are culturally and linguistic appropriate, and which build upon local community capacity, are favoured by much of the remote sector. To this end, digital therapies should supplement, but not make redundant, remote, practitioner-based services.

Other Related Matters

When considering the delivery of mental health services in regional parts of Australia, it is impossible not to reflect on the change the NDIS presents.

The same things that make it difficult to provide mental health services in rural parts of Queensland and the Northern Territory (distance, a higher proportion of Aboriginal and Torres Strait Islander people living in remote communities, workforce attraction and retention) complicate the delivery of the NDIS in our areas.

We remain extremely concerned by the rollout of the NDIS and the provision of services to people living in rural and remote parts of our jurisdictions. In Queensland, only 56 per cent of the bilateral estimates for people with an approved plan have been met (as at December 31, 2017). In Northern Territory only 58 per cent of the bilateral estimates have been met. In Queensland, just 7% of active participants with an approved NDIS plan list psychosocial disability as their primary disability[22]. In Northern Territory this number is even smaller, at 4%[23]. This is far below original estimates for the NDIS, which predicted around 14% of NDIS participants nationally would have a primary psychosocial disability. These numbers show there are still major challenges in encouraging people with a psychosocial disability to apply for the NDIS and, while work has been done in this space, there remains a lack of understanding of psychosocial disability within the National Disability Insurance Agency.

There are also major challenges in ensuring people in remote communities can both apply for the NDIS and, if successful, get access to the necessary supports provided through their NDIS plan. People with psychosocial disability living in rural and regional communities face all of these challenges. The difficulty in engaging them in the NDIS process is even more pronounced.

We remain concerned with the lack of NDIS market readiness. More work needs to be done to identify and respond to thin markets in rural and remote locations where there is less competition or no services at all.

The current NDIS pricing structure does not allow organisations in rural and remote locations to provide NDIS services at an economic cost. While there is remote weighting for these regions, the amount does not fully take into account the tyranny of distance, a thin market and the challenges of good governance and competition in rural and remote regions.

If there is a lack of suitable NDIS service providers for people with a psychosocial disability, this will have impacts on the delivery of wider mental health services across the rural and remote regions.

We also remain extremely concerned about continuity of support arrangements for people deemed ineligible to enter the NDIS. If a person currently accessing supports is ineligible for the NDIS, they should continue to receive supports that enable them to achieve similar outcomes to the ones they were aiming to achieve prior to the introduction of the NDIS. While the State, Territory and Federal Governments have committed to continuity of support, to date there has been no clear articulation of what those support arrangements actually look like.

Nationally, the NDIS is estimated to support 64,000 with a primary psychosocial disability. As highlighted in the Mind the Gap Report, 690,000 Australians live with a severe mental illness[24]. There is a very real possibility a gap in services will emerge for those people who are found not to be eligible for the NDIS unless continued investment is made in mental health programs. This gap will be especially pronounced for people living in rural and remote parts of the country, where accessing mental health services is already more difficult.

This is a hugely important issue for the Senate Standing Committee to consider. We can't afford to view the provision of mental health services in rural and remote locations and the rollout of the NDIS in separate prisms. They are intrinsically linked and the NDIS rollout issues listed above also require the attention of the Standing Committee to ensure all issues impacting mental health service delivery in country areas are addressed.

Solutions

To address the issues identified above, the QAMH and the Coalition recommend the establishment of an independent Queensland and Northern Territory rural and regional mental health taskforce.

Queensland and the Northern Territory are unique when it comes to regional Australia. Queensland is the most decentralised state in the nation, while in the NT there are a large proportion of distinct communities in remote and very remote locations. For these reasons our jurisdictions are the right fit for a taskforce to deliver recommendations on improving mental health services in rural and remote locations.

This taskforce should be completely independent from government and be made up of representative organisations from the QAMH and the Coalition.

The independent taskforce would consider all aspects of mental health service delivery, including Commonwealth-funded services, State and Territory Government services, the Primary Health Networks and non-government organisations.

Some of the priority areas for consideration would include:

- Major gaps in services and strategies for addressing these gaps
- Mental health workforce and training development
- Service coordination and integration across government and NGO services

Such a taskforce would be informed by the collation of PHN service mapping in rural and remote areas and other key datasets.

The independent taskforce would conduct regional hearings across Queensland and the NT and could call on government agencies to provide evidence and information as required. It would be established for a period of two-years and be required to provide an interim and final report outlining a key set of recommendations to improve the delivery of mental health services across rural and remote parts of Queensland and the Northern Territory. The findings of the taskforce would be used to inform strategies in other locations across Australia.

The taskforce would be funded by the Commonwealth Government. Our organisations would welcome the chance to lead the establishment of this independent taskforce. We would also welcome the chance to discuss this initiative directly with the Senate Standing Committee.

We believe the only way the issues identified in this submission will be fully addressed is by engaging mental health service providers and organisations delivering services in rural and remote locations to come up with a well-informed and complete package of recommendations following extensive consultation.

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