Senate Inquiry - Accessibility and quality of mental health services in rural and remote Australia

Department of Health

4 May 2018

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Contents

Foreword

This submission is made on behalf of the Australian Government Department of Health.[1] It refers only to the programs administered within that Department's portfolio.

The submission is made in response to:

> On 19 March 2018, the Senate referred the following matter to the Senate Community Affairs References Committee for inquiry and report:
>
> > *The accessibility and quality of mental health services in rural and remote Australia, with specific reference to:*
> >
> > - *the nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate (see Parts 2-3)*
> > - *the higher rate of suicide in rural and remote Australia (see Part 5)*
> > - *the nature of the mental health workforce (see Part 6)*
> > - *the challenges of delivering mental health services in the regions (see Part 3)*
> > - *attitudes towards mental health services (see Part 3)*
> > - *opportunities that technology presents for improved service delivery (see Part 6)*
> > - *any other related matters.*

[1] *Note:* for the purposes of this document 'Australian Government' is used to refer to the responsibilities of government departments and agencies, while activity described in this document is limited to that within the portfolio of the Department of Health. 'Commonwealth' refers to financial or other resource investment.

1 Executive Summary

In August 2017, all levels of government endorsed the Fifth National Mental Health and Suicide Prevention Plan. In doing so, each agreed to a collaborative approach to provide better mental health and suicide prevention services in Australia.

The centre piece of the Australian Government's contribution to this new approach has been to support Primary Health Networks (PHNs) as leaders in regional planning, coordinated funding and commissioning of mental health services. This will complement local general practitioner (GP) activity and address service gaps. PHNs are required to tailor services to local needs, making this an important development for accessibility and quality of mental health services in rural and remote Australia.

Some of the current PHN innovations and trials are having immediate impact, while others will take time to consolidate and develop. The new PHN minimum data set will provide information at a more refined level to inform future policy and local service decision-making. Through such initiatives, the Australian Government is contributing to improved mental health and suicide prevention services in rural and remote areas, but there is still some way to go.

1.1 Background

Mental illness is widespread in Australia, as it is in other developed countries. Data from the Australian Bureau of Statistics (ABS) indicates that one in five people aged 16 to 85 years will experience one of the common forms of mental illness in any one year[2]. Almost half of all Australians will experience a mental illness at some point in their lifetime.

The impact of mental illness on peoples' lives varies, with different levels of severity and implications for functional impairment. Some people may experience a single episode and recover fully, while others may experience ongoing effects on their quality of life and that of their families. Over 4 million Australian adults are estimated to have common mental disorders, while for 3 per cent of Australians their mental disorder is severe.

The Australian Government recognises this impact, including the emotional, social and economic cost of mental illness for individuals, families and communities. It also recognises the long-standing challenge of access to health services in rural and remote communities, as well as the associated risk factors that compound mental health needs.

The improved mental health of Australians has been a national priority for over 25 years. Over that time, there has been increased public awareness of the impact of mental illness and the role of all governments in supporting access to mental health and suicide prevention services. Currently, the total spending of all governments on mental health-related services and suicide prevention in Australia each year is $9 billion.[3] There has also been a growing, combined government effort to ensure delivery of quality services across public, private, non-government and community sectors. The contribution of general practitioners continues to be central to this through their role managing primary care and making specialist referrals. These practitioners are the front line of efforts to improve access to quality mental health services in Australia.

[2] Australian Bureau of Statistics. Media Release: One in five Australians have a mental illness: ABC, October 2008

[3] Australian Institute of Health & Welfare. Media release: Mental health spending hits $9 billion, 2 February

1.2 National Mental Health and Suicide Prevention

Australia was amongst the first countries to develop a national framework for mental health reform. Historically, our Federal governance arrangements have presented a challenge to these efforts. In some instances, the roles and responsibilities of government have been blurred, while in others, there has not always been adequate transparency and accountability for service delivery and quality. Despite examples of success in some regions, these did not translate across the nation. For many years, implementation of best mental health practice was inconsistent with many practitioners and services operating in isolation.

The Fifth National Mental Health and Suicide Prevention Plan, released in 2017, represents an important step forward. The Plan brings together Commonwealth, State and Territory governments and consolidates existing partnerships, in a single national approach that emphasises the need to be responsive to the specific needs of different regions. This approach is important because mental health challenges are complex and individual, while mental health system responses need to flexibly integrate public, private and community services. Planning and funding is to be undertaken at the regional level, without losing consistency and accountability at the national level.

The Australian Government has adopted a 'plan nationally, act locally' approach to build on its past leadership and leverage new and existing funding commitments. A key feature of the Commonwealth's new role has been to support PHNs as the vehicles of integrated regional planning, coordinated funding and targeted commissioning of mental health services. This is a ground-breaking new development for mental health reform in Australia. For the first time, there is a clear line of sight, transparent accountability and direct links between policy, resourcing and local delivery for quality mental health and suicide prevention services.

1.3 National leadership in mental health through regional PHNs

The network of PHNs forms the centrepiece of the Australian Government's recently expanded contribution to accessible and quality mental health and suicide prevention services. PHNs have been provided with a new flexible funding pool to coordinate and commission mental health services at a local level. They have quarantined funding for early intervention, youth and Indigenous mental health services and have been entrusted with the coordination of a range of other mental health initiatives. Accordingly, it is the role of PHNs to engage with general and mental health practitioners to ensure the provision of quality services to individuals.

This role of PHNs is vital as many people in rural and remote areas do not have access to local mental health professionals, and local general practitioners are usually the first point of contact and referral for mental health services. In recognition of this, the Commonwealth has allocated mental health flexible funding with significant weighting for rurality, Indigenous status and socioeconomic status. These three factors are known to be associated with higher levels of need and lower rates of access to services. Further, this approach promotes equity by addressing challenges around lower access to Medicare Benefits Schedule (MBS) mental health items in rural and remote areas.

Devolving national resources to provide maximum local benefit will provide significant benefits for rural and remote communities, and will support the improved quality of care that comes from delivering services through a stepped model that matches support to intensity of need (as discussed in Section 3.5).

The success stories from this approach in rural and remote Australia are growing, but the innovative mental health programs, initiatives and trials being developed by PHNs across Australia are still in their early stages. These initiatives need time to consolidate and demonstrate impact.

This submission by the Department of Health will demonstrate how good progress has already been made with the 'plan nationally, act locally' approach, and describe the foundations that are being put in place to provide for more such success into the future.

2 Mental Health in rural and remote Australia

Mental health is a state of emotional and social wellbeing where the individual can cope with the normal stresses of life and achieve their life potential. It includes being able to work productively and contribute to community life. On the other hand, mental illness refers to the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people.

The experience of mental illness is different for everyone. Mental illness has many causes, can manifest itself in different ways, and can have different outcomes. They may experience high levels of functional impairment, persistent symptoms, comorbidities and side effects of medication.

Mental illness has a substantial impact across Australia. However, there are higher levels of need experienced within rural and remote communities, and suicide is a significant concern, particularly amongst Aboriginal and Torres Strait Islander people. This section will outline the prevalence of mental illness in rural and remote Australia, as well as the significant challenges and substantial cost to all Australians. The range of programs, initiatives and trials within the Department of Health portfolio that seek to address these challenges will be set out in following sections.

2.1 Prevalence of mental illness in rural and remote areas

In Australia, as in many other countries, the prevalence of mental illness and suicide is high. In 2007, the Australian Bureau of Statistics (ABS) conducted the second National Survey of Mental Health and Wellbeing. The survey involved approximately 8,800 people aged over 16 years and living in private dwellings in all states and territories of Australia. It reported prevalence of mental illness at approximately 20 per cent.[4] That means that one in five Australians will experience a mental disorder in any given year, no matter where they live.[5]

The prevalence of mental illness in Australia, combined with the significant disability associated with it, results in a substantial personal burden of disease. Over 45 per cent of Australians will experience a mental illness during their lives.[6] The burden of mental illness is ranked only behind heart disease and cancer in contribution to the total burden of disease in Australia[7]. Depression and anxiety account for over half of this burden, with depression being the leading single cause of disability among all disorders. Most Australians have been affected by mental illness, either directly or indirectly, by being involved with someone who has a mental illness.

The latest AIHW report[8] on mental health services reported that approximately 2.4 million Australians received Medicare-subsidised services in 2016-17. In that same year, 4 million people received mental health-related prescriptions. While prevalence of mental illness is consistent between metropolitan and non-metropolitan areas[9], several indicators point to higher levels of need in rural and remote communities. This is of note because lower access to early intervention through MBS services can result in intensification of need, comorbidity, chronic conditions and greater hospitalisation. In 2016-17 there were

[4] Australian Bureau of Statistics, 4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007, p.21,2,7

[5] Royal Flying Doctor Service accessed 1 May 2018

[6] Australian Bureau of Statistics, 4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007 p.1

[7] Australian Institute of Health & Welfare, Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011, p.vii

[8] Australian Institute of Health & Welfare, Mental health services in Australia – web report, 3 May 2018, Prevalence and policies

[9] National Rural Health Alliance, Fact Sheet – December 2017, Mental Health in Rural and Remote Australia

495 MBS funded mental health encounters per 1,000 people in major cities, compared with 297 and 145 encounters per 1,000 people in outer regional and remote areas respectively.[10] As noted above, these figures do not indicate a higher prevalence of mental illness. Rather they are an indicator of differential service access in different communities. Figures such as these that have led groups, such as the National Rural Health Alliance,[11] to argue that it is the lack accessibility of services and other compounding factors in rural and remote that contributes to greater demand for mental health services.

2.2 Unique mental health challenges in rural and remote communities

People in rural and remote areas face a range of stressors that are unique to living outside major cities. These include a greater prevalence of some chronic conditions and disability, and generally poorer health. Rates of smoking, risky drinking and illicit drug use are also higher. Patients are more likely to present during the later stages of illness, and they do not have the same access to primary care and early intervention services. This often results in higher rates of complex comorbidities. Together, these influences can compound the risk factors for poor mental health.

Health challenges in regional areas are also compounded by social problems. Loneliness and isolation are acute issues and are in part a result of the gradual depopulation of remote and rural areas to cities. This is particularly challenging for young people growing up in these areas. Declining populations have led to the withdrawal of many basic services – such as banks, hospitals, offices, and schools. Fewer employment opportunities lead to lower incomes, less financial security and stress. This range of factors pulls at the fabric of regional social life and can contribute to higher rates of anxiety and depression.

Australians living in rural and remote areas are also vulnerable to environmental risk factors. Climate stresses, such as drought, bushfires, and flood, may present threats to peoples' livelihoods. Rural communities have also been affected by international trade pressures and the declining profitability of core industries, which can also be a factor in anxiety, depression and suicide. Higher rates of suicide in regional Australia, particularly amongst men, can also be linked to environmental specific factors (such as the greater availability of lethal means of self-harm).

The Australian Government recognises these unique challenges and their link to the substantial economic and social cost of mental illness and suicide for rural and remote Australia.

2.3 Social and economic cost of mental illness and suicide in rural and remote Australia

The social cost of mental illness can be high. This includes the intangible costs of reduced wellbeing, emotional distress, pain, and other forms of suffering. The stigma associated with mental illness can prevent people from discussing their condition with loved ones or being open about it in the workplace. When symptoms of mental health present they can have a significant social impact on individual sufferers. Individuals may struggle to participate socially, form meaningful relationships or contribute to their local communities. Some people may begin to disengage from society, and the social costs of this can be significant. The severity of this social impact varies across regions and is often compounded by a range of social factors. For example, Aboriginal and Torres Strait Islander people, those living in highly remote

[10] Australian Institute of Health & Welfare, Mental health services in Australia – web report, 2 February 2018, Medicare services 2016–17 tables, Table MBS.10: Medicare-subsidised mental health-specific services, by provider type(a), patient demographic characteristics, 2016–17

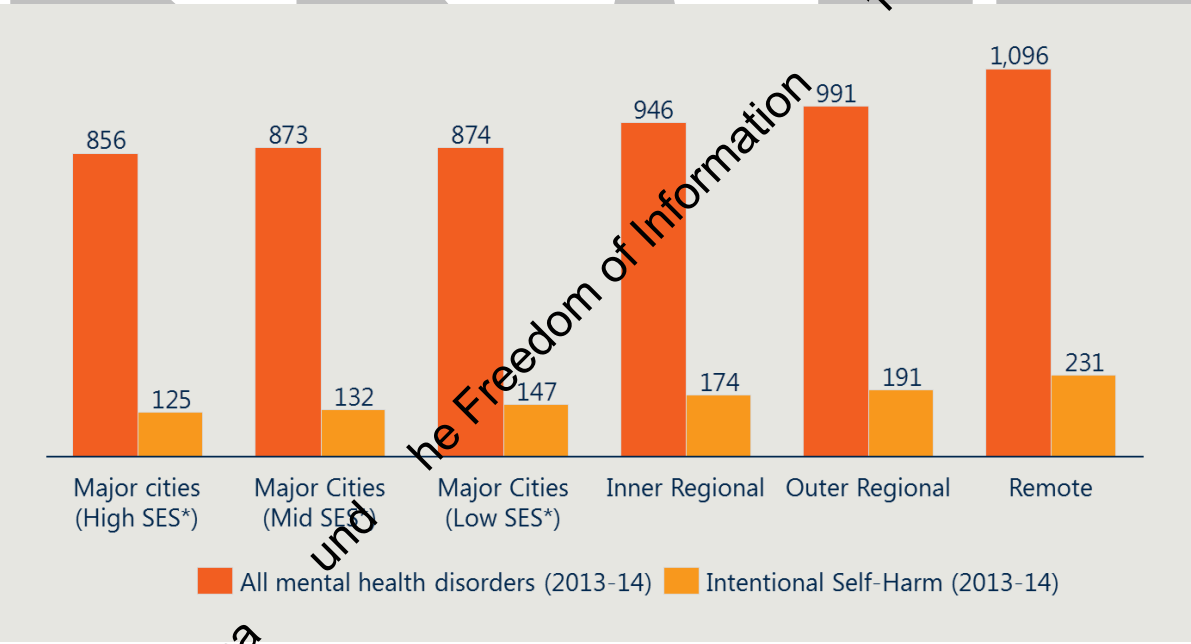
[11] National Rural Health Alliance. Mental health in rural and remote Australia: Fact Sheet December 2017, accessed 1 May 2018

areas, and those who are marginalized based on their sexuality or gender, can face compounded pressure on their condition.

The economic cost of mental illness can also be high. The OECD estimates that the average overall cost of mental health to developed countries is about four per cent of GDP.[12] At a national level, the economic costs of mental disorders are substantial. Mental illness accounts for substantial losses in the workplace through sick leave, lost working days and reduced productivity. The National Mental Health Commission has estimated the annual cost of mental illness in Australia is more than $60 billion, which represents four per cent of our overall GDP and equates to about $4000 for every tax payer.[13] It has been estimated that mental illness results in around 12 million days of reduced productivity a year for Australian businesses.[14]

Amongst the direct financial costs of mental health in regional areas are those to government through hospitalisation. The AIHW 'Healthy Communities' Report highlighted that the rate of hospitalisation from mental health conditions as well as drug and alcohol use and intentional self-harm, is higher in remote areas than major cities (as seen in Figure 1).[15] In 2013-14 the overall mental health overnight hospitalisation rate was higher in regional areas when compared with metropolitan areas.[16]

Figure 1: Age standardised rate per 100,000 population of same-day and overnight mental health hospitalisations, 2013-14[17]



**SES refers to Socio-Economic Status*

[12] OECD, Making Mental Health Count, 2014

[13] National Mental Health Commission. Economics of Mental Health in Australia, 2016

[14] Professor Allan Fels, National Mental Health Commission media release. The economic cost of physical ill-health and serious mental illness – 2016 web report, accessed 2 May 2018

[15] Australian Institute of Health and Welfare. Web update: Hospitalisations for mental health conditions and intentional self-harm in 2014-15, 16 February 2017

[16] https://www.myhealthycommunities.gov.au/our-reports/mental-health-and-intentional-self-harm/february-2017/web-update

[17] Australian Institute of Health and Welfare. Health Communities – Hospitalisations for mental health conditions and intentional self-harm in 2013-14: Table 4: Age-standardised rates of same-day and overnight hospitalisations related to intentional self-harm, per 100,000 people, by local area (SA3) remoteness and socioeconomic status, 2013–14, p.30.

While data indicates significant differences in the rates of hospitalisation in rural and remote Australia compared with major cities, it also reveals significant variation within regions – the rates of hospitalisation in some communities can be almost eight times higher than for other communities of the same level of remoteness.[18] Analysis of 2015-16 data also reflected this variation within remoteness categories. When considering all mental health disorders, the greatest range in the rate per 10,000 population of hospitalisations was over in the Outer Regional category, with the highest rate being 4.7 times higher than the lowest.[19]

To assess the economic cost of mental illness in rural and remote Australia, it needs to be recognised that our regional, rural and remote communities are home to many of Australia's primary industries, and therefore contribute significantly to our country's economy. Recent data shows that approximately 67 per cent of the value of Australia's exports comes from these areas.[20] This means that loss of productivity by lack of healthy workers not only has an important impact on the national economy, but also on regions and towns that rely heavily on one industry or export. To understand the true social and economic impact of mental illness in these regions, there is a need to look beyond costs in solely dollar terms.

2.4 Total government expenditure in mental health

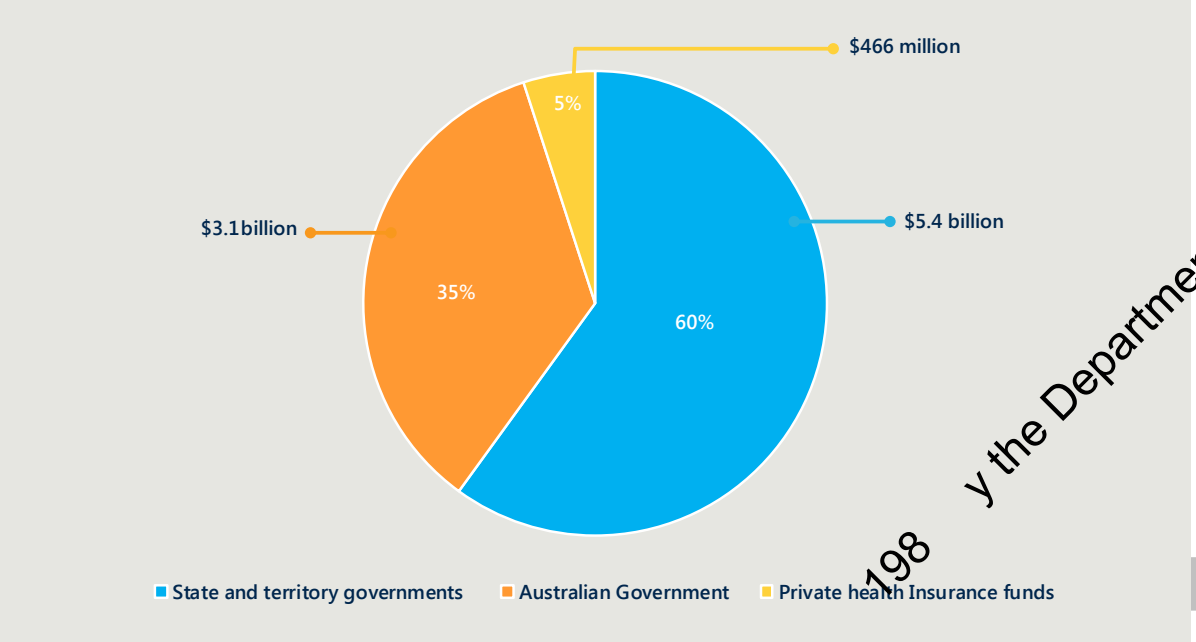
Australian governments invest significantly in mental health-related services for all Australians. In 2015-16, the Australian Institute of Health and Welfare reported 7.7 per cent of all government health expenditure was dedicated to mental health-related services, while national spending on mental health services totalled almost $9 billion in 2015-16. Of that expenditure, most was by state and territory governments (about 60 per cent of total mental health spending, or $5.4 billion), followed by the Australian Government (35 per cent, or $3.1 billion) and private health insurance funds (five per cent, or $466 million) (Figure 2 below).

[18] Australian Institute of Health and Welfare. Health Communities – Hospitalizations for mental health conditions and intentional self-harm in 2013-14

[19] Australian Institute of Health and Welfare. Web update: Hospitalisations for mental health conditions and intentional self-harm in 2015–16: Table 3: Hospitalisations of mental health conditions (overnight) and intentional self-harm (same day and overnight), by Statistical Area Level 3 (SA3), 30 November 2017

[20] National Rural Health Alliance: Economic contribution of regional, rural and remote Australia

Figure 2: National spending on mental health services 2015-2016[21]



The Commonwealth is a major contributor to national investment in the provision of mental health services. It provides direct or indirect funding to the major private sector services (including private psychiatrists and general practitioners) through the Medicare Benefits Scheme (MBS), as well as medications through the Pharmaceutical Benefits Scheme (PBS).

In 2016-17, the Department of Health total mental health expenditure was over $4 billion, covering MBS and PBS, the Commonwealth's share of public hospital funding and private insurance rebates, and departmental mental health programs. The $712.8 million of funding for mental health programs in 2016-17 including those supporting primary care, promotion and prevention, psychosocial support and suicide prevention.

The Australian Government also provided $1.485 billion to states and territories specifically for public hospitals, through which mental health services are delivered.[22] In 2015-16, $5.4 billion was spent on state/territory mental health services, which included $2.4 billion on public hospital services.[23] The states and territories add to funding provided by the Commonwealth and then disburse this funding to local in-patient and community-based services, as well as to non-government sector services.

In this way, the Commonwealth, state and territory funding partnership provides the foundation for accessible and quality mental health and suicide prevention services in Australia.

[21] Australian Institute of Health and Welfare. Mental health Services in Australia- web report 3 May 2018, Expenditure on mental health-related services 2015-16 – Key Points; Australian Institute of Health & Welfare. Media release: Mental health spending hits $9 billion, 2 February.

[22] Department of Health internal projected estimates.

[23] Australian Institute of Health & Welfare, Mental health services in Australia – web report, 3 May 2018, Expenditure on mental health-related services 2015-16 tables, Table EXP.1: Recurrent expenditure ($'000) on state and territory specialised mental health services, states and territories, 2015–16.

2.5 The role of public, private and non-government sectors in mental health

Mental health service provision within the Australian health care system is characterised by multiple providers working in primary, specialised mental health and other health services. For the purposes of this document, these are defined as:

- *Primary care* services are those providing socially appropriate, universally accessible, scientifically sound first level care, supported by integrated referral systems. They do so in such a way that gives priority to those most in need, maximises community capacity, collaborates with other services, and fosters the individual's independence and participation.
- *Specialised mental health* services are those in which the primary function is to provide treatment, rehabilitation or community support for people affected by mental illness, and in which such activities are delivered from a facility or service which is readily identifiable as both specialised and serving a mental health need.
- Other health services include those not classified above, such as public health services which provide some form of mental health care, education or rehabilitation.

These services are provided across the public, private and non-government sectors.

Public sector mental health services include psychiatric hospitals, psychiatric units in general hospitals, community residential units and community mental health services.

The term private sector refers to a range of providers including private psychiatrists, general practitioners, private psychiatric hospitals and private allied health professionals. The Commonwealth makes a significant contribution to this sector through its share of private health insurance rebates.

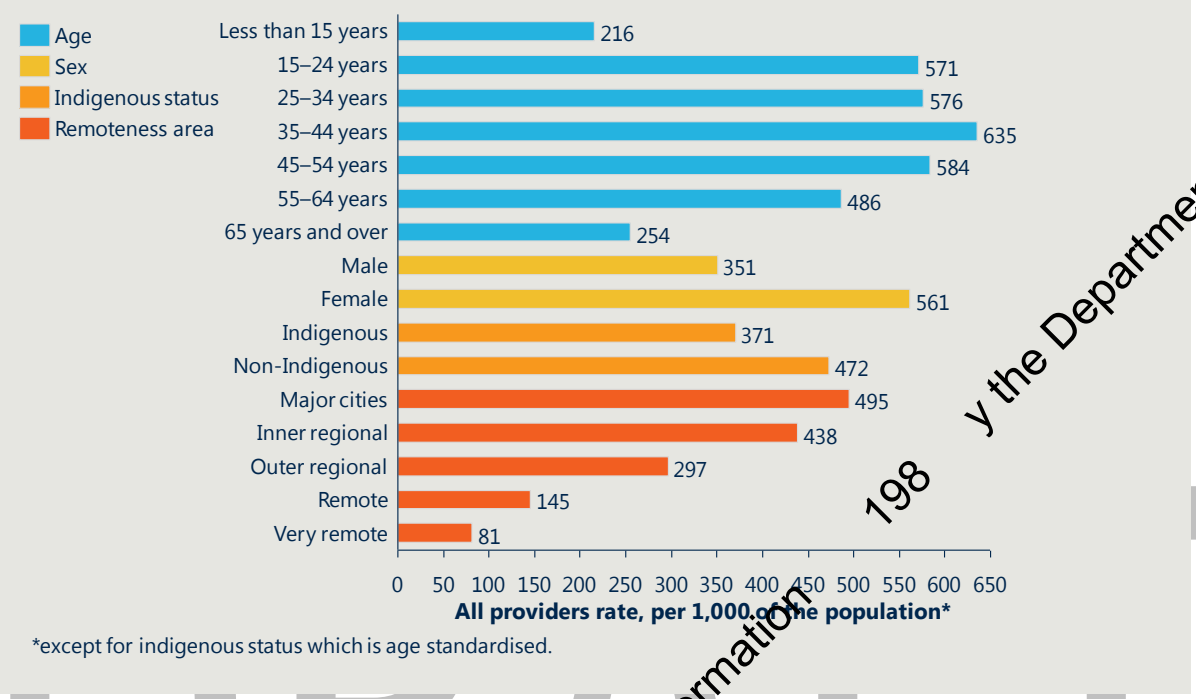
The non-government (NGO) sector includes not for profit and community managed organisations, which promote independence and mental wellbeing, provide support and advocacy, or provide specialised information, accommodation and rehabilitation services.

2.6 The distribution of mental health services in rural and remote Australia

The Australian Government and state and territory governments play different roles in mental health care. The Commonwealth's primary roles are in funding services through the MBS/PBS, supporting a nationally coordinated (but regionally delivered) system of services and providing leadership in mental health reform. Medicare item usage provides one important measure of the Commonwealth's contribution to mental health services. It also provides a mechanism to assess the distribution of services across Australia according to patient demographics.

A demographic distribution of Medicare-subsidised mental-health specific services (as seen in Figure 3) indicates a large difference in access to services in regional and remote areas.

Figure 3: Rate (per 1,000 population) of Medicare-subsidised mental health-specific services for all providers, by patient demographic characteristics, 2016–17.[24]



*except for indigenous status which is age standardised.

Further analysis of Medicare-subsidised mental health services by population rate reaffirms this disparity (as seen in Table 1).

Table 1: Number of people and rate (per cent of population) receiving Medicare-subsidised mental health-specific services, by remoteness area (2016–17)[25]

Remoteness area	Number of people	Rate (per cent of the population)
Major cities	1,754,938	10.2
Inner regional	457,817	10.4
Outer regional	168,166	8.1
Remote	14,872	4.8
Very remote	5,326	2.8

[24] Australian Institute of Health & Welfare, Mental health services in Australia – web report, 2 February 2018, Medicare services 2016–17 tables, Table MBS.10: Medicare-subsidised mental health-specific services, by provider type(a), patient demographic characteristics, 2016–17; Australian Institute of Health & Welfare, Mental health services in Australia – web report, 2 February 2018, Medicare services 2016–17 section, Figure MBS.5, p.6

[25] Australian Institute of Health & Welfare. Mental health services in Australia – web report, Medicare Services 2016-17 Tables, May 2018, Table MBS.5: People receiving Medicare-subsidised mental health-specific services, by provider type, remoteness area, 2016-17

When expressed in standardized population terms, there is still a clear disparity in mental health services between metropolitan and non-metropolitan areas. For the 2016-17 period there were 495 Medicare-subsidised mental health-specific services per 1,000 population in major cities, over three times that of remote and six time that of very remote Australia (refer to Table 2).

Table 2: Number and rate per 1,000 population of Medicare-subsidised mental health-specific services, by remoteness area (2016-17)[26]

Remoteness area	Number	Rate (per 1,000 population)
Major cities	8,535,456	495.3
Inner regional	1,920,417	437.8
Outer regional	619,577	296.6
Remote	44,680	145.2
Very remote	15,664	80.9

These figures demonstrate the high variability in MBS mental health service usage across Australia. Some groups have attributed this difference to the lower number of mental health care professionals in rural areas (see Table 3). In regional areas the numbers of psychiatrists, mental health nurses and psychologists, are respectively, 36 per cent, 78 per cent and 57 percent of those in major cities, with even poorer comparisons in remote areas.[27]

Table 3: Number of mental health professionals (Clinical FTE per 100,000 population) by remoteness (2015)[28]

	Major Cities	Inner Regional	Outer Regional	Remote	Very remote
Psychiatrists	13	5	4	5	2
Mental Health Nurses	93	74	46	53	29
Psychologists	73	46	33	25	18

[26] Australian Institute of Health & Welfare. Mental health services in Australia – web report, May 2018, Medicare Services 2016-17 Tables, Table MBS.14: People receiving Medicare-subsidised mental health-specific services, by provider type, remoteness area,2016-17

[27] National Rural Health Alliance. Mental health in rural and remote Australia: Fact Sheet December 2017, accessed 1 May 2018

[28] Australian Institute of Health & Welfare. Mental health services in Australia – web report, 3 May 2018, Mental health workforce 2015 tables, Table WK.4: Employed psychiatrists, Table WK.12: Employed mental health nurses, Table W.20: Employed psychologists

The reduced access to care highlighted above is also reflected in MBS data. When MBS expenditure on mental health services is analysed by remoteness, per capita expenditure in cities in 2015-2016 was just under four times that of remote areas and more than six times that of very remote areas (see Table 4).

Table 4: Per capita MBS expenditure, mental health services, by remoteness 2015-2016[29]

	Major Cities	Inner Regional	Outer Regional	Remote	Very remote
All Professionals	$52.42	$43.43	$29.40	$14.58	$8.26

The Commonwealth is committed to addressing these issues of relatively lower service access and accessibility of general, medical and allied health professionals. This has been demonstrated through a series of national initiatives over the past three decades (see Section 3).

2.7 Underlying causes for lower access to mental health services outside of metropolitan areas

Australians living in rural and remote communities continue to face a range of challenges in accessing mental health services to meet their need. This is despite the similar prevalence of mental illness in rural, remote and metropolitan areas.

As outlined above, fewer mental health professionals result in fewer services being available when and where they are needed.[30] People in rural and remote areas also face difficulties accessing mental health services from further afield. Factors such as distance and travel cost can result in delays in people obtaining assistance, which contributes to greater acuity.[31] These delays in access may result in an individual's illness becoming more advanced and presenting with complex physical comorbidities, and/or leading to greater chance of hospitalisation.

The societal stigma attached to mental illness can result in people not obtaining assistance, even when services area accessible. People can be reluctant to seek help. Stigma can prevent people from sharing their illness with work colleagues and their families or delaying contact with local health professionals. Fears and perceptions around stigma may also result in people being reliant on an individual general practitioner or mental health professional because the patient does not trust others in the community. This can result in a mismatch between the more complex or severe needs of the individual and the qualifications, skills and experience of the professional providing support.

The Better Access and telehealth initiatives (discussed in detail in Section 7.3) aim to address these exact issues by improving access to specialist mental health services that complement the established trust between general practitioner and patient with confidential, high quality, expert services that are matched to intensity of need.

[29] Australian Institute of Health and Welfare. Mental health services In Australia - web report 3 May 2018, Expenditure on mental health-related services 2015-16 tables, Table EXP.22: Australian Government Medicare expenditure on mental health-specific services per capita ($), constant prices, by provider type, remoteness area, 2006–07 to 2016–17

[30] Royal Flying Doctors Service, Media ready resources, accessed 1 May 2018

[31] *ibid*

3 Past initiatives in rural and remote health and mental health

A consistent feature of past Australian Government initiatives to improve health care in rural and remote Australia has been the inclusion of significant mental health components. This emphasis was enhanced by the endorsement of the Fifth National Mental Health and Suicide Prevention Plan by COAG.[32] This enables the Commonwealth to continue its leadership role as part of a new coordinated national approach to mental health service delivery and suicide prevention. This section provides a brief history of Commonwealth initiatives in rural and remote health care, some of which include mental health components, whilst others are not mental health specific (but have impact on mental health service providers). It also examines the nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate.

3.1 Australian Government commitment to health care in rural and remote Australia

The Australian Government has a long history of implementing initiatives to improve health care in rural and remote areas. There have been many successes and significant progress has been made since Federal, state and territory governments endorsed the first national health plan over two decades ago. However, the challenges around accessibility and quality of mental health services in rural and remote areas are multiple and complex, which makes the new integrated national approach a ground-breaking development in addressing these persistent challenges.

In the past, many Australian Government initiatives to address these challenges were driven by a need to address the shortfall in supply of general practitioners in rural areas, and to provide incentives for medical practitioners to relocate to rural areas. These practitioners are the front line of primary care and the main referral gateway to specialist mental health care and this underpinned this strategy. Data emerging from the mid-1990s onward also supported the view that there were general practitioner shortages in rural and remote areas.[33]

Following its election in 1996, the Howard Government introduced schemes intended to address the maldistribution of general practitioners, such as requiring overseas trained doctors to work in areas classified as District of Workforce Shortage (explained in more detail overleaf).[34] However, despite government initiatives, shortages of doctors persisted, and more evidence began to emerge in the early 2000s that shortages were also commonplace in the outer metropolitan areas of the capital cities. This led to another set of initiatives which included boosting medical student numbers overall, establishing rural clinical schools and regional medical schools, and increasing university admission of students who were already residents of rural areas. This commitment continues to attract general practitioners to non-metropolitan areas through a range of Australian Government schemes. Some of these initiatives include:

Federal government bonded scholarship initiatives

The Medical Rural Bonded Scholarship Scheme provides 100 scholarships annually. In return for support under this scholarship, students agree to relocate and practice in rural and remote areas for six years continuously upon completion of their medical and vocational training. Similarly, The Bonded Medical Placed Scheme provides funding to study medicine in return to a commitment from students to work in areas with workforce shortages.

[32] COAG. The Fifth National Mental Health and Suicide Prevention Plan, 2017, p.19-20

[33] Australian Parliamentary Library. Medical practitioners: education and training in Australia, Social Policy Section, 2009.

[34] *Ibid,* footnote 14

The Australian College of Rural and Remote Medicine Fellowships

These fellowships allocate places to trainees on either a general or rural pathway to fellowship. Rural pathway trainees complete all their practice in rural and remote areas, within hospitals and in specialised medical areas over a period of four years. Specific placement programs, such as the John Flynn Placement Program provide placements for shorter periods of time, such as a minimum of two weeks each year over a period of four years. Each recipient works closely with a rural doctor in a wide variety of health settings to experience one-on-one mentoring. It also serves to encourage students to interact with local communities.

The Rural Australian Medical Undergraduate Scholarship (RAMUS)

Administered by the National Rural Health Alliance, this scheme assists selected students from rural and remote areas to undertake medical degrees. To be eligible for RAMUS, students must have lived in rural and remote areas for a cumulative period of eight years. Although these students are not bonded to work in rural areas after the completion of their studies, efforts are made instead to reinforce student ties to the regions through a rural mentorship program and compulsory membership of university student rural clubs.

A further range of incentive, grant, education and training support initiatives are supported by funding from the Commonwealth (see Part 6).

By developing education quotas and policies, tracking the needs of the population and providing the right infrastructure to allow for relocation to rural and remote areas, the Australian Government has been working to assist with some core aspects of ensuring that there is adequate healthcare in the regions in question. Methods have been developed to determine the areas where the shortage of medical practitioners is being felt the most. These include:

Areas of need (AON)

A state and territory classification related to health workforce shortages was created, referring to any areas where there is a lack of specific medical practitioners. It also covers situations when there are unfilled medical positions in the private and public sector after recruitment efforts have been taken over a period of time.

District of workforce shortage (DWS) monitoring classifications

A classification for monitoring health workforce shortages was developed to accurately reflect the need of medical practitioners in specific areas. District of workforce shortage (DWS) refers to those areas where the community is considered to have lower rates of access to medical services than that experienced by the population in general. While for some time this classification was reserved for only rural and remote areas, DWS is also now applicable to outer metropolitan areas that suffer medical practitioner shortages.

Evidence from the Commonwealth Department of Health indicates that these incentives to influence the location of practice for general practitioners have been largely successful over the longer term. This is based on analysis of access to GP patterns for metropolitan and non-metropolitan Australia using MBS transactional data.[35]

More recently, attention has shifted to factors effecting the ability of general practitioners to refer to mental health specialists. These include a lack of training in identification of early signs of mental illness and attracting appropriately qualified mental health specialists to non-metropolitan locations. A range of Australian Government strategies to address these issues are detailed throughout this document.

[35] Department of Health internal data analysis.

3.2 Attitudes and challenges to delivering quality mental health services in rural and remote areas

The Australian Government is committed to providing all Australians with access to high quality and safe mental health services, where and when required. Its approach to delivering quality mental health services in rural and remote areas is underpinned by national quality standards, greater transparency across the system, a focus on quality within the design of PHN local service coordination, and a range of resource supports for mental health professionals.

At a national level, the Australian Commission on Safety and Quality in Health Care has responsibility for leading and coordinating improvements in safety and quality across the healthcare sector. In August 2017, the Commission published the *National consensus statement: Essential elements for recognising and responding to deterioration in a person's mental state*[36]. This statement will help health services in the implementation of the National Safety and Quality Health Service (NSQHS) Standards, including in mental health. A range of National Standards have also been specifically developed to support improved quality in mental health services, called National Standards for Mental Health Services (NSMHS).

Driving quality and continuous system improvement is also captured in two priorities of the Fifth National Mental Health and Suicide Prevention Plan by:

- *making safety and quality central to mental health service delivery; and*
- *ensuring that the enablers of effective system performance and system improvement are in place.*

These national efforts provide clear guidelines on expectations around quality and safety in service delivery and will be used by all partners in the national mental health system to drive continuous improvement across all parts of Australia.

The Fifth National Mental Health and Suicide Prevention Plan responded to the 2014 National Mental Health Commission review finding that the national mental health system was poorly planned, fragmented, badly integrated and lack of accountability.[37] In response, all levels of government, private and non-government sectors have committed to working together to deliver the best quality mental health care in Australia. With roles and responsibilities more clearly delineated, the respective activities of key players better coordinated, and new forums that make performance more transparent, the system is more accountable for improved quality in mental health service provision.

A third pillar of the Australian Government's contribution to improving the quality of mental health services in rural and remote Australia is delivered by PHNs through their local service coordination and commissioning. This involves PHNs regularly reporting against national and local indicators, which again increases transparency and drives greater accountability against quality standards. Fundamental to this is the requirement of PHNs to work with LHNs through a stepped care approach (see Section 3.5).

This approach is particularly important for ensuring quality in rural and remote areas because regional PHNs have direct responsibility for ensuring that the stepped care approach efficiently and effectively matches services to local mental health needs (including people in hard to reach areas and at-risk populations). PHNs are also responsible for genuine engagement with local consumers, carers, families and support people to plan, design and deliver high quality services.[38]

The Australian Government also supports improved quality in service delivery through the collection, dissemination and access of research and information across the mental health system to inform

[36] Australian Commission on Safety and Quality in Health Care. National consensus statement: Essential elements for recognising and responding to deterioration in a person's mental state, 2017

[37] National Mental Health Commission. Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services, 2014.

[38] National Mental Health Commission. The 2017 National Report on Mental Health and Suicide Prevention, 2017, p. 47

evidence-based best practices in mental health care and suicide prevention. Examples of these measures include centres of excellence in research (see Section 8.3) and a range of mental health professional networks (see Section 6.5). Of significant value for the quality of mental health service delivery in rural areas are new online training opportunities for mental health professionals, such as the Mental Health Professional Online Development (MHPOD) tool (see Section 6.5) and direct digital access to experienced mental health specialists through the new Better Access telehealth initiative (see Section 7.3).

3.3 Australian Government commitment to mental health care in rural and remote Australia

There has been significant change within the Australian mental health care sector since the first National Mental Health Strategy was endorsed by all governments in April 1992.

Mental health care is now delivered primarily in community settings, compared to the reliance on inpatient services that previously characterised the Australian system. There has also been an increased emphasis on the safety, quality and outcomes of care. Changes to the MBS at the end of 2006 substantially increased access to mental health care in primary care settings, while significant investment in mental health promotion initiatives have increased awareness and knowledge within the community. These achievements have led to Australia being regarded as a world leader in mental health system reform, but there is still much to do.

The Fourth National Mental Health and Suicide Prevention Plan, released in 2009, advocated a whole of government and collaborative approach to national service coordination and stronger accountability for mental health reform and service delivery. It also put a case for government to explore opportunities for upstream investment to reduce downstream demand on mental health care services.

Upstream investment refers to initiatives that seek to address the causes or risk factors for diseases rather treat the disease symptoms themselves. By contrast, a downstream agenda focuses on clinical interventions or other treatment services. While downstream interventions can be costly and include hospitalization, extended treatment with medication and advanced procedures, they can be even more costly with complex, chronic and comorbid conditions such as mental illness. While these costs of treatment are well known, the benefits of upstream initiatives that prevent or reduce chronic or comorbid conditions can be hard to quantify. Despite this, the Australian Government is committed across its range of portfolio activity to support education, housing, welfare and other programs that address the risk factors of mental illness upstream.

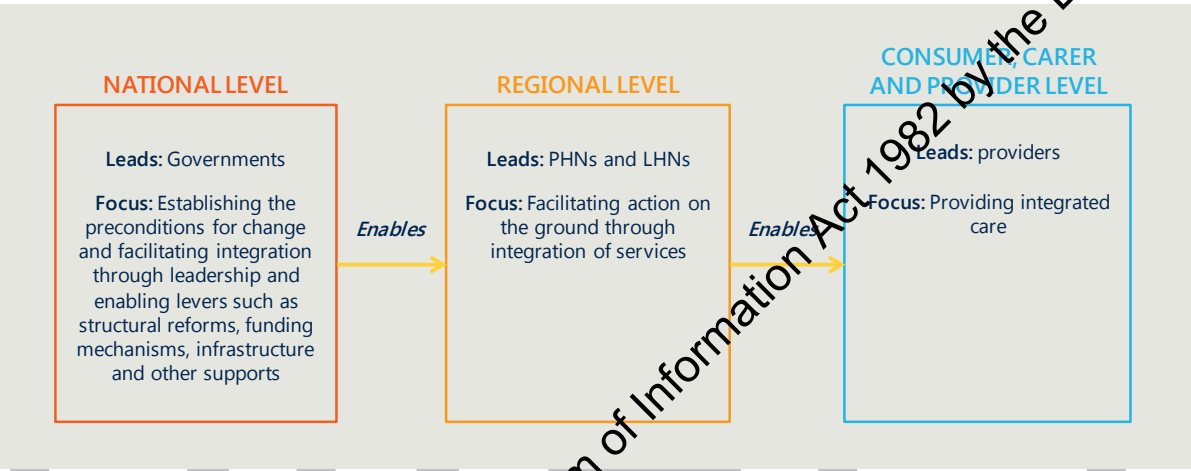
In 2014, the Australian Government tasked the National Mental Health Commission with conducting a national review of mental health programmes and services. The focus of this review was on assessing the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental illness and their families.[39] The findings of this review highlighted extensive challenges within Australia's mental health system and advocated a 'plan nationally, act locally' response that relied on the established network of Australian PHNs. The Australian Government response to this review endorsed the PHN approach and foreshadowed the development of new innovative models of care for rural and remote mental health services supported by flexible funding models. These directions were to provide the foundation of the Fifth National Mental Health and Suicide Prevention Plan, which was released in August 2017.

[39] National Mental Health Commission. Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services, 2014.

3.4 Fifth Plan - an integrated approach to regional service delivery

The release of the Fifth National Mental Health and Suicide Prevention Plan marked another significant point in the history of the National Mental Health Strategy. For the first time, one plan committed all governments to work together to achieve integration in planning and service delivery at a regional level. Importantly, it demanded that consumers and carers shape the way in which services are planned, delivered and evaluated. The plan recognised the tragic impact of suicide on the lives of many Australians and set a clear direction for coordinated action by all levels of government to more effectively address this important public issue (see Section 5.1).

Figure 4: National and regional roles in strengthening integration



This plan was also the first to specifically outline an agreed set of priority actions to address social and emotional wellbeing, mental illness and suicide amongst Aboriginal and Torres Strait Islander people (see Section 9.1), as well as being the first to elevate the importance of the physical health needs of people who live with mental illness.

This Plan was developed at a time of considerable change in social policy in Australia. Of paramount importance was the establishment of the National Disability Insurance Scheme (see Section 9.2), while state and territory governments were establishing Mental Health Commissions. In this way, the Plan reinforced the coming together around a whole of government approach that was already occurring and laid the groundwork for governments to partner in a new national approach to provide better mental health and related services in Australia.

The Commonwealth is committed to working with the states and territories to deliver services in this seamless system approach, through which a nation-wide policy program is designed to maximise flexibility in service delivery and consistency in service quality around consumer needs at the local level.

3.5 Implications of the Fifth Plan for rural and remote Australia

A fundamental implication of the Fifth National Mental Health and Suicide Prevention Plan was the emphasis on the partnership of PHNs with Local Hospital Networks (LHNs) to ensure that the national approach to mental health services delivery was effective at the local level.

As part of this, PHNs form the centrepiece of the Commonwealth's contribution to improving accessibility and quality of mental health and suicide prevention services in rural and remote Australia. PHNs are the key point for integrated regional planning, coordinated funding and commissioning to complement local service gaps in mental health care and suicide prevention. To achieve this, a range of previous funding

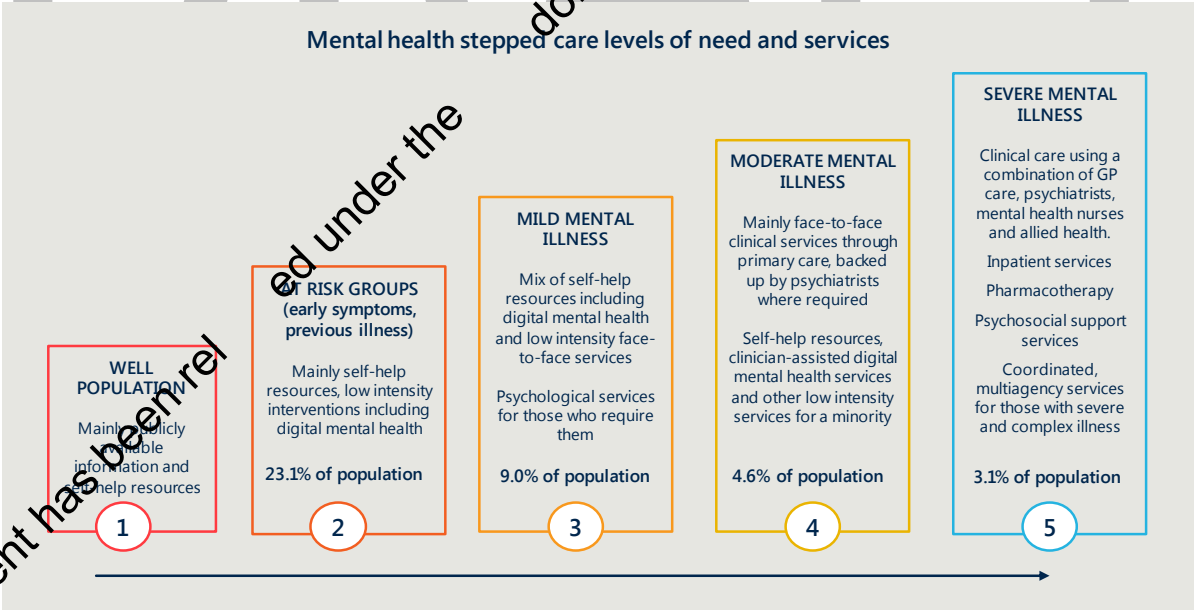
programs have been consolidated into flexible funding arrangements that can be used to target the specific health care needs of those in rural or remote communities. Core operational funding is also provided for the administrative, governance and core functions of PHNs. This funding is to be used to support the operations and maintenance of PHNs and to conduct needs assessments and associated population health planning.

Flexible funding is provided to enable PHNs to respond to identified national priorities as determined by Government, and to respond to PHN-specific priorities by commissioning required services. This funding is used to achieve health outcomes that are measured by national and local performance indicators. National indicators reflect government priorities and were selected because of their alignment with PHN objectives. Currently, mental health treatment rates (including for children and adolescents) are amongst the key national indicators for PHNs.

Local indicators are also produced by each PHN. These are derived from analysis of the health needs of local populations to enable better targeting of available resources and services. These indicators are orientated around a stepped care system approach. While this approach predated the new role for PHNs, its inclusion at the core of PHN regional planning, funding and commissioning was an important new contribution in improving quality service delivery. The Department of Health has developed guidance to help PHNs carry out this role including providing advice of best practice examples in stepped care.

Stepped care is "defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one directional steps, but rather offer a spectrum of service interventions"[40]. Through the stepped care approach, PHNs can target funding to areas of need, drive quality improvements and achieve better outcomes for the community and the healthcare system. A uniquely Australian version of the stepped care model has been developed by drawing international best practice and elaborating around sector and workforce requirements (see Figure 5).

Figure 5: Australian model of mental health stepped care [41]



This stepped care approach matches services to intensity of need and assists PHNs to identify gaps in local

[40] Department of Health. PHN Primary Mental Health Care Flexible Funding Pool Guidance No. 1: Stepped Care, 2018, p.1

[41] COAG. The Fifth National Mental Health and Suicide Prevention Plan, 2017, p.19-20

service provision. In turn, this allows PHNs to plan and support delivery of mental health and suicide prevention services that align with the specific needs of their consumers and their carers.

As part of their planning processes, PHNs are expected to select, periodically review and revise their indicators to allow measurement of PHN priorities and drive quality improvement activity in their region (see Part 8). This local focus to measuring performance, allocating funding and planning services gives rural and remote PHNs the capacity and flexibility to target the specific mental health needs of their communities. This contribution is enhanced because PHNs are also required to explore innovative funding and service delivery models to join with community and private providers to meet local needs.

Further, approximately $85m of mental health funding is specifically quarantined to improve access to, culturally appropriate, mental health services for Aboriginal and Torres Strait Islander people[42]. This funding builds on mainstream mental health funding provided to PHNs and aims to increase access to culturally appropriate and safe mental health services. Over 40 per cent of Aboriginal and Torres Strait Islander people live in outer regional or remote areas. Regional PHNs are to collaborate with their communities and local service providers to improve mental health and suicide prevention. This quarantined funding ensures that the specific challenges around suicide amongst Aboriginal and Torres Strait Islander people in rural and remote remains a focus of PHNs.

In addition to the above funding, PHNs are also required to harness opportunities for digital technologies to improve access to mental health care and suicide prevention services in rural and remote communities. The rationale behind this approach is to overcome the tyranny of distance to increase access to services by people outside cities, to counter the imbalance in availability of mental health professionals outside metropolitan areas, and to reduce the potential negative impact of stigma in small regional communities. This will also ensure greater equity in the receipt of quality, evidence-informed, best practice mental health services across Australia.

In these ways, the Australian Government's strategy to implement its responsibilities under the Fifth National Mental Health and Suicide Prevention Plan (through an emphasis on PHNs) provides the foundations and framework to partner in new initiatives to improve access and quality of rural and remote mental health services.

[42] Department of Health. PHN Primary Mental Health Care Flexible Funding Pool Guidance No. 6: Aboriginal and Torres Strait Islander Mental Health Services, 2018, p.1

4 Current initiatives to improve access and quality of mental health services

The Australian Government is driving integrated regional planning through PHNs which will link high-level planning to local specific need. There are already examples of the Commonwealth's funding contribution through PHNs making a positive difference for access and quality of rural and remote mental health services. This section examines in more detail how the Australian Government is contributions through PHNs to exciting mental health innovations and suicide prevention initiatives in rural and remote Australia.

4.1 The role of PHNs in mental health services

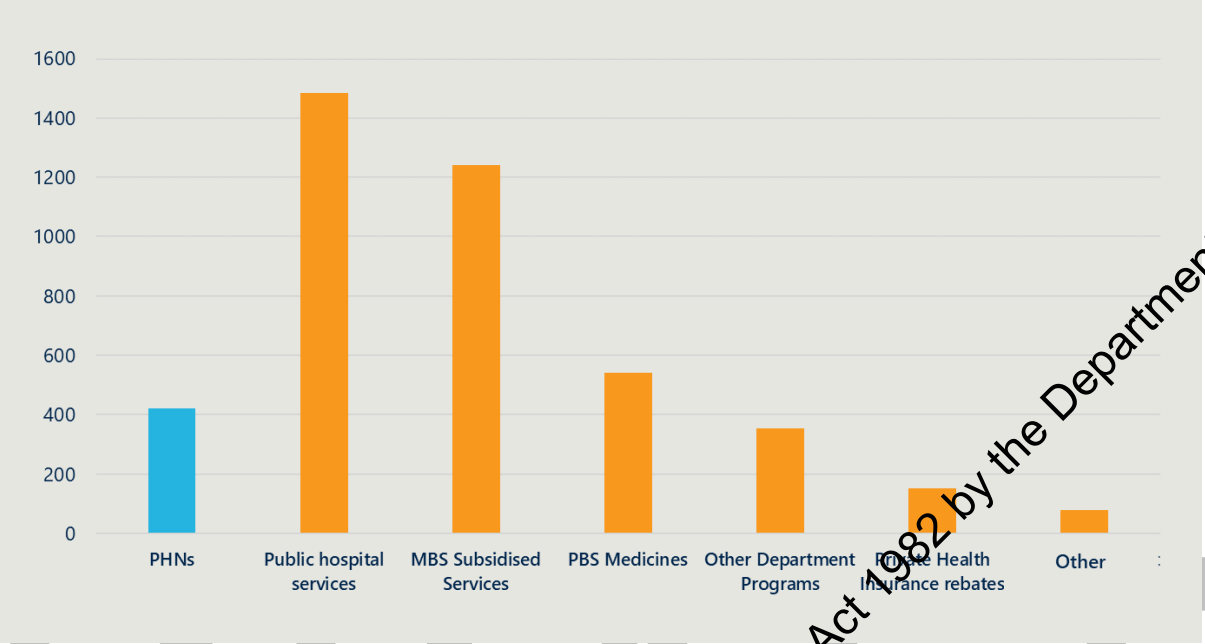
The Australian network of 31 PHNs form the centrepiece of the Australian Government's contribution to delivering mental health and suicide prevention services (see Appendix B). PHNs have been provided with a new flexible mental health care and suicide prevention funding pool to plan, integrate and commission mental health services at a local level, in partnership with relevant services. This regional approach distinguishes what services are available to identify and address service gaps where needed, including in rural and remote communities. Accordingly, it is the role of the PHN, to engage with medical practitioners and mental health professionals to ensure the provision of quality services to individuals. This role is vital for mental health and suicide prevention services in rural and remote communities, where most people do not have access to local mental health professionals, and local GPs are the first (sometimes only) accessible avenue of referral to appropriate services.

The Australian Government provides core and flexible funding to support PHNs with their leadership responsibilities. A flexible funding pool has been established within core funding to enable PHNs to respond to identified national priorities and meet key health outcome indicators. In 2018-19, around 59 per cent of this funding will be fully flexible. This flexible funding component includes provision for a range of low intensity to severe youth services and severe/complex adult mental health need. It also provides for suicide prevention and delivery of psychological services for harder to reach groups (such as those in rural and remote areas). This flexible funding incorporates the previous Access to Allied Psychological Services (ATAPS), Mental Health Services in Rural and Remote Areas (MHSRRA) and Mental Health Nurse Incentive Program (MHNIP). It is expected that PHNs will invest this flexible funding into programs that will continue the principles and success of these previous initiatives.

Additional funding to support integration of Indigenous mental health and other services will be further quarantined and can only be spent on specific programs. In 2018-19, this quarantined funding will make up the remaining 41 per cent of PHN flexible funds to PHNs with 32 per cent tied to youth psychosis and headspace initiatives. It also provides specific support for Aboriginal and Torres Strait Islander mental health (9 per cent). These provisions improve the accessibility and quality of mental health services in rural and remote Australia because PHNs, whose coverage include these areas, are required to use them to target services to the needs of these communities.

As can be seen in Figure 6 below, the Commonwealth's contribution to mental health and suicide prevention services is the fourth largest within the Health portfolio. In 2017-18, this contribution is anticipated to be approximately $423million.

Figure 6: PHN funding in the context of mental health spending in Health portfolio 2017-18 ($million)[43]



The total PHN funding to mental health and suicide prevention is not distributed evenly across Australia. In recognition of the specific challenges of mental health service delivery in rural and remote communities, the Commonwealth has developed and applied a model to allocate mental health flexible funding with significant weighting for rurality, Indigenous status and socio-economic status. These three factors are known to be associated with higher levels of need and lower rates of access in rural and remote regions. As a result, PHNs with populations resident outside major city/metropolitan areas receive over double the per capita funding of metropolitan PHN regions (see Table 5 below).

[43] Department of Health public resource document.

Table 5: Mental health flexible funding to PHNs – predominantly non-metropolitan regions vs metropolitan regions (2018-2019 estimate) [44]

Programs	Number of regions	Percent of Australian population	Percent of PHN funding 2018-19	Per capita funding 2018-19
Non-metro PHN regions: with predominantly (>50%) non-major city populations	15	33%	50%	$24.70
Metro PHN regions: predominantly (>50%) major cities populations	16	67%	50%	$11[illegible]
Total	**31**	**100%**	**100%**	**$16.14**

However, if a more stringent definition of non-metropolitan is applied, and only those PHNs with significant populations resident in outer regional and remote (RA3-RA5) areas are compared, the per capita funding differential is even greater. These PHNs receive 2.4 times the per capita funding compared to other PHN regions (see Table 6).

Table 6: Mental health flexible funding to PHNs – regions with significant RA2 -RA3 populations vs others[45]

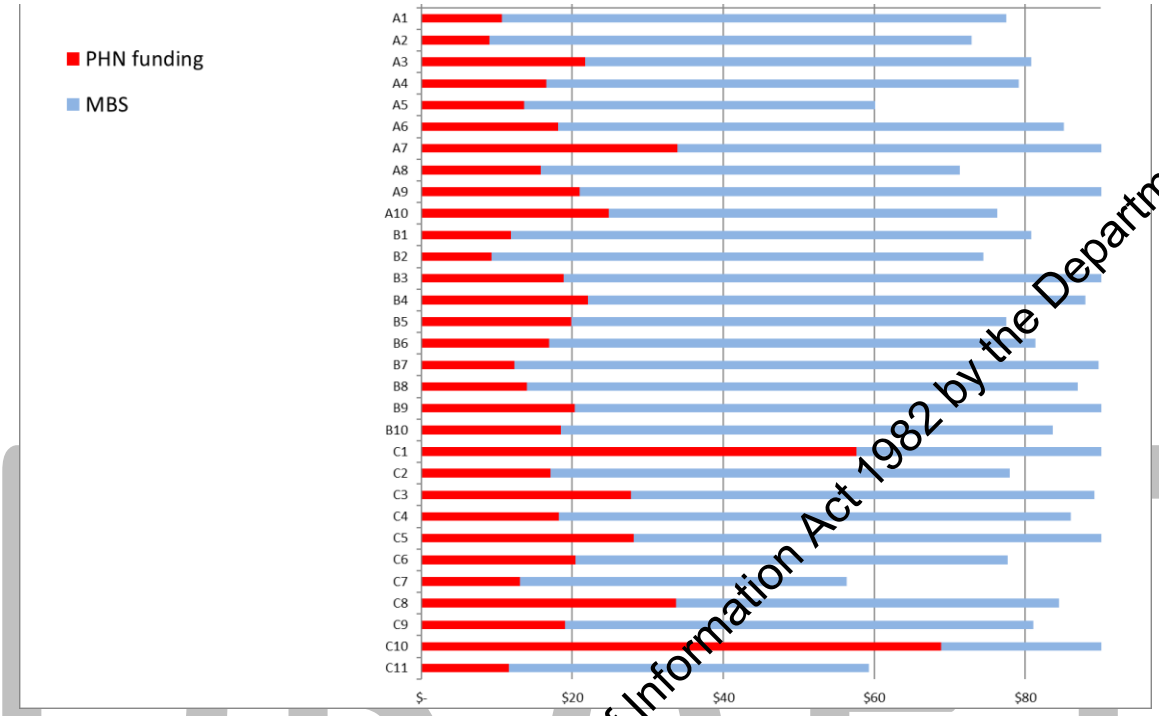
Programs	Number of regions	Percent of Australian population	Percent of PHN funding 2018-19	Per capita funding 2018-19
PHN regions with significant populations (>20%) living in areas classified as Outer Regional, Remote, Very Remote	9	16%	31%	$31.77
Other PHN regions	22	84%	69%	$13.19
Total	**31**	**100%**	**100%**	**$16.14**

Data from the Australian Institute of Welfare on Medicare-subsidised mental health-specific service use illustrates the significantly lower rates in outer regional and remote areas.

[44] Department of Health public resource document.
[45] Department of Health public resource document.

The Department has conducted analysis of AIHW data on MBS mental health funding by PHN region and correlated it funding allocation for each PHN (see Figure 7).

Figure 7: Funding allocation to PHNs per capita vs MBS funding (2018-19 estimate) [46]



This analysis illustrates that the weighting for flexible funding results in greater evenness in overall mental health service funding across regions. This insight is particularly relevant to rural and remote Australia given the lower rates of MBS mental health use outside metropolitan Australia (see Part 2).

Hence, a result of the Commonwealth's approach to mental health flexible funding for PHNs is that there is greater potential consistency and equity in availability of services across metropolitan, rural and remote communities. Through its targeted approach to mental health funding, the Australian Government has laid the foundation for PHN partnership with other levels of government, private providers and community services to coordinate and deliver innovative mental health and suicide prevention services.

4.2 PHN community innovations

The Commonwealth's support of the 31 PHNs across Australia to plan, coordinate and commission the delivery of mental health and suicide prevention services is resulting in exciting innovations in rural and remote communities. The following case studies illustrate the good work of PHNs around improved accessibility of mental health services and suicide prevention.

Case Study: Partnering with local business to support older men with depression and anxiety

For many inner regional, rural and remote areas, mental illness amongst men is a common problem. One suicide prevention trial in the Esperance-Goldfields region of Western Australia has devised an innovative way to connect men with mental health services. By training hardware and agricultural store staff to spot the signs of depression and anxiety, this community is reducing the stigma and lifting the profile of local

[46] Department of Health public resource document.

mental health services.

This region has a large proportion of famers and fly-in-fly-out workers. The isolation of working on the land and rarely getting respite is a key risk factor, as is constant FIFO travel and long periods away from family support. Unfortunately, many men do not seek help for their concerns due to pride in their independence and the stigma associated with seeking mental health services.

The WA PHN is working on ways to tackle these issues through targeting resources to 'where blokes go'. This includes training staff from local businesses and agriculture firms or putting up posters in pubs and clubs, to identify and provide information to men who may be suffering from depression and anxiety. Although this trial is still in its early stages, there has been strong local support and high levels of engagement in the community co-design process.

As one trial leader remarked, this intervention can be as simple as the local cashier noting a regular looking flat and asking, 'how are things?' But it could also be the first step in saving a life.

Case Study: RFDS and headspace partnering to provide support to youth in very remote areas

The Royal Flying Doctor Service is a national icon, having served rural and remote communities for 90 years. The national headspace network of services provides holistic care for young people aged 12 to 25 years. Through the coordination of Country SA PHN, these two services have come together to provide face-to-face support to children in remote areas for the first time.

Accessing mental health services is challenging in remote areas of Australia. Transport costs, travel times and fears around stigma are real challenges for everyone in these communities. They can be even more so for young people who must rely on adults to support their accessing help. Country SA PHN is working with the RFDS and headspace to target these specific barriers for young people.

The Royal Flying Doctor Service is one of the largest and most comprehensive aeromedical organisations in the world, providing extensive primary health care and 24-hour emergency service to people over an area of 7.69 million square kilometres. Its service include far northern South Australia. The Country SA PHN is currently funding a trial which sees youth mental health clinicians joining RFDS flights to remote areas to provide face-to-face support. These sessions are supported by follow-up telehealth consultation if required. This innovative model is providing remote mental health services that young people and their families would once have never imagined.

Case Study: Collaborating regionally to address mental health workforce pressures

Regional communities struggle to access the mental health services they require. This is due to a shortage in clinical and non-clinical mental health support that prevents people seeking help or puts pressure on local GPs. One model in the Dubbo region of New South Wales has an innovative approach to attracting and retaining mental health professionals.

One of the key priorities of the local PHN is to find ways to ensure people in their region have access to high quality care that matches their need. The PHN is working closely with two local health districts and the rural doctors' networks on ways to make mental health professionals more accessible.

In March this year, the PHN provided funding to the Royal Flying Doctor Service to bring in mental health nurse support to work with local general practitioners. The nurses are already helping alleviate the pressure on general practitioners to treat patients with severe and complex mental health problems. To date, the community feedback has been very positive, with GPs praising the impact of this new program.

The flexible funding available to PHNs is also resulting in innovations that improve the quality of mental health services in rural and remote communities. The following case studies illustrate this potential.

Case study: Reducing suicide rates amongst young men in regional WA

A community south of metropolitan Perth has had long term problems with depression and suicide amongst their young men. Since the commencement of a local suicide prevention trial with the Western Australia PHN eight months ago, there have been no suicide deaths within the target 15 to 26 age group.

The inland location of this community makes it hard for its young men, many from the Maori community, to find work and stay or seek respite in the city or at the coast. Its location also means that this community has struggled to access the mental health services it needed to help, if not, prevent suicides occurring into the future.

In line with the national approach to regional PHN service coordination and the principles of the national trials, community leaders have engaged deeply in the trial design process. This has given the community a real sense of ownership. Across the whole community there is a consistency of language and a concerted effort to raise the profile of mental health, to increase awareness and reduce stigma.

One member of the community spoke publicly about the trial, describing it as empowering them to take better care of their community at a time when they did not know what to do.

While there is never a guarantee that youth suicides won't still occur, there is a definite sense in this community that the trajectory is beginning to change for the better.

Case Study: Developing and performing drama that deals with mental illness

In Australia's far north, one group is tapping the deep creative resources of its community to be more resilient in social situations and to better understand their mental health. Supported by the Northern Territory PHN, a group of locals of all ages recently performed 'In My Skin' at the Darwin Fringe Festival.

Australians from all walks of life draw confidence, respite and delight in the performing arts. Dramatic performance can help people work through life scenarios, adopt different perspectives on issues or have an outlet for intense emotion. Joining a drama group can create new relationships, build social confidence and provide new avenues of growth. When the focus of this dramatic activity is people's personal mental health journeys it can provide personal legitimation, combat stigma and reduce the sense of being along with one's struggles.

Supported by the NT PHN, a drama group was formed to perform 'In My Skin', which marked the culmination of months of sharing and reflecting on their experiences of living with a mental illness.

One of the group, an older Aboriginal man, publicly shared the impact this performance had on his life. He observed it was rare that he felt safe and not judged. He said it was the first time he felt like he was moving closer to recovery and greater functionality.

Case Study: Using rural footy association boundaries to coordinate flexible care

The plight of a rural town is often tied up with the plight of its footy team. The whole town celebrates when it travels home together after a big away win. Its economic and social plight becomes evident when a lack of young people means the team must merge with its once local rivals.

The circle of community connections in regional and rural Australia are often shaped by the extent of the local football association. Country South Australia PHN has recognised this and coordinates its mental health services within the footprint of regularly competing local towns. This approach has helped galvanise the idea that what works in one area or town may not work in the next one. Such an approach aligns well with the regional focus and local action approach of PHNs.

This model also uses funding flexibly across the regions within the PHN according to changing need. For instance, a substantial outreach service was run in one regional town until a headspace was established. When community concerns were raised about a nuclear waste dump being located in another region,

resources were commissioned, and levels of anxiety addressed. In another small rural town, every adult had been placed on a mental health care plan. Now, two years after targeting resources to this 'footy region', the service has ceased because there is no longer demand.

4.3 PHN-managed support for younger Australians

The headspace network of services provides holistic care for young people aged 12 to 25 years in four key areas – mental health, related physical health, alcohol/drug use, and social and vocational support. Currently, there are 110 Headspace locations across Australia. Of these, 57 are in rural or remote areas.

PHNs and headspace models are responsible for leading community consultation and decision making in the establishment and operations of services. Each headspace service must establish a consortium of local organisations and a Youth Reference Group of local young people to guide and advise the operations of the service. This means that lead agencies in rural and remote areas are expected to demonstrate that they can provide services responsive to the needs of local young people.

The headspace service has had success in reaching people who live outside cities. The proportion of rural young people accessing headspace is greater than that in the general population, while the proportion of those accessing the service in remote areas is similar to the general population (although numbers are small). Service provision through headspace is dependent on attending a dedicated centre. This can present a barrier to rural and remote young people accessing the service. In recognition of this, the Australian Government has committed $28.9 million to establish an additional ten headspace services by 2019 with a specific focus on increasing access in rural and regional areas.[47] It also continues its support for eheadspace which complements the centre-based program.

The following case studies illustrate the potential contribution to accessibility and quality of headspace services in rural and remote Australia.

Case Study: Delivering headspace to youth in North Coast NSW

Early intervention continues to be one of the leading ways to reduce the impact of mental illness. Acting when signs first appear with our youth is an important early intervention strategy. Communities who regularly experience the tragedy of youth suicide, feel the need to act even more urgently.

Currently, the Grafton and Clarence Valley communities in regional New South Wales are embracing the services that headspace provides. In response to rate of suicide amongst youths this region, the North Coast PHN worked closely with GenHealth and the Clarence Valley Council to establish a headspace in Grafton in 2017. In line with PHN and headspace principles, the service was co-designed around the specific health needs of the local youth community.

An important contribution of this suicide prevention model was mental health first aid and early intervention training for local health professionals. It has also set up a support program for families and communities in the wake of a suicide completion. This model is a clear example of using headspace as a catalyst to whole of community responses to protect their youth at risk.

Case Study: Communities seeking out headspace services and support

The location of a headspace service at Whyalla in South Australia was the result of strong community

[47] Department of Health 2016-17 Health Portfolio Additional Estimates Statements, p.8

action. As a community with a history and high risk of youth suicide, the local community identified that the 80-kilometre trip to Port Augusta to access headspace services was too much of a barrier. Working together, the Country SA PHN and community leaders successful secured funding to open Whyalla headspace in April 2017.

This service ensures that local youth have access to a range of services including counselling and mental health professionals. Another service that is offered helps young people to hold and find work, which is a key factor in mental health and a significant challenge for a community where unemployment is 12.4 per cent (almost double that of the rest of Australia).[48] A Youth Reference Group has been established to provide advice to the PHN and headspace centre on what young people need, and to also play a key role in determining which specialised programs will be rolled out.

This is an example of communities putting their people at the centre of service design and will help ensure that programs are relevant and sustainable.

4.4 eheadspace

Young people who are unable to access a headspace service can seek support through the eheadspace service, which provides the headspace model of services for free, either online or over the phone. The eheadspace service is delivered across Australia via synchronous webchat, telephone and email. The service operates as both an alternative to centre-based treatment, and as a form of support that complements the centre-based program (see Section 9.3). Designed specifically for young people and families who have limited access to support across regional and remote areas, the eheadspace service plays a role in linking young people in regional areas and boosting the capacity of headspace to have an impact in rural and remote areas.

4.5 PHN-managed support for senior Australians (budget in confidence)

The Australian Government is establishing new mental health services for older Australians with a diagnosed mental disorder living in residential aged care facilities (which will be available from early 2018). The funding for this initiative will be formulated according to eligible population, regionality and disadvantage and will be managed by PHNs. This measure will ensure that mental health services for senior Australians will be more equally distributed and ensure better access for those living in rural and remote areas.

The above examples of PHN innovations and other initiatives illustrate that good progress has been made with the Australian Government's commitment to improving access and quality of mental health services. However, there remain significant and stubborn challenges. Amongst the most persistent of these is the significant impact of suicide in regional communities.

[48] Australian Bureau of Statistics. 2016 Census Quick Stats- Whyalla, Table: People - Employment, accessed 1 May 2018

5 Reducing suicide in rural and remote Australia

Despite considerable government investment over many years, suicide continues to be a significant health issue in Australia, particularly in rural and remote communities. The Australian Government's National Suicide Prevention Strategy details an integrated regional approach to suicide prevention led by PHNs in partnership with LHNs. This section explores the prevalence of suicide in rural and remote communities and details several programs relating to suicide prevention.

5.1 Prevalence of suicide in rural and remote Australia

The impact of suicide on all Australians is significant. According to research from Suicide Prevention Australia and the University of New England, each suicide death can impact hundreds of people. Their findings also indicated that 85 per cent of their respondents knew someone who had died by suicide.[49]

Suicide and mental illness are closely interlinked, with mental illness being the major risk factor for suicide. The rate of suicide in regional and remote areas tend to be higher than in major cities, particularly among marginalised groups, including Aboriginal and Torres Strait Islander people and disadvantaged males.[50]

In 2016, there were 2,866 suicide deaths in Australia which equates to a suicide death rate of 11.7 deaths per 100,000 population.[51] The rate of death by suicide was one and a half times higher for people living outside capital cities (15.3 deaths per 100,000 population) compared to those living within capital cities (10.0 deaths per 100,00 population)[52]. In 2016, 47 per cent of all suicides occurred outside capital cities, even though these areas account for only 32 per cent of the total population.

Although slightly fewer people died by suicide in 2016 compared to 2015, the trend between 2012 and 2016 was for an overall increase in the rate of suicide outside of capital cities (Figure 8).

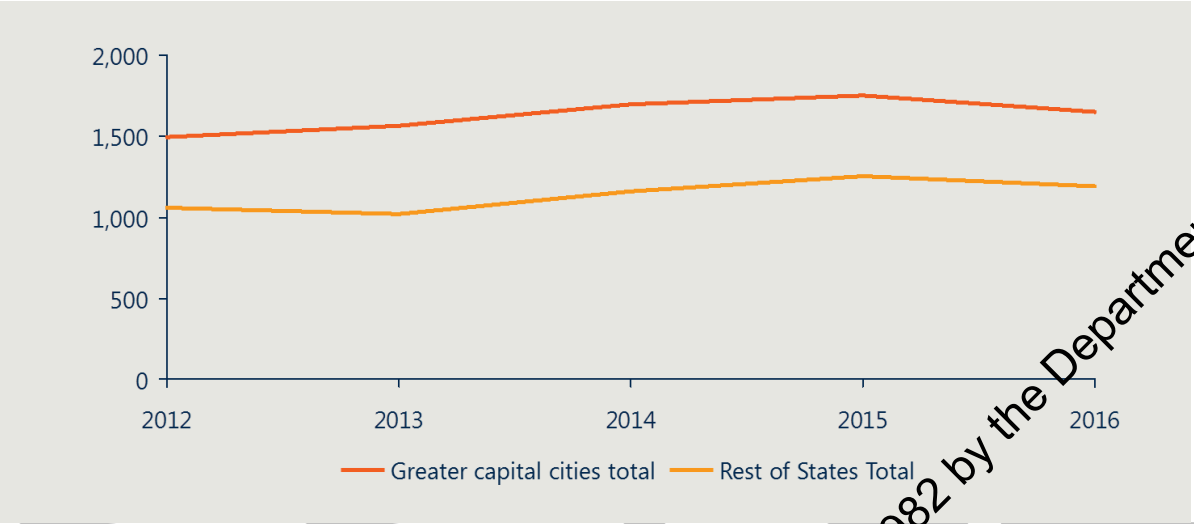
[49] Maple, M., Kwan, M., Borrowdale, K., Riley, J., Murray, S. & Sanford, R. (2016). *The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia.* Sydney: Suicide Prevention Australia.

[50] National Rural Health Alliance, Fact Sheet – December 2017, Mental Health in Rural and Remote Australia

[51] Australian Bureau of Statistics. Causes of Death, Australia, 2016, Suicide in Australia, September 2017

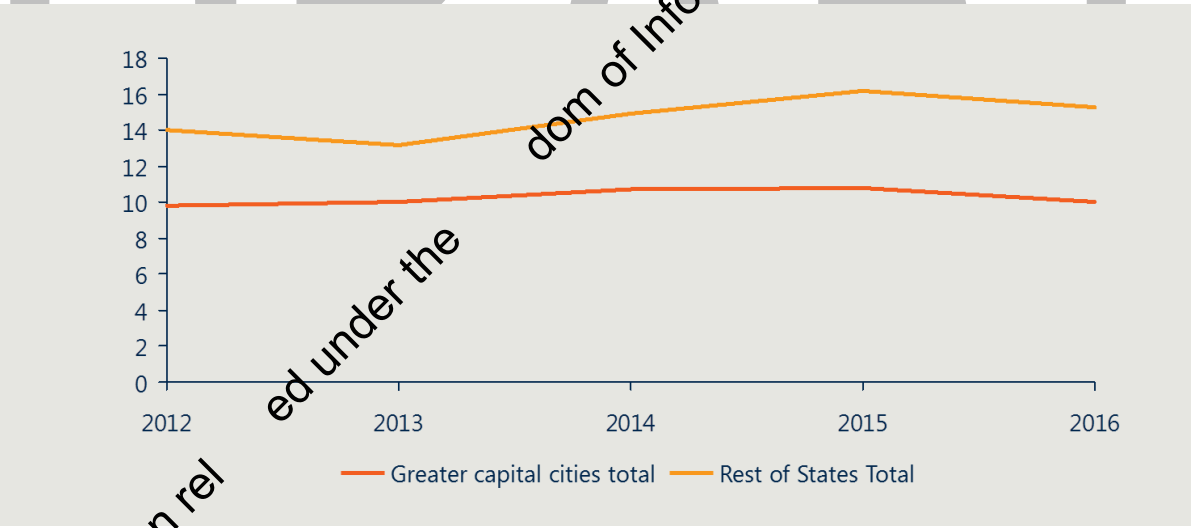
[52] Australian Bureau of Statistics. Causes of Death, Australia, 2016, Table 11.16 Intentional self-harm, Region of usual residence, Age-standardised death rates, 2012-2016, accessed 1 May 2018

Figure 8: Number of suicide deaths within and outside Australian capital cities, Intentional self-harm, Region of usual residence, Number of deaths, 2012 – 2016.[53]



The gap between the rate of suicide between people who live in and outside capital cities also grew over this period (Figure 9).

Figure 9: Age-standardised suicide deaths within and outside Australian capital cities, Intentional self-harm, Region of usual residence, Age-standardised death rates, 2012-2016[54]

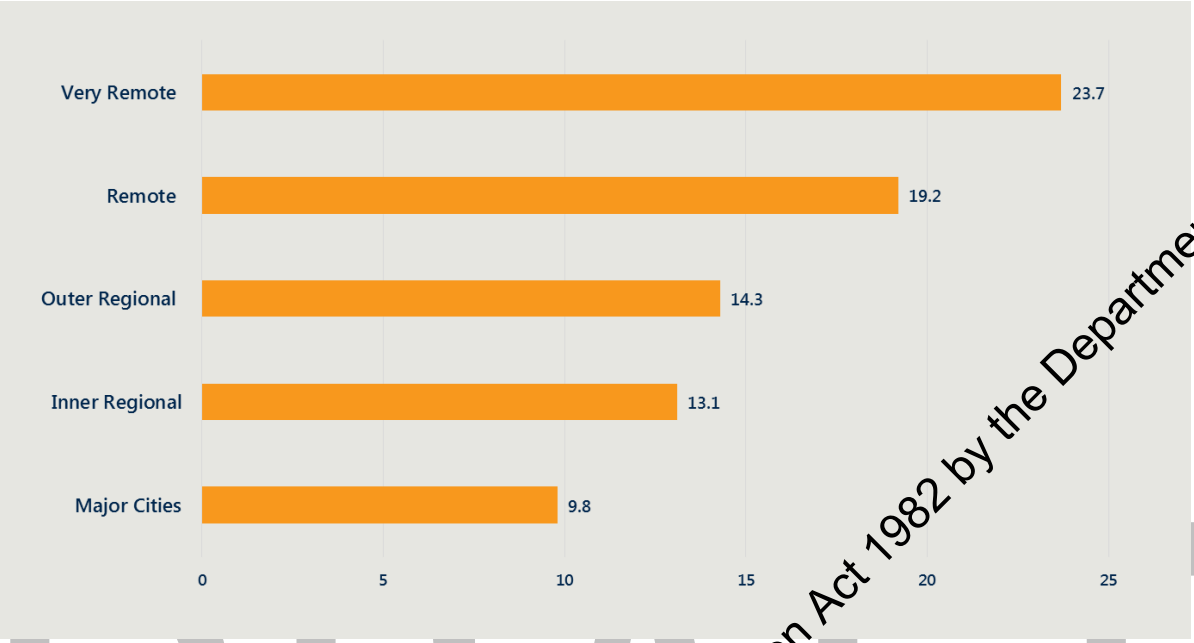


Suicide becomes more likely as remoteness increases (Figure 10). Between 2010 and 2017, the suicide rate in remote locations was double that of major cities, while the rate in very remote regions was almost 2.5 times that of major cities.

[53] Australian Bureau of Statistics. Causes of Death, Australia, 2016, Table 11.15 Intentional self-harm, Region of usual residence, Number of deaths, 2012-2016, accessed 1 May 2018

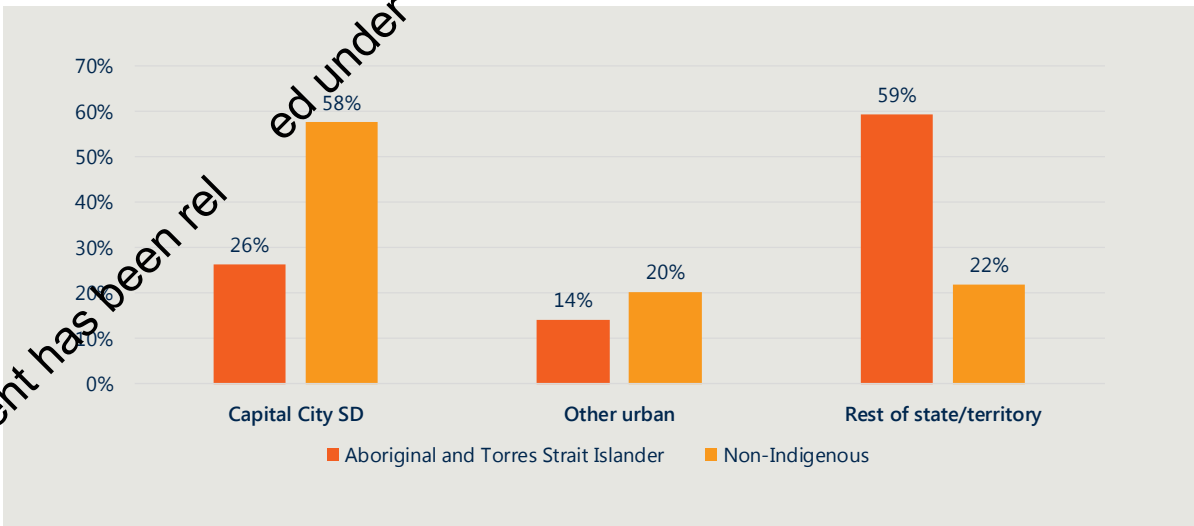
[54] Australian Bureau of Statistics. Causes of Death, Australia, 2016, Table 11.16 Intentional self-harm, Region of usual residence, Age-standardised death rates, 2012-2016, accessed 1 May 2018

Figure 10: Avoidable deaths from suicide and self-inflicted injuries, persons aged 0 – 74 years, 2010 – 2014 (%)[55]



Another factor contributing to poorer health outcomes for rural and remote Australia is the rate of suicide amongst Aboriginal and Torres Strait Islander people. The overall high rate of suicide in remote and very remote locations is driven in part by very high suicide rates within these locations. Section 9.1 discusses the drivers of poor mental health outcomes among Indigenous Australians. In 2010, there were 946 suicides by people who identify as Aboriginal or Torres Strait Islander, of which 59 per cent occurred outside of cities or other urban areas. Among the non-Indigenous population, only 22 per cent of suicides occurred in these locations (Figure 11).

Figure 11: Number of suicide deaths as a percentage of total suicides by geographic region and Indigenous status (NSW, QLD, SA, WA, NT, 2001 – 2010).[56]



[55] PHIDU Social Atlas. Avoidable deaths from suicide and self-inflicted injuries 2010-2014, 2017, accessed 30 April 2018

[56] Australian Bureau of Statistics. Suicides, Australia 2010: Geography, accessed 2 May 2018

The situation of Aboriginal and Torres Strait Islander people is also exacerbated by additional historical and cultural factors, which can contribute to higher levels of suicide attempts (see Section 9.1).

The higher rates of suicide in non-metropolitan areas may contribute to a greater relative impact on smaller rural and remote communities. What lies beneath this higher prevalence and these specific costs are the unique challenges for reducing suicide in rural and remote communities.

5.2 Unique challenges for preventing suicide in rural and remote communities

The factors that contribute to high suicide rates in rural and remote communities are in most respects like those that lead to poor mental health outcomes more generally. These include personal isolation, stigma, lifestyle pressures and lack of awareness of available support. However, there are other specific factors that contribute to high suicide rates in rural and remote areas.

Availability of means to commit suicide, including firearms and pesticides, contributes to higher suicide rates in rural and remote communities. Compared to residents of major cities, rates for hospitalisation and death by firearm are four times higher for residents of remote areas and six times higher for residents of very remote areas (note that this includes both intentional self-harm and other firearm injuries)[57].

For young people, having friends move to urban areas for work, community attitudes to sexual orientation and higher levels of drug use can all be important factors. Another factor that can contribute to higher rates of suicide, particularly amongst older farmers, is the limited opportunity for time away from work and the stress caused by unpredictable seasons or natural events.

Compounding these factors further are challenges to accessing mental health support that are unique to rural and remote communities. These challenges are vital because failure to access appropriate mental health support is a key suicide risk factor.

The communal nature of many rural and remote areas should potentially protect individuals at risk of self-harm or suicide. However, the tendency for 'everyone to know everyone's business' in smaller rural communities, which can be a barrier to seeking mental health support. Contributing to this are attitudinal barriers, such as a stoic, traditionally masculinity, strong work ethic and an ideal of rugged individualism, both of which can discourage individuals from seeking help. The potential isolation, dislocation and frequent travel of fly-in-fly-out workers in rural and remote Australia can also be a barrier to accessing services. Meanwhile, the stigma associated with seeking mental health support is felt uniquely in small country towns, with the location of services and long unexplained absences to travel to services both being significant influences on people not accessing services.

When mental health services are available in rural and remote locations, there are additional issues around workforce. These include access to medical practitioner expertise to identify individuals at risk, mental health professionals providing services above their level of training and potential delays in accessing clinical specialists (see Section 6.2). There can be a reluctance on the part of those living in rural and remote areas to discuss their private lives with acquaintances from local services, or to access distant services where cultural differences could be misunderstood. This challenge is particularly relevant for communities with resident refugee or Aboriginal and Torres Strait Islander populations. For this reason, local mental health services and programmes should be designed in consultation with the communities they aim to serve and be based on formal analyses of need. It is this realisation that underpins the

[57] Australian Institute of Health and Welfare. Firearm injuries and deaths fact sheet, 2017, accessed 1 May 2018

Australian Government's position that PHNs are ideally placed to develop person centred local suicide prevention responses.

5.3 A renewed approach to suicide prevention

The Australian Government has outlined a renewed approach to suicide prevention through a systems-based regional approach led by PHNs. It has tasked PHNs with planning and commissioning of regionally appropriate suicide prevention services in partnership with LHNs, states and territories, and other local organisations. As part of this role, PHNs must ensure appropriate follow-up and support arrangements are in place at the regional level for people who have attempted suicide, or who are at high risk of suicide. PHNs are also required to identify the suicide prevention needs of Aboriginal and Torres Strait Islander communities within their region and support the implementation of culturally appropriate suicide prevention activity. The regional approach led by PHNs allows for community needs and strengths to be recognised in planning and delivery of services.

5.4 National Suicide Prevention Trial

In June 2016, the Australian Government announced additional measures to Strengthen Mental Health Care in Australia. As part of this commitment, the Government is providing $36 million over three years (to 2018-19) for the National Suicide Prevention Trial to fund twelve suicide prevention trial sites in identified priority areas. Trial sites have been established across Australia including in rural and remote locations such as the Kimberly, Western New South Wales and country South Australia.

The Trial will improve understanding of what strategies are most effective in preventing suicide at a local level and for at-risk populations (including veterans, young people, men, and Aboriginal and Torres Strait Islander people). Trial sites are being led by PHNs in consultation with local communities, service providers, and other local organisations. This will allow the trial sites to design and deliver services that are tailored to the needs of different metropolitan, rural and remote communities. A key focus for PHNs is to coordinate existing services, while ensuring professionals and the community are clear about referral pathways and treatment options. PHNs will also contribute to regional capacity building to better identify and support people who are at risk of suicide.

The Trial will be independently evaluated over the funding period. The University of Melbourne has been appointed to lead this evaluation which will draw on information collected from mental health, suicide prevention, other relevant service providers, and from consumers of services. The evaluation is being guided by a steering committee comprising representatives of the Department of Health and PHNs, experts and people with lived experience of suicide. Findings from the trial will be made available to all PHNs to guide future suicide prevention activities.

5.5 National Suicide Prevention Leadership and Support Program

In addition to support for PHN activities, the Australian Government has also strengthened its national leadership role in suicide prevention through the establishment of a National Suicide Prevention Leadership and Support Program. The aim of the Program is to deliver national suicide prevention activities and reduce the rate of suicide and suicidal behaviour. It also aims to increase the preventive capacity of individuals and communities to respond to suicide. The Program supports PHNs to lead a regional approach to suicide prevention.

Several projects funded under the Program provide support to people living in rural and remote areas who may be at heightened risk of suicide. For example, the StandBy Response Service provides a 24-hour face-

to-face service for those bereaved or affected by suicide, training for front-line emergency response services in the community, and coordination of suicide responses. The Program also supports research on suicide through the University of Melbourne's national leadership role in suicide prevention and the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention.

Other projects funded under the Program focus on media and stigma reduction. The Mindframe National Media Initiative supports the responsible, accurate and sensitive representation of suicide in the Australian media while the RUOK? project builds the confidence of Australians to connect and have conversations with those who are struggling with mental illness. The RUOK? project also supports several media campaigns including RUOK? Day and an annual Conversation Convoy that reaches rural and remote communities across Australia.

5.6 Support around suicide hotspots

In the 2017-18 Budget, the Australian Government announced two elements that seek to prevent suicide in specific locations (or hotspots), where suicide incidents repeatedly occur. The Government has committed over $11 million over three years to deliver hotspot initiatives.

Hotspot infrastructure projects

The Australian Government has committed $9 million for state and territory governments to deliver approved infrastructure projects to improve safety at suicide hotspots. Approved infrastructure projects include fencing, physical and anti-trespass barriers, signage and removal of objects that could enable access to high-risk locations.

Research indicates that people intending to end their life often prefer a means which may include a specific site. The reasons why particular locations become hotspots is unclear, but they are often scenic or iconic public structures or sites, around which a certain history, infamy or mythology has developed.[58] Suicide hotspots can be tall buildings, bridges, cliffs and other structures that provide an opportunity for successful attempts. Rural or secluded locations such as car parks have also become known suicide hotspots. Sections of train-lines, particularly near mental health facilities, and roads may also become hotspots. Projects identified as suitable under the measure will be in urban and regional areas across Australia.

Funding for Lifeline Australia

Lifeline Australia is currently responsible for the operation of a 24-hour dedicated telephone crisis support line (13 11 15) for people who may be contemplating suicide. Funding of $2.1 million over three years will be provided to Lifeline to increase their capacity to deliver these activities, with a focus on meeting additional demand around Australian suicide hotspots. This is in addition to the over $9 million of Commonwealth funding to Lifeline in 2017-18.

Early progress with the initiatives detailed in this section, particularly the roll out of new suicide prevention trials in regional areas, has been encouraging. However, as is the case with these and other Commonwealth-supported mental health initiatives, the availability of an appropriately skilled workforce is fundamental to the sustained success of such initiatives. This challenge is only intensified by the lack of mental health professionals and specialists in rural and remote areas.

[58] University of Melbourne. (2011). *Preventing suicides at suicide hotspots*, Victoria, p. 6.

6 Expanding and upskilling the mental health workforce

A mental health workforce must have enough clinicians from the various professions to meet the growing need for care. These clinicians must be appropriately trained, experienced and accessible if people are to access quality care when they need it. The Australian Government is partnering with state, territory and local government in a coordinated national approach to mental health workforce reform to create a regionally accessible and appropriately qualified pool of professionals. However, large scale change in the composition and profile of a national workforce takes time and carefully targeted initiatives.

6.1 Mental health workforce composition

The Australian mental health workforce operates through a complex set of interrelated services, where people rely on a range of public, private and community providers for treatment and support. Due to services being provided in a range of settings and being funded by different levels of government (or departments), it can be difficult to develop an exact estimate of the size and distribution of the mental health workforce.

Data collected by the AIHW indicates that general practitioners comprise a significant proportion of the primary health care workforce, and as a single group of providers, deliver most of mental health care to people experiencing mental illness (see Section 2.3). They are a vital first point of contact and referral to mental health support. They are not, however, the only important component of the national mental health workforce. Other key professions include mental health nurses, psychiatrists, psychologists, social workers, occupational therapists, vocationally qualified mental health workers and community care workers. A key change from recent decades is that mental health care is now being delivered primarily in community settings. As a result, a substantial non-government mental health workforce has developed.

This shift away from traditional institutional to community approaches potentially enhances the tailoring of mental health service delivery to local needs. However, a scarcity of psychiatrists, clinical psychologists, specialist GPs and other mental health professionals in rural and remote areas has been recognised as a barrier to consistently providing people with mental health services for some time.

6.2 Workforce issues in rural and remote areas

The issues around recruiting, training, supporting and retaining mental health professionals in rural and remote areas are like that of other health professionals. Negative perceptions of rural employment and lifestyle opportunities present a barrier. Lower wages, cost of living and availability of quality housing are all considerations, while there can be concerns about adequate support for family needs, such as education and health services. For private providers, such as general practitioners, the viability of business models in smaller communities can be a concern., as can the difficulty securing locums or other services to cover periods of leave. Another disincentive can be the prominence of individual health professionals in local communities, where people fear they will always be on call.

There are also a range of workforce issues that relate specifically to mental health in rural and remote areas. The stigma often experienced by suffers of mental illness can sometimes extend to those who care for them, which can have an impact on a person's local identity. This concern can extend to fears about quality of life and personal safety, when mental health crisis services do not operate fully out of hours. Meanwhile, the absence or distance from professional networks of support can be a disincentive for mental health specialists, particularly psychiatrists and psychologists.

The degree of specialisation and training required for advanced levels of mental health care create expectations of higher salaries, which cannot be met either by local providers or across regions. The

episodic and unpredictable nature of mental illness can make it difficult to develop sustainable business models. Meanwhile, many of the existing and experienced regional professions, such as mental health nurses, are ageing which will reduce supply. This comes at a time when the population expectations of health care are rising, and general awareness of mental illness and its treatment is growing.

Together, these shortages of accessible and appropriately trained mental health professional can have important implications. Crisis events can result in less skilled mental health professionals undertaking complex clinical responsibilities for which they have not been fully trained. Mental health demand on local general practitioners can be much greater because of a lack of other local options, often when they do not have specialist mental health training. And when opportunities for further specialist training are sought, the time lost to travel and training can be prohibitive, while it can be difficult to secure locum or other support to cover absences.

The Australian Government recognises these and the other issues around the mental health workforce in rural and remote Australia. In response, it provides leadership and support through a range of initiatives that aim to attract, train, retain and deliver a more accessible mental health workforce.

6.3 Leading a national response to rural workforce accessibility

The Australian Government supports a range of nation-wide measures to improve the accessibility of health professionals in regional areas. Many of these initiatives include a dedicated component to improve mental health services.

National Rural Health Commissioner

The National Rural Health Commissioner is an integral part of the Government's broader agenda to reform rural health in Australia. The Commissioner's priority is to provide advice to Government on the development of a National Rural Generalist Pathway. This is a medical training pathway that will attract, retain and support doctors in rural and remote areas. It is widely recognised that rural generalists often have advanced training and a broader skill-set than is required by doctors in metropolitan centres. In many instances, they perform duties in areas such as general surgery, obstetrics anaesthetics and mental health. They not only work longer hours but are frequently on-call after-hours in acute care settings, such as accident and emergency hospital admitted patient care.

In developing the National Rural Generalist Pathways, the Commissioner will consult with the health sector and training providers to define what it means to be a Rural Generalist. The role will also include consultation with stakeholders to consider the nursing, dental health, pharmacy, Indigenous health, mental health, midwifery, occupational therapy, physical therapy and allied health needs in rural and remote Australia. Further, the Minister for Rural Health recently announced the Collingrove Agreement. This Agreement brings together the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine to build a strong, sustainable and skilled national medical workforce to meet the needs of Australia's rural and remote communities.

Rural Workforce Agencies (RWAs)

The Australian Government funds Rural Workforce Agencies (RWAs) in each state and the Northern Territory to deliver the Rural Workforce Agency Program. Under this program, RWAs will be funded around $86 million over three years to 2020 to deliver a range of activities aimed at improving health workforce access, quality and sustainability. Developed in consultation with the RWAs and other areas of the department, the programs will focus on meeting the current and future community health workforce need through three program areas.

- *Access* (Health Workforce Access Program): will improve access and continuity of access to essential primary health care, particularly in priority areas, through a jurisdictional workforce assessment process involving health workforce stakeholders.

- *Quality of access* (Improving Workforce Quality Program): will build local health workforce capability with a view to ensuring communities can access the right health professional at the right time, reducing the reliance on non-vocationally recognised service providers in rural communities.
- *Future planning* (Building a Sustainable Workforce Program): will grow the sustainability and supply of the health workforce with a view to strengthening the future health workforce.

A key element of the RWA program is the establishment of Health Workforce Stakeholder Groups who will develop a shared understanding of rural workforce needs and develop strategies to best meet those needs. RWAs are also funded to deliver the Health Workforce Scholarship Program ($11 million per year to 2020), which aims to increase access to health services in rural and remote areas experiencing skill shortages through the provision of scholarships and bursaries to increase the skills, capacity and/or scope of practice of health professionals committed to rural service. A rural return of service obligation may be attached to some higher value scholarships to provide a greater return on investment.

Royal Flying Doctor Service (RFDS)

The Royal Flying Doctor Service (RFDS) is funded to deliver emergency aeromedical evacuations, primary health clinics, medical chests (containing pharmaceutical products and associated medical supplies), remote (telephone) consultations and dental outreach services in areas beyond the normal medical infrastructure and in locations of market failure. The RFDS is responsible for the needs assessment, prioritisation and delivery of outreach health services.

In recognition of the important contribution that the RFDS is making in rural and remote Australia, in March 2018 the Prime Minister announced the provision of an additional $84 million over four years (to 2021-22) to increase the availability of dental services, deliver new mental health services and continue traditional services to rural and remote Australia. This is in addition to the recurrent funding that will be provided to the RFDS over the same period to deliver services to people living in rural and remote Australia.

General Practice Rural Incentives Program (GPRIP)

The General Practice Rural Incentives Program (GPRIP) aims to encourage medical practitioners to practise in rural and remote communities and to promote careers in rural medicine through the provision of financial incentives. The GPRIP supports medical practitioners, and GP Registrars on approved training pathways, who provide eligible primary care services and/or undertake eligible training in rural and remote Australia. Currently, over 7,000 medical practitioners are receiving GPRIP incentives. The GPRIP was redesigned in 2015 to better target incentives to doctors working in smaller regional towns, and in rural and remote communities. The redesigned GPRIP has an ongoing annual appropriation of funding, with $114 million being provided in 2017-18.

Rural Health Outreach Fund (RHOF)

The Rural Health Outreach Fund (RHOF) aims to improve access to health services for people who live in regional, rural and remote locations, investment of more than $82.9 million is being provided over three years to 2019-20. This fund improves access to medical specialists, GPs, allied and other health professionals. There are four identified health priorities under the RHOF, including mental health. Funding is provided to address a range of disincentives incurred by health professionals seeking to provide outreach services (such as travel, accommodation, room hire and lease of equipment). Needs assessment and service planning is done in consultation with a range of stakeholders including PHNs, location communities, regional working groups and Indigenous health organisations. RHOF service plans are developed annually and services are prioritised according to greatest needs. In 2017-18, around $4.7 million is being provided under the RHOF for 393 planned services related to mental health nationally.

The Rural Locum Assistance Program (RLAP)

The Rural Locum Assistance Program (RLAP) is funded under the Health Workforce Program to address an identified workforce disincentive around lack of back up for specialist absences and to generalist medical practitioners undertaking specialist training. Funding of $35.6 million will be provided to the RLAP to 2019.

The RLAP is an amalgamation of three programs: The Nursing and Allied Health Rural Locum Scheme (NAHRLS), the Rural Obstetric and Anaesthetic Locum Scheme (ROALS) and the Rural Locum Education Assistance Programme (Rural LEAP). Funding is provided to enable locum relief support to organisations in rural and remote Australia to backfill specialists (obstetrics and anaesthetics), procedural general practitioners (obstetrics and anaesthetics), nurses, midwives and allied health professionals in rural Australia. This is in order that they can take leave and/or undertake Continuing Professional Development (CPD) activities. The RLAP also benefits urban health professionals wishing to experience rural or remote practice by undertaking a locum placement or for GPs to undertake additional training so that they can undertake locum work in non-urban Australia.

CRANAplus

The Australian Government provides core funding to CRANAplus to deliver programs that help to improve access to health services in rural and remote areas. This includes increasing the quality of health care provided in rural and remote areas and improving the safety and security of the remote area health workforce. CRANAplus achieves this in three ways.

As a registered training organisation, CRANAplus offers accredited professional development courses to the remote health professionals at an affordable cost. Ready access to professional development opportunities helps reduce the professional isolation that may be experienced by health professionals working in remote locations, increasing retention rates and the quality of health care provided in rural and remote locations.

Through the Bush Services Support Line, CRANAplus provides a telephone and internet-based counselling service to remote health professionals and their families. The Bush Services Support Line is available 24 hours a day, seven days a week. This service helps remote health professionals maintain their mental health, reducing burn-out and improving retention rates.

CRANAplus also offers short courses to help remote health professionals gain the knowledge, confidence, ability and skills to identify and respond to potential or actual episodes of aggression and violence.

6.4 Developing resources to improve accessibility to mental health services

The Australian Government has supported several initiatives to improve the accessibility of mental health services that have now been entrusted to PHNs to lead and coordinate. These programs have been highly successful in improving accessibility to mental health services, particularly in rural and remote communities. It is anticipated that PHNs will develop initiatives that pursue the objectives and continue the success of these programs.

Access to Allied Psychological Services program (ATAPS) – now in PHN flexible funding

The Australian Government has reallocated these payments to PHNs as part of their flexible funding. The Access to Allied Psychological Services (ATAPS) program was a successful mental health program that funded the provision of short term psychology services for people with mental disorders through fundholding arrangements administered by Divisions of General Practice. ATAPS aimed to produce better outcomes for consumers with common mental disorders and offer referral pathways to general practitioners, as well as offer non-pharmacological and team approaches to mental disorder management. ATAPS enabled GPs to refer consumers with high prevalence mental health disorders to allied health professionals for six sessions of evidence-based mental health care.

Mental Health Services in Rural and Remote Areas (MHSRRA) program – now in PHN flexible funding

The Australian Government has reallocated these payments to PHNs as part of their flexible funding. The Mental Health Services in Rural and Remote Areas (MHSRRA) program was a highly successful program that addressed issues of mental health service inaccessibility in rural and remote areas of Australia. It aimed to complement other programs such as Better Access by increasing access to mental health services in rural and remote areas where usage of the MBS is low.

6.5 Training and supporting appropriately skilled rural and remote workforces

In Australia, as in comparable countries, mental health treatment, care and support continues to evolve as it moves away from the historical focus on institutionalised care. The need for clinical services remains high, but approaches are shifting toward person-centred and stepped care approaches. Workforce development needs to be flexible to adapt to these changes. This can be a substantial shift for long-term mental health workers. Further, the opportunity for better mental health care from constantly developing technology also brings with it new challenges and new skill demands. In addition to this, there are specific mental health care requirements for rural and remote communities, as well as the special population groups within them. All of these require an adequately trained and appropriately skilled regional mental health workforce. The Australian Government provides support for targeted workforce training initiatives that impact on the delivery of quality mental health services in rural and remote areas.

Australian General Practice Training (AGPT) program

The Australian General Practice Training (AGPT) program is a Commonwealth funded postgraduate vocational training program for medical graduates wishing to pursue a career in general practice. The training standards for the delivery of training on the AGPT program are set externally by the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine and includes training on mental healthcare. A minimum of 50% of registrar training on the AGPT program occurs in rural and remote Australia resulting in greater access to mental healthcare for rural and remote communities.

Specialist Training Program (STP)

The Australian Government has improved access to psychiatry services in rural communities through the Specialist Training Program (STP). The STP funds specialist medical training in expanded settings, while STP trainees provide specialist services, including psychiatry, to the community throughout their training. The Government has recently implemented two key reforms through the STP that will bring significant benefits to rural and remote communities. These include increasing the rural training target under the program from 2018 and funding 100 additional dedicated rurally focused training posts. Trainees in these posts must undertake at least 66 percent of their fellowship training in regional, rural and remote areas. The STP also has additional rural raining posts for psychiatry as part of the Integrated Rural Training Pipeline (IRTP) initiative. Under the IRTP initiative, there are 31.3 FTE funded psychiatry places in rural areas each year from 2018 to 2020.

Remote Vocational Training Scheme (RVTS)

The Remote Vocational Training Scheme (RVTS) offers GP registrars an alternative pathway to Fellowship of the Royal Australian College of General Practitioners (RACGP) and/or the Australian College of Rural and Remote Medicine (ACRRM). RVTS is an independent (Commonwealth-funded) program with its own application process and intake quota. RVTS brings educational opportunities to General Practitioners practicing in areas where accessing mainstream training is impractical or impossible. Training is provided via distance education and remote supervision, allowing RVTS registrars to practice in some of Australia's remotest locations while training for fellowship.

Rural Health Multidisciplinary Training Program

The Australian Government has provided funding for the Mental Health Academics (MHA) Project, delivered through the Rural Health Multidisciplinary Training (RHMT) Program. While the overall aim of the RHMT program is to make a measurable impact on addressing the maldistribution of the rural health workforce, the MHAs are placed in University Departments of Rural Health (UDRH) to ensure that there is an availability of mental health services across all universities associated with the RHMT program.[59] The key goals of the Mental Health Academics project are to:

- Support increased access for communities to mental health services;
- Ensure rural health professionals are better equipped to recognise and deal with mental health problems in individuals;
- Engage with rural communities to increase awareness of mental health issues; and
- Create clinical training capacity to provide support for the expansion of training places in mental health disciplines.

As a part of the RHMT program, in early 2017 an additional $54.4 million of funding was committed to establishing 26 regional health training hubs and bringing the number of URDHs across remote and rural Australia up to 15.[60] Both initiatives are components of the Integrated Rural Training Pipeline (IRTP) for Medicine and have associations with universities in each state to help ensure high quality training networks and service provision across rural communities Their objectives include identifying and prioritising activity around regional workforce needs. [61]

Mental Health Nurse Incentive Program (MHNIP) – now part of PHN flexible funds

The Mental Health Nurse Incentive Program (MHNIP) operated as a demand-driven program that provided incentive payments to community-based general practices, private psychiatrist practices and other appropriate organisations who engaged mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders. MHNIP services provided patients with support during periods of significant disability and assisted in maintaining long-term health protective behaviours and resilience.

The Australian Government's mental health reforms included the transition of primary mental health care programs, including the MHNIP, to PHNs from July 2016. The transition of MHNIP funding into the PHN flexible funding arrangements allows more equitable distribution of funding across the country, while PHNs have responsibility for directing funding to address specific areas of need in their region. It is expected that PHNs will invest this flexible funding into programs that will continue the principles and success of this previous initiative.

Rural Mental Health Nurse Workforce (MHNW) project

The Australian Government is providing $1.5 million to the Australian College of Mental Health Nurses for the Mental Health Nurse Workforce (MHNW) project. This project will deliver education and training to develop the mental health care skills of the existing primary health care nursing workforce. It will also support a program to support the transition of mental health nurses across the acute and primary care sectors to develop a flexible and sustainable mental health nursing workforce. Whilst not specific to rural and remote areas, practice nurses will be able to access on-line learning modules to improve their mental health literacy and clinical skills for working in primary health care settings. One day face-to-face workshops are also being rolled out and include regional areas.

[59] Department of Health. Rural Health Multidisciplinary Training (RHMT) Program, 2017, accessed 30 April 2018

[60] Assistant Minister for Health, The Hon Dr David Gillespie, MP. Media Release: Government announces 26 regional training hubs and 3 new University Departments of Rural Health to boost clinical training in regional Australia, 2017

[61] Department of Health. Regional Training Hubs, 2017, accessed 29 April 2018

National framework for mental health in nursing programs

The Australian Government is also funding the Australian College of Mental Health Nurses to review the mental health content of undergraduate nursing degrees and clinical nursing placement in mental health settings. The findings will inform the development of a national framework for mental health content in undergraduate nursing programs, which will be distributed to Australian universities, and provided to inform the Australian Nursing and Midwifery Accreditation Council review of Registered Nurse Standards. Whilst not specific to rural and remote area this project aims to support the development of a suitably quailed nursing and midwifery workforce to improve the mental health and wellbeing of all Australians.

Mental Health Professional Online Development (MHPOD) tool

The Mental Health Professional Online Development (MHPOD) tool is a national web-based professional mental health education resource for professionals and allied health workers. It is available to mental health nurses, social workers, occupational therapists, psychiatrists and psychologist working in mental health in Australia in their first two years of practice. It is also available to GPs, consumer workers, carers, Aboriginal health workers and other allied health workers. Due to its being an online resource, this provides important training opportunities for mental health professionals in rural and remote areas.

The Mental Health Professionals' Network (MHPN)

The Mental Health Professionals' Network (MHPN) provides practitioners with an opportunity to participate in locally-based interdisciplinary networks and national online professional development webinars. The opportunities facilitated by MHPN are open to a wide range of mental health workers but are particularly important to address the challenges of professional isolation in rural and remote locations.

Recently, the MHPN partnered with the Commonwealth Department of Health to deliver a webinar on improving practice using Better Access's new Telehealth options. This webinar occurred pre-implementation of the new MBS telehealth items and targeted allied mental health practitioners. The webinar considered an interdisciplinary approach focusing on improving practice through use of the new Better Access Telehealth options. who may be interested in expanding their practice to include telehealth options. The webinar was endorsed for professional development points, credits or hours by the Royal Australian College of General Practice, the Australian College of Rural and Remote Medicine and the Australian College of Mental Health Nurses. Additional webinars are currently in planning.

The answer to providing an accessible and appropriately trained workforce to support mental health services in rural and remote area is neither simple nor swift. The Australian Government continues to contribute to coordination and advance in this space, but sustained workforce change takes time. This serves to reinforce the important of government support for a range of digital and online innovations that not only help address short term issue of workforce availability, but also support ongoing issues around equity of access to high quality, new technology, mental health services across Australia.

7 Using new technology to improve service delivery

The 2014 National Mental Health Commission's review of mental health programs and services noted that digital technologies can be used to provide mental health services that are more flexible and less stigmatising for people with mental health difficulties.[62] The Commonwealth has made a significant commitment to support digital, online and new technological approaches to improve the quality of mental health service delivery. While many of these initiatives are phone or web-based and accessible nationally, the potential impact of having reliable and confidential professional support at all times in rural and remote regions is immense. Further, with the constantly improving national coverage of internet and mobile services, as well as new Government initiatives to supplement 'black spots' in these digital services, means more Australians have access to these services than ever before.

7.1 The potential of digital technology in rural and remote areas

Digital technologies are transforming Australia's mental health system. These technologies align with the new national approach to regional service delivery because they can be an accessible part of a person-centred stepped care approach. They also enable stronger connections between services and sectors. While these technologies have the potential to enhance access to support and information, they also have the potential reduce discrimination through stigma, which has been identified as a significant barrier in regional Australia.

Importantly, digital technologies have been identified as an important way to address specific barriers to accessibility and quality of mental health services in rural and remote areas. Digital mental health services can bridge the gaps between services in the cities and country and, in doing so, help address inequity due to higher levels of unmet need in rural and remote communities. These technologies can also improve quality of services by connecting people to best practice and leading practitioners, where the delivery of mental services by underqualified professionals has been identified as a challenge in rural and remote areas. Digital technologies can also ensure mental health services are delivered with privacy in smaller communities and at all hours of the day or night.

The Australian Government is maintaining support for traditional person-to-person community-based telephony services, while at the same time substantially increase capacity for crisis support through new online and voice-activated technologies. It has committed funding to several national digital approaches that have specific benefit in rural and remote communities. It also recognises that while 88 per cent of Australian households in Australian cities have internet access, this falls to 79 per cent in outer regional and remote areas. That is why it is rolling our new telephone phone support services for internet-based programs (such as headspace) and introducing privacy mechanisms for its digital services so that they can be used in local centres (such as community libraries).

As part of the national approach, PHNs and LHNs have been tasked with the responsibility of identifying and harnessing the potential for digital technologies to better integrate and provide mental health services. The Australian Government provides specific funding to PHNs to innovate in this space and draw on the rapidly expanding range of supports in the digital space.

Case Study: Expanding rural and remote access through the online MindSpot service

Prior to the establishment of the Western Australia PHN, there were areas of Western Australia where

[62] National Mental Health Commission. Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services, 2014.

people had minimal, if any, access to mental health services. Now, as the result of a range of initiatives by the Western Australian PHN, people can access high quality clinical care via telephone, online or face-to-face any time day or night.

MindSpot is a free telephone and online service for people suffering from depression and anxiety. The WA PHN is working in collaboration with Macquarie University to expand this into a state-wide service. Through MindSpot general practitioners and nurse practitioners can automate referrals to Aboriginal Health Workers or other mental health professionals. The online support allows people to be referred to psychologists, psychiatrists and mental-health workers for counselling. MindSpot has improved quality of services across many parts of regional WA and provided access to a level of care that previously wasn't there. One of the greatest advantages of MindSpot is that uses technology to keep local general practitioners constantly updated on the progress of the clients they refer.

Since rolling out a suite of digital and online services the WA PHN has found that 20 per cent of access of digital services/telephone services from the country are Aboriginal and Torres Strait Islander people. This figure is far larger than expected and indicates that in many areas people may value anonymity. This highlights the importance of providing a range of different channels from which people seek support.

There are also potential opportunities for the use of digital mental health and electronic health records in coordinating care at the local level. While sharing clinical records amongst treating practitioners is best practice always, the scarcity of mental health professionals in rural and remote areas, as well as the distances between their practices, can present a significant challenge.

7.2 Head to Health

Central to the Australian Government's mental health reform is making optimal use of digital mental health services, including through the development of a consumer-friendly digital mental health gateway.[63] The Head to Health site aims to provide a genuine and trusted gateway to early intervention and lower-level mental health services. It does this by helping people more easily access information, advice and digital mental health treatment options. This service provides flexibility and choice by linking directly to eighteen different digital mental health services, all of which complement or act as an alternative to face-to-face services.

The Australian Government has been listing online information about mental health services since 2006. However, since its launch in October 2017, Head to Health has provided three important additional functions for rural and remote users. These are:

- A page dedicated to information for rural and remote people
- A search function (that includes a regional filter)
- A decision support 'chatbot' tool

A strong governance and advisory structure has ensured Head to Health is informed by its potential users. This has included a Core Community Group representing diverse populations groups, including rural and remote areas to assist in system design.

Head to Health provides a trusted government access point to nationwide services, including those specifically tailored to the needs of diverse local communities. One example is the returned servicemen

[63] See: Department of Health. Head to Health

communities where Head to Health provides a comprehensive body of information about mental health services available to veterans.[64]

7.3 Better Access initiative

The Better Access initiative aims to improve treatment and management of mental illness within the community. This initiative increases community access to mental health professionals and team-based mental health care. It encourages general practitioners to work closely and collaboratively with psychiatrists, clinical psychologists and registered psychologists, as well as appropriately trained social workers and occupational therapists.

Under the initiative, Medicare rebates are available for patients with a mental disorder to receive up to ten individual and up to ten group allied mental health services per calendar year. These services are generally provided in courses of treatment, with each course of treatment involving up to six services provided by an allied mental health professional. At the end of each course of treatment, the allied mental health professional must report back to the referring medical practitioner on the patient's progress and the referring practitioner assesses the patient's need for further services.

In the 2017-18 Federal Budget, the Australian Government announced funding of $9.1 million over four years to enable Australians who live in rural and remote Australia to access Better Access services via telehealth.[65] This support takes the form of a psychological therapy service that is delivered via video conference where both a visual and audio link has been established between a patient and their treating allied health professional. People are eligible for this service through residence in rural and remote areas according to the Modified Monash Model (MMM 4-7).[66]

A requirement of this initiative is that one of the first four Better Access sessions is delivered face-to-face to facilitate a personal connection with the treating allied health professional, as well as help support and retain mental health specialists outside metropolitan regions. After this, clinicians will be able to deliver up to seven out of the total ten Better Access consultation by videoconference. These new provisions allow people to meet promptly, conveniently and privately with mental health professionals after referral by their medical practitioner. This initiative helps address the challenges associated with a scarcity of mental health professionals working in rural and remote communities.

7.4 Life in Mind portal

Life in Mind is a national initiative that connects organisations, programs, researchers and professionals working in suicide prevention to each other, and the community. It does this by providing a digital platform for knowledge exchange around suicide prevention activities across Australia. Life in Mind is supported by funding from the Australian Government under The National Suicide Prevention Leadership and Support Program.

The program's overall objective is to reduce suicidal behaviour, rates and better support people to communicate about, and respond to, suicide and its impacts. The Life in Mind website[67] explains that it aims to:

- link policy to practice, communities to help-seeking and practitioners to the evidence base through the development of an online portal

[64] In addition to these services, the Department of Veterans' Affairs also provides specific support to veterans living in rural and remote areas.

[65] See: Department of Health. Telehealth, 2015

[66] See: Department of Health. Modified Monash Model, 2016

[67] See: Everymind. Life in Mind program, accessed 1 May 2018

- support coordinated, consistent messaging around suicide prevention through the operationalisation of the National Mental Health and Suicide Prevention Communications Charter
- promote leadership and support in the communication of the project to the sector, and to the broader community, through the implementation of a National Champions Leadership Group.

By supporting the work and efforts of the organisations working in suicide prevention, Life in Mind will be able to facilitate a coordinated approach that is based on research evidence, quality standards and best

This initiative has specific importance to regional Australia because it can connect organisations, local services and rural communities to the latest information, activities, evidence-based resources and research. This contribution will be particularly valuable to PHNs and mental health professionals working outside of metropolitan areas so that they can keep abreast of the latest developments and practices in suicide prevention.

7.5 Online initiatives for special populations

The Australian Government is also supporting and partnering several other measures to use technology to improve mental health and suicide prevention services in rural and remote locations.

beyondblue

beyondblue is an Australian, independent non-profit organisation working to address issues associated with depression, anxiety disorders and related mental disorders. It works in partnership with health services, schools, workplaces, universities, media and community organisations. *beyondblue* takes a public health approach to anxiety and depression, focusing on improving the health of the whole population, across the whole lifespan. It also works with specific population groups in a range of settings to be accessible to as many people as possible. Amongst its suite of offerings is information and links to support men facing the challenges of living in rural and remote communities. The service is supported by the Australian Government and every state and territory government.

ReachOut youth suicide call-back service

Recent research shows that more than fifty percent of young people turn to the internet for help with mental health.[68] The ReachOut service uses the internet to make digital self-help available for young people. It draws on the latest evidence and works with experts to deliver safe, relevant and trusted self-help tools. ReachOut provides immediate telephone counselling and support in a crisis. This includes linking young people to a Kids Helpline (ages 5 to 25) and the national Suicide Call Back Service (for ages over 15). These services are a vital resource given the impact of youth suicide in rural and remote communities. ReachOut is a free service that is funded by the Australian Government, as well as corporate, community and philanthropic donations.

QLife service for LGBTI communities

QLife is Australia's first nationally-oriented counselling and referral service for people who are lesbian, gay, bisexual, trans, and/or intersex (LGBTI). QLife provides nation-wide, early intervention, peer supported telephone, online chat and web-based services to people of all ages. QLife will enable communities to work towards better health outcomes by providing a place to talk about mental health, the challenges associated with coming out, and other concerns. This service also supports LGBTI Australians in rural and remote areas to reduce the potential impact of isolation and stigma in their local community. QLife is funded by the Australian Government.

Perinatal Depression support trial

[68] See: ReachOut, accessed 2 May 2018

International studies show that up to one in ten women experiences depression while pregnant, and one in seven women in the year after birth. The Australian Government has identified a gap in online self-help support tools and services specifically tailored to and targeted toward pregnant women and new mothers with perinatal mental illness. In response, it has contracted the Parent-Infant Research Institute on behalf of the Perinatal Depression e-Consortium to deliver, manage and trial three new technological supports. These include:

- an online self-directed treatment program for women with or at risk of perinatal depression
- a smartphone app providing support for expectant and new mothers experiencing stress (but not necessarily experiencing a mental disorder)
- a landing website that hosts a range of evidence-based perinatal mental health resources and psychoeducational tools.

The Commonwealth is in the early stages of collecting data on the effectiveness and uptake of the treatment through this important trial. It is anticipated that these supports will specifically assist people who are unable to access professional face to face services due to geographical isolation.

eMHPrac mental health training

In line with Australia's move towards a stepped care model of mental health treatment, models of care are being developed to ensure that the needs of each patient are matched with the intensity of care they receive. The e-mental health in practice (eMHPrac) programs have been developed as a suite of online training modules, webinars and e-resources designed to introduce health professionals to online programs and tools, and to demonstrate how e-mental health technologies can be integrated into primary care. These programs are evidence based, low-intensity online programs available to practitioners, in most cases, at no cost. [69]

As can be seen from the above examples, innovation with digital technology is working to address barriers to service access and to improve service quality. As is examined in the next section, it is also supporting the development of a richer and more localised evidence base to inform policy and service delivery decisions.

[69] Black Dog Institute. e-Mental Health in Practice, accessed 2 May 2018

8 Producing evidence to improve rural and remote mental health outcomes

The shift to person-centred stepped care and consumer focussed health outcome evaluation through PHNs will provide new opportunities to improve evidence-based practice. The partnership between the Commonwealth and local PHNs to create a national minimum data set will produce new information to support richer research into accessible and effective mental health care. While it will take up to a decade to consolidate a robust database to inform national policy and decision-making, this information is already available to PHNs to support them in their planning. This section explores the potential of a range of PHN led and research partnerships to improve the evidence base beneath our delivery of mental health services.

8.1 The shift to person centred approaches

The Fifth National Mental Health and Suicide Prevention Plan called for national mental health services to be coordinated at the regional level and delivered though integrated and person centred care models. This approach aligns with a population-based model that aims to match available resources to identified need, placing emphasis on population groups which are at higher risk or have special needs.

The Australian Government funds the national network of PHNs to lead and assess the above activity through a range of national and local indicators. These indicators are orientated around a stepped care model that incentivizes PHNs to plan and support effective and efficient delivery of services that match the specific needs of consumers and their carers. Further, as part of an evidence-based process, PHNs are expected to collect data against these indicators to allow measurement of delivery against national priorities and inform the delivery, coordination and commissioning of services.

These developments represent a significant shift in how mental health services are delivered and assessed nationally. Increasingly, funding will be justified according to health improvements for consumers, rather than the number or type of services delivered by providers. Such approaches are well suited to the mental health sector, which aims for those who have experienced episodes to regain health fully and maintain independence. This may not be possible in all cases and mental illness will have ongoing effect on their lives. However, this shift in focus (and funding) from measuring service outputs to health outcomes will still have the benefit of minimising the level of individual dependency. Importantly, this shift will also create different requirements and make new demands on mental health data and information systems.

8.2 PHN data sets to target and improve local health outcomes

The Australian Government's contribution to improve rural and remote mental health service use relies on local PHNs to deliver integrated regional planning and services. Central to this is the provision of flexible funding to match resources to local need. PHNs have been provided with a new flexible funding pool to plan, integrate and commission mental health services at a local level, in partnership with general practitioners and relevant services. This regional approach distinguishes what services are available to identify and address service gaps where needed (including in rural and remote communities).

As part of this responsibility, PHNs are required to collect performance data against national and local indicators. The Australian Government has provided funding through a Primary Mental Health Care flexible funding pool to support commissioning of mental health and suicide prevention services in six key service delivery areas:

- low intensity psychological interventions for people with, or at risk of, mild mental illness
- psychological therapies delivered by mental health professionals to under serviced groups

- early intervention services for children and young people with, or at risk of mental illness
- services for people with severe and complex mental illness who are being managed in a primary care setting
- enhanced Aboriginal and Torres Strait Islander mental health services
- a regional approach to suicide prevention activities with a focus on improved follow-up for people who have attempted suicide or are at high risk of suicide.

The Primary Mental Health Care Minimum Data Set (PMHC MDS) will provide the basis for PHNs and the Department of Health to monitor and report on the quantity and quality of service delivery. Where confidentiality and ethics requirements permit, this data will be shared to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Government.

This data collection and collation activity will provide a more localised data picture than has been available through previous mental health data collection mechanisms. This minimum data set has been in operation since mid-2016 but will take 5-10 years consolidate and produce rigorous data to better target policy development to needs at local, rural and remote levels. Currently, this new data is available to PHNs to inform their local service delivery decision making. This new data collection activity will continue to grow as a significant contribution by the Australian Government to better access and quality to mental health services in the future.

8.3 Commonwealth support for stronger evidence bases

The Australian Government is committed to research-driven and evidence-based approaches to improve access and quality of all mental health and suicide prevention services. This commitment is reflected through the funding and establishment of several key initiatives, including:

- **National Suicide Prevention Research Fund:** As part of its commitment to *Strengthen Mental Health Care in Australia* the Australia Government is providing $12 million over four years for a National Suicide Prevention Research Fund managed by Suicide Prevention Australia. This fund is designed to provide sustainable financial support for Australian suicide prevention research and ensure outcomes have the greatest impact by addressing nationally agreed priorities. Research with a focus on the needs of rural and remote focus will be included as part of this process. The Fund will support targeted research and a Suicide Prevention Best Practice Hub.
- **Suicide Prevention Best Practice Hub:** The Suicide Prevention Hub: Best Practice Programs and Services is the first investment made by the Fund. It provides an online resource supporting communities to find quality, evaluated, suicide prevention programs and services. One aim of the Hub is to assist the work of PHNs and others involved in community-based suicide prevention. The Hub is the first resource of its kind in Australia.
- **National Suicide Prevention Leadership and Support Program** (discussed in Section 5.5): As part of its role, the Program supports research on suicide through the University of Melbourne's national leadership role in suicide prevention and the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention.
- **National Suicide Prevention Trial** (see Section 5.4): This trial will improve understanding of what strategies are most effective in preventing suicide at a local level and for at-risk populations (including veterans, young people, men, and Aboriginal and Torres Strait Islander people). The Trial will be independently evaluated over the funding period, with The University of Melbourne appointed to lead this evaluation. Findings from the trial will be made available to all PHNs to guide future suicide prevention activities.

- **National Centre of Excellence in Suicide Prevention:** The aim of this Centre of Excellence is to provide advice around evidence-based best practices and evaluation in suicide prevention and inform the approach of the Australian Commonwealth Departments, non-government agencies, academics and community groups in their suicide-prevention initiatives. The objectives of the centre are to:
    - Enhance awareness of the work of the National Centre of Excellence in Suicide Prevention
    - Provide evidence based practical assistance to organisations;
    - Provide advice to the Department of Health on evidence-based best practice in suicide prevention activity, approaches to evaluation of suicide prevention activities, development of evaluation frameworks and credibility of suicide prevention data and data issues;
    - Provide bi-annual critical literature reviews to the department.

As can be seen from above, the Australian Government is building richer, stronger and more localised evidence bases to inform future policy and service delivery decisions.

9 Meeting the needs of Special Population Groups in the regions

The 2014 National Mental Health Commission's review of mental health programs and services identified that many people with mental health difficulties face compounding disadvantage.[70] These compounding factors can include adolescence, coming from a different cultural background, living with a disability and having experienced war or trauma in the past. When living in rural and remote Australia, these special population groups can experience stigma or isolation which can further intensify the pre-conditions for mental illness and suicide. This compounding effect is particularly relevant with Aboriginal and Torres Strait Islander people, where historical alienation and cultural marginalisation can be further compounded by lived experience.

Different communities have different compositions, characteristics and cultures. This principle also applies to 'hard-to-reach' or special population groups within those communities. For these reasons, models for delivering mental health services in major cities may not operate successfully in rural and remote Australia. This need for flexibility and adaptability with specific population groups was a key consideration in the Australian Government's decision to assign PHNs as leaders in regional planning, coordinated funding and commissioning of local mental health services. This section builds on the previous information in this document to highlight additional Commonwealth activity to serve the needs of special population groups in rural and remote Australia.

9.1 Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people with mental illness experience extremes of social and psychological divorcement. Alienated from their families and country of origin, and hence from their identity, many are out of touch with traditional networks of help. This has important implications for the nature of services to be provided. Primary prevention requires a greater focus on the social determinates of mental illness amongst Aboriginal people. This includes the need to recognize and address the historical trauma created by the experience of colonization and dispossession as well as the specific trauma of the Stolen Generations. It has been suggested that the extent of this trauma is such that many Aboriginal people are suffering from symptoms suggestive of Post-Traumatic Stress Disorder.

Aboriginal and Torres Strait Islander people are the largest group as a proportion of remote and rural populations and experience problems consequent to that isolation. The important realization arising from these findings is that culturally appropriate assistance to urban Aboriginal and Torres Strait Islander people is urgently needed. It was suggested that urban-based services must recognize the psychological effects of cultural dislocation, such as through the stolen generations policy, and still be responsive to the different Indigenous cultural expectations, linking back to the beliefs of the client's country of origin.

Mental health plans with a specific Indigenous component will inform what is required to meet the mental health needs of Aboriginal and Torres Strait Islander people. Services are to complement and link with other closely connected activities, such as social and emotional wellbeing services, headspace, suicide prevention approaches and alcohol and other drug services. Services should be integrated across the whole mental health system.

Aboriginal and Torres Strait Islander mental health services can be provided through a variety of avenues including ACCHSs, and Aboriginal Medical Services (AMSs), as well as mainstream services which may include Local Hospital Networks (LHNs), headspace or suicide prevention services. Mental health services are to be supported by clinical evidence and delivered by an appropriately skilled workforce.

[70] National Mental Health Commission. Contributing Lives, Thriving Communities - Report of the National Review of Mental Health Programmes and Services, 2014.

Culturally appropriate health services and providers will facilitate more effective mental health service delivery and improved mental health outcomes for Aboriginal and Torres Strait Islander people. This requires cultural awareness, cultural respect, cultural safety and an understanding of the cultural determinants of health.

Aboriginal and Torres Strait Islander people are to have the same access to mental health services that are joined up, integrated, culturally appropriate and safe, and designed to holistically meet the mental health and healing needs of people at the local level.

Funding for mental health service to Aboriginal and Torres Strait Islander people

The Australian Government is providing $1.2 billion to 2018-19 for PHNs to commission primary mental health and suicide prevention services through the mental health flexible pool. As part of this funding, approximately $85 million of funding is specifically for Aboriginal and Torres Strait Islander mental health.

Indigenous mental health funding is provided from the Indigenous Australian's Health Programme (IAHP). The objective of the IAHP is to provide Aboriginal and Torres Strait Islander people with access to effective high-quality health care services in urban, regional, rural and remote locations across Australia. This includes through Aboriginal Community Controlled Health Services (ACCHS), wherever possible and appropriate, as well as through mainstream services delivering comprehensive, culturally appropriate primary health care.

Indigenous mental health funding is specifically quarantined to improve access to culturally appropriate mental health services for Aboriginal and Torres Strait Islander people. This funding builds on mainstream mental health funding provided to PHNs and aims to increase access to culturally appropriate and safe mental health services for Aboriginal and Torres Strait Islander people.

The role of PHNs in mental health support for Aboriginal and Torres Strait Islander people

The Fifth National Mental Health and Suicide Prevention Plan includes provision for governments to work with PHNs and LHNs to implement integrated planning and service delivery for Aboriginal and Torres Strait Islander people at the regional level. PHNs aim to work with mainstream service providers, the Aboriginal Community Controlled Health Sector and peak bodies to ensure culturally appropriate programs are implemented as part of the ongoing mental health and suicide prevention reforms.

Funding allocations to PHNs for primary mental health and suicide prevention services are weighted for rurality, Indigenous status and socio-economic disadvantage. In 2018-19, 9 per cent of quarantined funding to PHNs will be devoted to mental health services that are coordinated, culturally appropriate, and designed to meet the needs of Aboriginal and Torres Strait Islander people at the local level.

PHNs should take a flexible and innovative approach in meeting the mental health needs of Aboriginal and Torres Strait Islander people in their regions. A joined up, innovative and integrated approach is needed to bring together programs which are currently designed to separately support services such as social and emotional wellbeing, suicide prevention, and where appropriate alcohol and other drug services, to improve support for Aboriginal and Torres Strait Islander people.

Each PHN is expected to undertake regional needs analysis in collaboration with relevant local Indigenous organisations including ACCHSs and peak bodies and with mainstream primary health care organizations to identify the specific mental health needs and service gaps for Aboriginal and Torres Strait Islander people. This analysis should be done in the context of providing holistic, culturally appropriate and safe mental health services. Local engagement with Aboriginal and Torres Strait Islander communities will also help to identify community needs.

As part of their regional planning, mental health plans with a specific focus on Aboriginal and Torres Strait Islander needs will be required. In preparing this plan, PHNs should take into consideration existing service arrangements provided through a variety of organizations and services in the region, including those delivered by ACCHSs.

PHNs should commission a continuum of primary mental health services for Aboriginal and Torres Strait Islander people within a person-centered stepped care approach providing a range of services to meet local needs. This could include but is not limited to access to services for low intensity interventions; hard to reach populations; severe mental illness; child and youth services; and suicide prevention.

Commissioned services are to make the best use of available workforce and technology, for example early identification of mental health illness through a GP or providing access to telephone and/or online services such as headspace.

PHNs should not commission mental health activities that are not supported by clinical evidence, or that duplicate existing activities. Services commissioned should holistically meet the needs of each patient, including providing support for affected families and/or communities.

PHNs are expected to collaborate with existing services and seek opportunities to join up or integrate mental health, suicide prevention, social and emotional wellbeing and alcohol and other drug services to minimize duplication of services, including those delivered by state and territory governments and maximize workforce resources.

In doing this PHNs should:

- engage with local communities and consult with relevant local Indigenous and mainstream primary health care organisations to identify the specific mental health needs of Aboriginal and Torres Strait Islander people;
- determine the most appropriate mix of service delivery modalities for commissioning in each region; and
- ensure referral pathways are in place to enable and support patients to seamlessly transition between services as their needs change.

Longer term, PHNs will be expected to:

- establish linkages between commissioned and existing services to facilitate a joined up, integrated approach to the provision of mental health services;
- support providers to develop and maintain culturally appropriate and safe services that holistically meet the needs of patients and their families; and
- ensure referral pathways are in place to enable and support patients to seamlessly transition between services as their needs change.

Case Study: Working with Aboriginal health care services to deliver headspace services

Young people aged between 12 and 25, in Katherine now have access to a range of support in mental health, alcohol and drug and social and vocational support from their local headspace centre. Katherine has been shown as an area of high need, and with young people making up to nearly 23 per cent of Katherine's population, it is important that they have access to the right support, as early as possible. A focus of this headspace service will be on supporting Aboriginal and Torres Strait Islander community who make up about 60 per cent of young people in Katherine. Anglicare NT, with funding from Northern Territory PHN, has established and manages Katherine's headspace service. In carrying out this role they work closely with local stakeholders and the Aboriginal community to tailor health care services to community and to share lessons learned with other regional headspace initiatives (such as Darwin).

Aboriginal and Torres Strait Islander suicide prevention trials

The Australian Government has committed to reducing the prevalence of Aboriginal and Torres Strait Islander suicide and the impact on individuals, their families and communities. In 2016, suicide was the fifth leading cause of death for Aboriginal and Torres Strait Islander people. The standardized death rate

of 23.8 death per 100,000 population for Aboriginal and Torres Strait Islander people was twice that of non-Indigenous people.

As part of the National Suicide Prevention Trial program, two Indigenous-specific suicide prevention trial sites have been established in the Kimberley and Darwin regions. The Aboriginal and Torres Strait Islander specific trials are being guided by community based advisory groups. Each trial site is receiving $3 million in funding to 2018-19.

The Australian Government has provided a blueprint for the provision of culturally appropriate suicide prevention services in Aboriginal and Torres Strait Islander communities. This blueprint is informing the activities of the Kimberly and Darwin Suicide Prevention Trials.

Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

Through the National Suicide Prevention Leadership and Support Program, the Department is providing $1.75 million in funding to the University of Western Australia (to June 2019) to establish a Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention. Activities of the Center include supporting the development of suicide prevention activity tailored to specific community needs, providing evidence-based information and advice, building the capacity of PHNs, and supporting Aboriginal and Torres Strait Islander communities to act on to suicide and self-harm in their region.

9.2 The NDIS and people with mental illness

The National Disability Insurance Scheme (NDIS) is the most significant change made to the way that disability services are provided in Australian history.

The NDIS aims to improve the lives of Australians with a significant and permanent disability, their families and carers. It will ensure people with disability receive the supports they need, by assisting them to access mainstream and community services and supports. It will maintain information support arrangements and receive reasonable and necessary funded supports. At a system level, the NDIS aims to support capacity building to further develop the disability services sector.

The NDIS provides a new approach for psychosocial support in Australia, with an emphasis on personal choice and control over the services they use. The NDIS also supports the further development of community-based support for people with mental illness that has been a direction of the National Mental Health Strategy since its inception.

Due to the significance of the change, the NDIS is being rolled out in stages, with earlier roll out in some states and territories, and staged roll out within others. As with any reform of the scale of the NDIS, there have been some concerns raised during implementation, and this staged roll out has provided an opportunity to review and refine aspects of NDIS operation.

In recognition of the specific issues faced in rural and remote areas, the NDIS has developed a Rural and Remote Strategy. The Strategy aims for a balanced approach in responding to:

- lack of supply in areas of high demand growth such as personal care
- provider readiness such as profitability, working capital and contact with the National Disability Insurance Agency (NDIA)
- services in remote, rural and lower socio-economic regions
- impact of transition of state and territory government specialist disability services
- services to meet episodic/unpredictable demand. For example: in crisis supports and mental health
- transport needs that arise because of a person's disability
- support for people with complex support needs e.g. challenging behaviours

- support to assist with independent/informed choices and access
- housing needs that arise because of a person's disability
- availability of specific types of therapy/therapists
- supporting linkage and local coordination between services/agencies (such as with Aboriginal Medical Services).

While recognising the benefits that the NDIS will provide, stakeholders have raised concerns about implementation of the NDIS for people with psychosocial disability, and for people living in rural and remote areas. These concerns have focussed on:

- Supporting the fluctuating needs and recovery orientation for people with mental illness
- Continuation of psychosocial support services for people with mental illness who are not eligible for the NDIS
- The pricing model and service availability, particularly for people with complex care needs and in rural and remote areas.

The NDIS can support the fluctuating needs and recovery orientation for people with mental illness through flexible core budget funding and capacity building budget funding for individuals. Core budget funding is the most flexible, and includes four categories of support:

- Consumables (e.g. purchasing everyday use items)
- Daily Activities (e.g. assistance with self-care activities during the day or evening)
- Assistance with Social and Community Participation (e.g. supports to enable engagement in social or recreational activities)
- Transport.

Generally, core budget funding allocated against one support category can be used to purchase supports under another support category. This means that if someone's support need fluctuate over time, they can use this funding to flex up and down different elements of their supports.

In addition to the core NDIS funding arrangements, the Australian Government has proposed two further funding commitments to support people with psychosocial needs who may not be eligible under the NDIS and to support stronger continuity of care.

- *Psychosocial support needs:* the Australian Government announced in the 2017-18 Budget that it will provide $803 million over four years from 2017-18 for psychosocial support services for people with mental illness who do not qualify for the NDIS but are existing clients of Commonwealth-funded psychosocial services (such as the Partners in Recovery, Day to Day Living Program and Personal Helpers and Mentors programs). This funding is to be delivered by PHNs through a stepped care approach. Overall responsibility for funding psychosocial support services is shared between the Commonwealth and States and Territories, and accordingly, this funding is contingent on a matching commitment from the States and Territories. This will ensure a national approach to maintaining community mental health services outside the NDIS. This funding remains contingent on the agreement and contribution of the states and territories.
- *Continuity of support (budget in confidence:* the Australian Government recognises that continuity of support will be vital in people's transition to the new arrangements for support of severe mental illness and psychosocial disability. While primary and acute care will continue to be covered through the MBS and the NDIS will fund specific disability needs around MBS supports, it is expected that some people eligible for existing Commonwealth support will no longer be eligible. These people may have been eligible under a range of supports which ceased with the commencement of the NDIS. For these people, the Commonwealth is committing new funding for

community mental health services (such as respite care) to provide continuity of support until long-term support arrangements (if requirements) are found. This funding is time limited and not contingent on the states and territories.

Successful implementation of the NDIS is based on the availability services to respond to participants' needs and information and support available to participants and their families to exercise effective choices. Sector capacity is particularly important in rural and remote areas where historically the number and range of services has been limited. The Government established the Sector Development Fund (SDF) to support the substantial changes required in the disability sector to realise the vision of a flourishing support market driven by the choices and needs of people with disability. Specifically, the SDF funds projects that are intended to:

- build community capacity and engagement
- increase capacity of people with disability and their families to exercise choice and control and develop new forms of support to meet the needs of people with disability
- build disability sector capacity and service provider readiness to manage the NDIS transition
- assist with the expansion and diversification of the workforce required to meet increased demand
- build the evidence base about what works.

In June 2017, the NDIA Board commissioned McKinsey & Company to undertake an Independent Pricing Review, whose purpose was to assist with providing a vibrant provider market to deliver quality and timely supports to participants. The NDIA has been engaging with providers and peak bodies to understand the best way of implementing the recommendations, with a view to ensuring robust implementation. A recommendation about how to respond to people with complex care needs has been endorsed in principle, but in consultation with the sector, it has become apparent that the implementation this recommendation requires further detailed work. That work is being undertaken as a matter of priority.

9.3 Youth suicide prevention trials and other initiatives

As highlighted in Part 5, suicide is a national challenge that is felt acutely in rural and remote areas. The rate of suicide in rural and remote areas is approximately 40 percent higher than in major cities.[71] Meanwhile, the rate of suicide amongst men aged 15 to 29 years who live outside major cities is almost twice as high as it is in major cities. Furthermore, the rate of suicide among Aboriginal and Torres Strait Islanders aged 15 to 24 years old is 3.7 times higher than with non-Indigenous young people in the same age bracket.[72]

The acute obstacles faced by youth in local remote and rural communities have been recognized by Federal, state and territory governments, with focus being placed on providing long term solutions to the higher prevalence of poor mental health in rural and remote regions. This submission has already documented numerous youth-related online and community mental health initiatives, but four areas of activity are worthy of discussion in greater detail.

Primary Health Networks (PHNs) – flexible and quarantined funding

The Australian Government provides PHNs with flexible funding, including quarantined funding allocations for severe youth mental health need, suicide prevention and delivery of psychological services. Approximately 32 per cent of the quarantined funding component is tied to early psychosis youth services and suicide prevention initiatives through headspace. The Australian Government has committed a further

[71] Australian Institute of Health and Welfare. Mortality Over Regions and Time (MORT) books – web report, November 2017, accessed 30 April 2018

[72] National Rural Health Alliance, Fact Sheet – December 2017, Mental Health in Rural and Remote Australia

$28.9 million in 2018-19 to establish additional headspace services young people aged 12 to 25 years.[73] This additional funding will help to boost headspace locations across Australia, including increased representation outside metropolitan centres. Initiatives such as the one in Katherine (see earlier Case Study) embody the Australian Government's commitment to deliver early intervention youth mental health services to young people in rural and remote areas. [74]

Youth suicide prevention trials

In 2016, the government has committed an additional $192 million to the establishment of four new suicide prevention trial sites, bringing the total number up to twelve.[75] These sites are a sign of the government's commitment to supporting Aboriginal and Torres Strait Islander and remote communities, youth and veterans. For one trial site in Kimberley, Western Australia, the age-adjusted rate of suicide is more than six times the national average. The launch of such initiatives is an attempt to tackle such troubling statistics. [76] Within each region, the local PHNs commission the trials to bring together best practice, expertise and local knowledge to tailor mental health solutions specific to community needs. Commissioning them through local PHNs is done to ensure a focus on community education, integrating services at the local level and ensuring that there is capacity for post-discharge follow up.

eheadspace

eheadspace has developed a novel moderated online social therapy intervention called enhanced moderated online social therapy. This therapy approach integrates real-time clinician-delivered Web chat counselling, interactive user-directed online therapy, expert and peer moderation, and private and secure peer-to-peer social networking. It has been designed specifically to give young people immediate, 24-hour access to anonymous, evidence-based, and short-term mental health care. This approach is a central pillar to delivering high quality mental health supports outside metropolitan Australia.

The Australian Government prioritises eheadspace support for young people and families who have limited access to support across rural and remote areas. Since eheadspace commenced in 2012, 25.5 per cent of serviced clients were in rural or remote locations. This compares with 28.2 per cent of Australians living outside major cities. An independent evaluation of headspace in 2015, found that almost one third of headspace clients that received services at a centre also used eheadspace. Hence, the online service can play a role in linking young people in regional areas and boosting the capacity of headspace to provide services in rural and remote regions. Recent five-year data on eheadspace usage also indicates that overall, there has been a gradual increase in service usage amongst young people in these areas, which is a measure of success.

Other initiatives

A survey commissioned by *beyondblue* in February 2015 revealed that the main reason nearly 80 percent of young people did not get help for anxiety or depression was the fear of resulting social stigma. *beyondblue*, which receives significant funding from the Australian Government, provides many different programs targeted at mental health problems facing young populations. Many of these resources are available online, making access from rural and remote areas a possibility.

Although specialist mental health services continue to provide vital services for younger generations suffering from mental health issues, research has shown than early signs of mental health struggles are

[73] Department of Health 2016-17 Health Portfolio Additional Estimates Statements, p.8

[74] Northern Territory Primary Health Network. Anglicare NT to deliver headspace services in Katherine, 2018, accessed 1 May 2018

[75] National Rural Health Alliance. New suicide prevention trial sites in rural Australia, 2017

[76] The Hon Sussan Ley MP. Suicide prevention trial for Kimberley region, 2016, accessed 2 May 2018

largely picked up on within in primary care and the education system. With individual counselling being cited as a main method of coping with mental stress for youth across wider Australia.[77]

As a result, it is being recognized that educational institutions in remote and rural areas may also need assistance to be able to provide the same support received by students as in metropolitan areas. Initiatives such as MindMatters have attempted to provide schools in remote and rural areas with the resources, along with support from *beyondblue*, to be able to develop their own unique mental health strategies that target the most relevant issues facing local school communities.

The Australian Government has committed $6 million to bring the mental health conversation into mainstream education channels, which, with time, can play a large role in reducing the stigma that leads to less people speaking out about the problems they are facing, Further, funding has been provided to ReachOut which is an online tool aimed at allowing youth to access self-help on a digital platform. The service also provides immediate telephone counselling and support in a crisis. In addition to funding from the Australian Government, it is also backed by corporate, community and philanthropic donations to remain a free-to-use service.[78]

9.4 Refugees and survivors of trauma

Australia has a long record of providing support to refugees that have experienced torture and trauma prior to their resettlement. The Program of Assistance for Survivors of Torture and Trauma (PASTT) provides one seamless program of mental health services to assist refugees successfully settle in Australia. The aim of PASTT is the development of resources to support and enhance provision of specialist counselling and related support services for settlement. It provides mental health and other supports to those who are experiencing psychological and/or psychosocial difficulties resulting from their pre-migration experiences of torture and trauma.

PASTT services are delivered by member agencies of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT). The Australian Government also supports FASSTT which is a network of eight not-for-profit torture and trauma support agencies, one in each capital city, which also provide services in regional Australia. FASSTT coordinates information and training resources to support GPs in the delivery of care to refugees who have experienced torture and trauma. These initiatives are important mental health supports for refugees and survivors of torture and trauma who live in rural and remote Australia.

The Australian Government seeks to encourage the regional and rural settlement of humanitarian entrants where possible. The Humanitarian Settlement Program currently refers humanitarian entrants that arrive without existing links or proposers into 25 designated locations across Australia, including 19 regional locations. In recent years, approximately 20 per cent of humanitarian entrants have arrived without a link or proposer. Wherever possible such entrants are settled in regional locations. In addition, the Safe Haven Enterprise Visa (a temporary visa available to Illegal Maritime Arrivals who are found to engage Australia's protection obligations), encourages regional settlement by making permanent visa pathways available to those who have worked or studied in areas deemed regional. For refugees or survivors of trauma living outside metropolitan Australia, both PASTT and FASSTT are important means of support.

[77] Australian Institute of Family Studies. Young Minds Matter: Use of services by young people with mental disorders, 2016, accessed 2 May 2018

[78] See: ReachOut, accessed 2 May 2018

10 Conclusion

The impact of mental illness touches every Australian. For some it may be a profound decline in quality of life, while for others it might be the personal pain of losing a loved one. The struggles and stigma associated with mental illness may impact on the formation of lasting relationships, gaining secure employment or maintaining community connection. Although the prevalence of mental illness is similar between urban and regional Australia, barriers of awareness, accessibility and quality of mental health services contribute to much higher levels of need in rural and remote locations.

For several decades, the Australian Government has had a strong commitment to improving health care in rural and remote Australia, including in mental health. Amongst these have been numerous initiatives to encourage better access to more local GPs, who are often the first point of contact in accessing mental health services in rural and remote communities.

The Fifth National Mental Health and Suicide Prevention Plan built on this past commitment by bringing together a national approach for the Commonwealth, states and territories to provide better mental health and related services in Australia. This Plan demonstrates the Australian Government's commitment to working collaboratively to deliver mental health services in an integrated system.

A key feature of the Fifth National Mental Health and Suicide Prevention Plan was its focus on the limitations identified in previous plans, with an emphasis on integrated local planning at the regional level. While the role of the Australian Government in this field is not new, the Plan demonstrates its commitment to drive this new emphasis, while ensuring national consistency in implementation and local flexibility to design stepped-care models. This focus on regionally and locally tailored approaches will be crucial to ensuring improved access to mental health services in rural and remote areas.

Primary Health Networks are a key point of Commonwealth support for integrated regional planning, better coordinated funding and commissioning to complement local service gaps. Currently, the Australian Government is supporting rural and regional PHNs to develop innovative new models and trials of integrated mental health care. The headspace program, which is coordinated by local PHNs, is another example of the Australian Government's focus on local service delivery and responding to individual needs A series of trials and new sites for this program are currently being placed in regional areas to support services that respond to local and individual needs.

The growing recognition of the national significance of the impact of suicide in the Fifth National Mental Health and Suicide Prevention Plan, particularly in rural and remote regions, has also been endorsed by the Australian Government. Currently, it is funding national suicide prevention trials and new infrastructure around suicide hot spots. The Australian Government is also delivering on its commitment to provide digital responses to support mental health and suicide prevention, with services including more rural online access to the Better Access initiative and complementing other mental health initiatives with expanded telehealth support.

The above actions have already made a difference for the mental health needs of people in rural and remote areas. Some initiatives are having immediate impact, while others will take time to consolidate and improve as the PHN minimum data set grows to inform better policy and service decision-making.

Since the release of the Fifth National Mental Health and Suicide Prevention Plan, Australian governments have together made significant progress in improving access and quality of mental health and suicide prevention services for rural and remote areas. A strong foundation has been laid for current and future action, but there is still some way to go.

Appendix A Abbreviations, acronyms and references

The following acronyms have been used in this submission.

Acronym	Definition
ABS	Australian Bureau of Statistics
AIHW	Australian Institute Health and Welfare
AON	Areas of need
ATAPS	Access to Allied Psychological Services
COAG	Council of Australian Governments
DWS	District of workforce shortage
FIFO	Fly-in-fly-out
GP	General Practitioner
GDP	Gross domestic product
LHN	Local Hospital Networks
MBS	Medicare Benefits Scheme
MHPOD	Mental Health Professional Online Development
MHNIP	Mental Health Nurse Incentive Program
NGO	Non-governmental organisation
NSMHS	National Standards for Mental Health Services
NSQHS	National Safety and Quality Health Service
OECD	Organization for Economic Cooperation and Development
PBS	Pharmaceutical benefits scheme
PHN	Primary Health Network
RAMUS	Rural Australian Medical Undergraduate Scholarship
RFDS	Royal Flying Doctor Service
SES	Socioeconomic status

Appendix B Australia's Network of PHNs