Community Mental Health Australia submission to inquiry into accessibility and quality of mental health services in rural and remote Australia

Introduction

Community Mental Health Australia (CMHA) would like to thank the Senate Standing Committee on Community Affairs for the opportunity to make a submission to the inquiry into the accessibility and quality of mental health services in rural and remote Australia.

CMHA is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. CMHA provides a unified voice for approximately 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

CMHA promotes the recovery of people living with a mental health condition so that they are contributing citizens and included in all the economic and social aspects of their community. The organisation presents a united and representative voice for the community managed mental health sector who work every day on mental health issues and have the expertise through a specialised workforce, including a peer workforce and lived experience.

The challenges that impact mental health in general across the country such as workforce, including quality and availability; service availability and quality; and the impact of reform processes, are amplified in rural and remote areas and add to the challenge of dealing with these factors. The National Disability Insurance Scheme (NDIS) and the Primary Health Networks (PHNs) are significant influencing factors in what services will be available into the future in rural and remote areas. Also the intersection with issues for Aboriginal and Torres Strait Islander communities and how this links to engagement with the community managed mental health sector, are important factors in the accessibility of mental health services.

CMHA's submission will not directly address the inquiry terms of reference, but will focus on the following issues that are relevant to all aspects of the Committee's inquiry process:

- Workforce, including workforce planning
- Impact of the NDIS
- Aboriginal and Torres Strait islander communities, including engagement of the community managed mental health sector with Aboriginal and Torres Strait Islander communities
- Stakeholder views on the key issues with the quality and accessibility of services

A number of the issues raised in this submission have been raised by CMHA in other Committee inquiry processes.

Workforce

A central part of delivering quality mental health and psychosocial supports is the workforce, to ensure there is an informed and properly planned approach to developing, supporting and maintaining the workforce to deliver the range of mental health reforms that are occurring. CMHA's 2017-18 Federal Pre-budget submission recommended a National Mental Health Workforce Strategy be undertaken to develop, support and maintain the mental health workforce. This should include the community mental health sector, the mental health peer workforce, and the primary health workforce. This is particularly important for rural and remote areas where the workforce is already limited and required to cover large distances.

CMHA notes that the Implementation Plan for the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) includes the development of a Workforce Development Program to guide strategies to address future workforce supply requirements and assist with recruitment and retention of staff. Specifically looking at rural and remote areas and the inclusion of the community mental health workforce in this Program will be vital, as the various reforms in mental health are having an impact on the workforce in community-managed mental health sector.

CMHA also notes that the 2018-19 Federal Budget includes provisions and funding for a rural health strategy and we would urge this to incorporate a focus on mental health.

CMHA's members are actively engaged in activities addressing access to services in rural and remote areas, particularly as it relates to the availability of the workforce to provide these services.

The Mental Health Coordinating Council (MHCC) NSW undertook a sector mapping project with a report published in 2000 demonstrating that most community sector mental health programs were clustered in metropolitan areas. The results of a repeat MHCC NSW sector mapping was reported in 2010 and demonstrated growth for community sector mental programs outside of regional areas. Growth of community sector mental health services in regional, rural and remote areas of NSW, and its workforce, is a trend that continues to this day[1]. However, all regional, rural and remote community sector infrastructure established through Federal Government funding and programs is at risk through NDIS implementation.

MHCC undertook strategic community sector workforce development and capacity building from 2006. This was done in response to sector growth and the identified need to build a workforce able to respond to people affected by mental health conditions that extends beyond, for example, doctors/psychiatrists, nurses and psychologists, that is community sector mental health workers including but not limited to peer workers. This has included consideration of regional, rural and remote areas.

Between 2011 and 2014, MHCC represented CMHA in contributing to a Health Workforce Australia Advisory Group guiding their mental health workforce reform initiative. The initiative was established in

[1] Mental Health Coordinating Council (2010). The NSW Community Managed Mental Health Sector Mapping

response to projected severe mental health workforce shortages by 2025 – especially for regional, rural and remote Australia. The value of community sector mental health workers, including but not limited to peer workers, was highlighted across their mental health workforce reform work.[2] CMHA notes that while this work has since been superseded by a number of reforms including the transferring of federal mental health program funding to the PHNs and NDIS and the Fifth Plan, this is valuable research and information that should be used to inform the work of all governments.

Impact of the NDIS

The Mind the Gap project and report undertaken by University of Sydney in partnership with CMHA[3] found that in some instances NDIS participants were unable to implement NDIS plans as the services were not available. The project engaged with over 60 stakeholders across consumers, carers and service providers in Western Australia, the Northern Territory, Queensland, New South Wales, the ACT and Victoria. Stakeholders described a frequent inability to find an available provider for services. Lack of providers was a national issue, it was particularly emphasised in rural and remote contexts where often no service providers existed. Where services did exist, the market was very limited with consumers having no choice of provider[4].

Stakeholders explained that their organisations had decided not to provide services in rural and remote environments because they were unable to provide quality, safe service within the pricing structures of the NDIS. Some of the reluctance to work in rural and remote regions was related to the slow roll out of the scheme and therefore work-load was not high enough to make it viable. The lack of recognition of the extensive time involved in travel in rural and remote regions within NDIS pricing structures also greatly impacted on the ability to deliver financially viable service[5].

CMHA notes the recommendations in the McKinsey Independent Pricing Review for the NDIS allowing providers to charge up to 45 minutes of travel time in rural areas; and allowing providers to quote on the delivery of services in isolated areas[6]. CMHA has heard anecdotally that the 45 minutes increase will assist in immediate service provision in a regional are but is not likely to address issues in those areas, particularly rural, which require longer travel distances for both NDIS participants and service providers.

---

[2] Appendix ii: Health Workforce 2025 – summary, Review of Australian Government Health Workforce Programs, Australian Government Department of Health, http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~appendices~appendix-ii-health-workforce-2025-summary

[3] Mind the Gap: The National Disability Insurance Scheme and psychosocial disability, Final Report: Stakeholder identified gaps and solutions. January 30th 2018, The University of Sydney, Sydney Policy Lab and Community Mental Health Australia

[4] Ibid

[5] Ibid

[6] McKinsey and Company (2018) Independent Pricing, National Disability Insurance Agency, Final Report, February 2018

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601

Aboriginal and Torres Strait communities

The Productivity Commission inquiry into Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform identified remote Indigenous communities as one of the target areas for competition. CMHA's submission to the second stage of the inquiry – the Study Report - questioned the rationale for including services to remote Indigenous communities for consideration is unclear. CMHA agreed with the Productivity Commission's comments that these areas are underserviced, particularly in mental health, and that there are fragmented and complex funding arrangements which create difficulties.

CMHA believes the key issue is looking at how to build the capacity of existing local services in remote Indigenous communities, and developing an understanding of current services to then identify the gaps and improve quality, equity, efficiency, accountability and responsiveness via this pathway. In remote Indigenous communities adding, building and investing in local people to develop and deliver programs and services needs to be highlighted. This is the same approach which should be taken with the NDIS in other thin markets including in rural and remote areas in general, along with examining best practice.

CMHA has highlighted in a number of submissions an example of a best practice community-led mental health program model. The example is a community-developed and community-led mental health program in a community in East Arnhem called Galiwin'ku. Galiwin'ku, a Yolngu community of approximately 2500 people, situated on Elcho Island. The health service – Ngalkanbuy – was managed by the local council until 2008 when Miwatj Health Aboriginal Corporation took over management. Ngalkanbuy provides a 24/7 service and is characterized by the prominent role of local Yolngu in its staffing profile.[7] The Healthy Minds team runs the mental health program. This team undertakes activities such as monthly and fortnightly injections and supervised daily administration of oral medication. The team works collaboratively with families, with much of their work undertaken in the community (rather than in the clinic). They respond to acute situations and people with chronic mental health conditions, this includes responding to overnight emergencies.[8]

The Productivity Commission's Final Report of the competition inquiry acknowledge that effective service provision in remote Indigenous communities required strategies that suit particular circumstances, builds local capacity and enables the communities themselves to influence the services they receive. CMHA reiterates that a better approach is looking at how you can build the capacity of existing local services and develop an understanding of current services to then identify the gaps, and improve quality, equity, efficiency, accountability and responsiveness via this pathway.

CMHA supports the Aboriginal Community Controlled Services (ACCHS) being considered the preferred providers for health services for Aboriginal and Torres Strait Islander people, and calls on Government to

[7] Ngalkanbuy health service at Galiwin'ku, Miwatj Health Aboriginal Corporation, http://miwatj.com.au/what-we-do/clinical-services/at-galiwinku/, Accessed 8 February 2017

[8] Ibid

ensure this is done collaboratively with the community-managed mental health sector to extend and retain the expertise that exists in the community-managed mental health sector. This once again should be about providing the conditions for collaboration and strong relationships between different sectors.

Stakeholder views on the key issues with the quality and accessibility of services

Western Australia

The Western Australia Association for Mental Health (WAAMH) conducted a consultation survey regarding the Committee inquiry - 195 responses were received. Input was received from respondents from all regions of WA, with the following percentages for each region: Gascoyne 2%, Goldfields-Esperance 8%, Great Southern 16%, Kimberley 10%, Mid West 6%, Peel 3%, Pilbara 5%, South West 22% and Wheatbelt 26%.

Respondents identified as either a person who uses mental health services (30.4%), a carer or family member of someone who uses mental health services (30.4%) or a provider of mental health services (35%).

The key themes from the survey were:

- Shortage of services is a primary concern for people in the regions
- Shortage of community and preventative services are the top priority, followed by lack of acute services
- Stigma plays a key role in deterring people from accessing services and is a significant barrier to delivering services in the regions
- Social determinants affect mental health in regional areas, with alcohol and other drug use issues, social isolation and stress identified as the most significant
- There are a range of issues associated with accessing NDIS services in regional areas

Respondents were asked three questions regarding access to mental health services in regional areas. Respondents were asked about the main challenges to seeking support for mental health in their area and about problems with accessing mental health services in the regions, and were asked to provide information about what services or changes were needed to improve mental health services in regional areas. The table below summarises the main challenges to seeking support for mental health services.

Shortage of community mental health services	73.33%
Shortage of preventative mental health services	71.79%
Shortage of emergency mental health services	66.15%
Stigma	64.10%

Social isolation	63.59%
Lack of support services	59.49%
Mental health services too far away	51.28%
Lack of employment opportunities	43.59%
Lack of housing services	40.51%
Mental health services too expensive	35.38%
Shortage of doctors	32.31%

Respondents were also asked to explain what factors contributed to problems with accessing mental health services in their area. Notably, 83% of respondents indicated that there were factors contributing to difficulties in accessing mental health services in their region. The most common factors were a lack of services at 42.2%; distance to services at 27.7%; lack of staffing at 19.8%; and transport at 13.3%.

Improvements to increase access included – increased community support services (including families and carers) 36.4%; increased acute services 19.2%; 16.4%; and increased information and education resources for communities 15.8%.

Providers of mental health services identified the issues, which were the main barriers to delivering services in regional areas, including remoteness (including distance from clients and other services) 23.8%; funding 22%; stigma 17.5%; and lack of access and connection to other services 17.4%. Staffing issues were also a factor including lack of staff (14.3%) and lack of appropriately trained staff (12.7%), and high staff turnover (11.1%).

Respondents were also asked to identify the challenges to accessing disability services related to mental health needs through the NDIS in regional areas (33 responses). The main factors were lack of available services (21.21%), and being ineligible for disability services related to mental health needs under the new NDIS (27.27%). Other issues were identified (27.27%) being the significant investment of time and resources required to complete applications for the NDIS; the lack of training for both clients and professionals on how to complete paperwork; and unacceptably long waiting times for processing and outcomes of NDIS applications.

Tasmania

The Mental Health Council of Tasmania (MHCT) conducted a survey of members for the Committee inquiry – 123 responses were received. Respondents identified as a person who uses mental health

services (30.08%); a carer or family member who uses mental health services (25.20%); a provider of a mental health service (19.51%); and other (25.20%).

The main challenges to seeking support for mental health in rural or remote areas were:

Access to a range of services	78.86%
Access and availability of GPs	47.97%
Cost of services	57.72%
Transport to services	50.4%
Having to take time off from work or family commitments to travel to services	39.02%
Admitting and recognising the need for support	51.22%
Knowing which supports are available and how to access them	82.11%
Anonymity within small communities	48.78%
Other (included lack of supports, access times, access to mental health services)	30.89%

The main issues affecting people's mental health were:

Lack of housing	52.85%
Unemployment	73.98%
Lack of income	67.48%
Negative community attitudes about mental health issues	54.47%
Social isolation	82.93%
Lack of community support	53.66%
Stress	76.42%
Access to food	21.95%
Access to transport	47.15%
Violence	52.85%
Alcohol and other drug use	75.61%
Trauma	61.79%
None of these things affect mental health in my area	1.63%
Other (included knowledge of service access, quality of services, stigma)	20.33%

Queensland and the Northern Territory

The Queensland Alliance for Mental Health (QAMH) and the Northern Territory Mental Health Coalition (NTMHC) have provided a joint submission to this Committee inquiry. The following information summarises the key issues for Queensland and the NT.

In terms of why people in rural and remote areas are accessing mental health services at a much lower rate:

- Stigma is a dominant issue including the need for privacy when everyone is known to each other; the difficulty in recruiting health professionals to rural areas - living in the community they are not able to separate their personal life from their rural setting; and people prioritising running a business (such as a farm) before personal health.
- Changing nature of the mental health workforce, such as a lack of experienced, mature-aged professionals and the churn of younger professionals. This makes people in rural and remote areas less likely to seek treatment.
- Accessibility to services - GPs are the first point of call for many people, but it is difficult to get into see them. There is a lack of bulk-billing GPs, which can mean higher costs in lower socioeconomic regional areas. There is also a lack of awareness amongst GPs of mental health issues.
- The lack of options when people want to seek treatment - if there is only one type of service and it is not tailored to the specific individual they have no other choice. For example, a service might not be suitable for an Aboriginal and Torres Strait Islander person.

Specific NT issues included:

- Social determinants of health – poverty, unemployment, drug and alcohol use, family violence and chronic disease are central to high rates of distress (particularly among Aboriginal and Torres Strait Islander people).
- The mental health system is skewed to high intensity services, which are under-resourced and not properly equipped to provide supports across large regions.
- Not enough mental health training amongst GPs.
- Difficulties around recruitment and retention of staff.

For both Queensland and the NT, Aboriginal and Torres Strait issues and the differing cultural needs in these communities is a significant issue. Mental health services are not meeting these needs, which is limiting access.

The challenges of delivering mental health services relate to attracting and retaining suitably trained staff into these communities and is an ongoing mental health workforce challenge. Specific issues include:

- Difficulty in attracting people with the right skills
- Cost of attracting and retaining staff in rural locations
- Inability to keep staff in regional locations for a prolonged period of time
- Need for better professional development programs in regions
- Uncertainty of short-term contracts
- Staff burnout

Organisations hiring staff in rural and remote regions face significant recruitment and training costs, adding to the difficulty in retaining staff. The uncertainty around funding contracts adds to the challenge of attracting the right staff into communities - for example the lack of certainty about an existing contract being renewed and staff leaving due to the uncertainty can increase costs. The NT has supported a well-trained and supported Aboriginal mental health workforce as a way of delivering culturally engaged mental health care in the NT.

Other challenges relate to limited services meaning longer wait times which impacts on the attitudes towards services, and travelling large distances to access services which costs more money and takes more time.

Opportunities for telehealth should be explored further and enhanced to address concerns regarding stigma and that a clinician providing a service knows friends or family. It can link people directly to experienced professionals connected to other services, and provide access to a service typically unavailable or that would require significant travel distances. The key issue for telehealth will be for properly trained staff using these services, and addressing the difficulties for internet connection in more remote communities, particularly in Aboriginal communities.

Conclusion

The challenges that impact mental health in general across the country such as workforce, service availability and quality and the impact of reform processes, are amplified in rural and remote areas and add to the challenge of dealing with these factors. The NDIS and PHN reforms are significant influencing factors in what services will be available into the future in rural and remote areas.

The key points made by CMHA in this submission are:

- A central part of delivering quality mental health and psychosocial supports is the workforce, to ensure there is an informed and properly planned approach to developing, supporting and maintaining the workforce to deliver the range of mental health reforms that are occurring. The Implementation Plan for the Fifth Plan includes the development of a Workforce Development Program to guide strategies to address future workforce supply requirements and assist with recruitment and retention of staff. Specifically looking at rural and remote areas and the inclusion of the community mental health workforce will be vital.
- The Health Workforce Australia Advisory Group guided the mental health workforce reform initiative in response to projected severe mental health workforce shortages by 2025 – especially for regional, rural and remote Australia. While this work has since been superseded, this is valuable research and information that should be used to inform the work of all governments.
- The Mind the Gap project and report identified a lack of providers as a national issue, which was particularly emphasised in rural and remote contexts where often no service providers existed. Where services did exist, the market was very limited with consumers having no choice of

provider. The lack of recognition of the extensive time involved in travel in rural and remote regions within NDIS pricing structures also greatly impacted on the ability to deliver financially viable service. CMHA notes the recommendations in the McKinsey Independent Pricing Review for the NDIS allowing providers to charge up to 45 minutes of travel time in rural areas, however it may not address issues in areas, particularly rural, which require longer travel distances for both NDIS participants and service providers.

- In Aboriginal and Torres Strait Islander communities, the key issue is looking at how to build the capacity of existing local services in remote Indigenous communities, and developing an understanding of current services to then identify the gaps and improve quality, equity, efficiency, accountability and responsiveness via this pathway. Adding, building and investing in local people to develop and deliver programs and services needs to be highlighted.
- CMHA supports the ACCHS being considered the preferred providers for health services for Aboriginal and Torres Strait Islander people, and calls on Government to ensure this is done collaboratively with the community-managed mental health sector and to retain the expertise that exists in the community-managed mental health sector.
- Common issues across the country for rural and remote communities are availability, shortage and access of and to services; the role of stigma in deterring people from accessing services; and social determinants affecting mental health including alcohol and other drug use issues, social isolation and stress. People also have to travel longer distances and pay a higher cost to access the services they need. These issues of affordability, availability and responsiveness must be addressed to encourage people to access mental health services. If there are more available and responsive services, delivered by experienced staff with a demonstrated commitment to the community, then attitudes are likely to improve and more people are likely to seek treatment.
- Increasing access to community services and providing information to consumers, families and carers are also factors which would improve both service access and provision.
- Opportunities for telehealth should be explored further and enhanced, however they require properly trained staff and must address difficulties for internet connection in more remote communities.