Advice and recommendations

Specific challenges for regional, rural and remote Australia
in support of

THE 2014 NATIONAL REVIEW OF MENTAL HEALTH
PROGRAMS AND SERVICES

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1 Executive Summary

Location matters for the mental health of approximately thirty per cent of Australians who live outside our major cities. Despite the numbers of people potentially affected, Australia is without an agreed approach nationally to mental health service delivery in regional, rural and remote areas and for closing the gap between city and non-city dwellers.

This report concludes that access to the advice of specialist mental health professionals in emergency situations, 24-hours a day, 7 days a week and year round, is now possible – no matter how remotely a person might live. Suggestions are outlined for achieving this goal.

1.1 The main indicators of access to mental health services and supports and the level of inequity of access across geographical areas

Conclusions about indicators of access to mental health services in regional, rural and remote Australia are limited because current indicators are derived on sparse data across geographical areas and an underlying framework emphasising volume and activity as indicators of service provision rather than outcomes and quality. For example, there is no clear statistical evidence that geography is a significant factor affecting perceived need for specific types of mental health services by people with a lifetime mental health disorder.

However, there is some evidence of a relationship between socio-economic disadvantage and presentation of mental illness in regional, rural and remote areas (particularly outer regional and remote) in respect of per capita service provision (McLachlan et al., 2013).

While differences between rural and metropolitan communities are easily recognised, it is important to recognise there are also wide variations between regional, rural and remote communities. These variations may relate to geography, community and population characteristics, socioeconomic circumstances,
infrastructure and health status, which can strongly influence the mental health and wellbeing of people and communities or their ability to access the services they require. As a consequence, no ‘one size fits all’ approach can be applied across all parts of regional, rural and remote Australia. The application of broad-brushed national measurement and policy approaches will be limited if based on geographical areas or distance from mainstream services alone.

A conceptual framework that describes place-based dynamics and the way that mental health issues interact with other issues (such as education, employment, housing, physical health, drug and alcohol use and other risk factors) provides a reference point for guiding change in service provision.

Outcome-oriented project, program, and place-based indicators need to be developed to create a more robust, meaningful framework for service provision.

Indicators of integration of mental health services with other local service provision to reflect a systemic framework would be beneficial to understanding access in regional, rural and remote communities.

1.2 Differences in access across States/Territories and contributing factors

There is insufficient existing and publically available data to derive meaningful conclusions about differences in access to mental health services across States/Territories. Having said this, the following observations are noted:

- State and territory average expenditure on specialist mental health services was $198 per person in 2011/12 and ranged between $182 in Victoria and $243 in Western Australia.
- There is some evidence of a higher dependence on publically provided services and non-specialist hospital care in non-urban areas.
- Whilst rates of community mental health service contacts averaged at about 300 per 1000, Queensland reported 230 and the Northern Territory reported 175.
Though caution is needed in interpreting this data, a factor contributing to these reported differences in health service utilisation appears to be the relative shortage of specialist and generalist clinicians in outer regional, rural and remote communities that limits the number of services provided and rebates claimed.

1.3 **Factors contributing to the inequity of access to mental health services and supports between metropolitan areas and regional, rural and remote areas in Australia**

The unique geographic, cultural, social, and economic characteristics of places in regional, rural and remote Australia provide the basis for understanding factors that contribute to inequity and how they may be addressed.

Underlying place-based systematic characteristics, especially socio-economic and cultural characteristics, can interact with dimensions of service provision to drive inequity.

Inequity in the opportunity for people from regional, rural and remote communities to live a ‘contributing life’ is a useful way of understanding factors contributing to inequity.

1.4 **Key features of metropolitan-rural-remote inequity more generally that impact on mental health service access and outcomes**

Metropolitan-rural-remote inequity is expressed statistically in the following ways.

- Lower life expectancy (COAG Reform Council, 2014).
- Access to Medicare-funded services diminishing with increasing remoteness (AIHW, 2013).
- Reduced health workforce distribution (AIHW, 2013).
- Lower rates of mental health service access, with access to psychological services significantly less than in major cities (AIHW, 2013).
- Reduced survival rates once diagnosed with a health problem (COAG Reform Council, 2014).
- Lower levels of education and educational outcomes (AHMAC Standing Council on Health, 2012).
- Lower levels of literacy (AHMAC Standing Council on Health, 2012).
- Reduced access to infrastructure; communications and cost to access services (AHMAC Standing Council on Health, 2012).

To complicate matters, physical illness commonly coexists with mental health problems in the form of dual diagnosis and co-morbidity (CRRMHQ, 2011).

Living outside the major cities exposes people to a number of risk factors; a fact which underlines the need for governments to improve access and services to people living in rural and remote Australia (AHMAC Standing Council on Health, 2012).

1.5 Key challenges

A major challenge arises from the clumping together of regional, rural and remote areas, despite the complexity of their diversity, for the purposes of service planning and delivery. Though regional, rural and remote communities can face significant hardships, they report higher levels of satisfaction with life than their city counterparts (National Rural Health Alliance, 2014). A challenge in closing the gap in mental health service access and outcomes is to harness the resilience, innovation, creativity and social capital that reside within these communities.

Additional specific challenges include:

- Finding solutions given the diversity of regional, rural and remote communities – figuring out what works where;
- Addressing the multifaceted nature of inequity of mental health service access and outcomes including lower educational and literacy levels;
- Maximising local access and thereby freeing up resources;
• Tackling barriers to seeking help for mental health issues; and
• Building and sustaining fit for purpose workforces.

1.6 Advice and recommendations on the appropriate use of technology

We have concluded that the technology now exists to enable a person, no matter how remotely they live, and no matter the time of day or year, to access the advice of specialist mental health professionals in emergency situations. There is sufficient evidence confirming that when specialist mental health and recovery support professionals and services cannot be present on the ground, it is now possible to provide the necessary assistance and interventions in real time via telephone or over the internet via computers, iPads and other hand-held devices.

We have concluded that to make this happen there is the need for national leadership (possibly under the auspice of the Australian Health Minister’s Advisory Committee) to ensure national coverage of telepsychiatry and other telemental health services and to develop nationally agreed guidelines for the use of these services. (Suggestion 11)

We have also recommended the strengthening of action nationally to promote e-mental health services with a particular focus on targeting regional, rural and remote communities (Suggestion 9). Again, every Australian no matter how remotely they live, needs to be in the know about these programs and services and how they can access them.

Health and community professionals also need to be in the know about e-mental health services and programs. For this reason, we have recommended national leadership through the Australian Government E-Mental Health Support Service to embed the use of e-mental health services as a routine form of treatment, recovery support and referral pathways. This could be achieved through the upskilling and training of all primary health, allied health and specialist mental health professionals with a particular focus on regional, rural and remote Australia. (Suggestion 10)

Attaining 24-hour coverage, seven days a week is now within our reach.
1.7 Advice on workforce distribution and access to an appropriate workforce

We have provided advice about the current inequitable distribution of health workforces including mental health professionals. To ensure a fit-for-purpose workforce with the appropriate skills and aptitudes required, we have emphasised the need to consolidate the roles and competencies of existing health, allied health and community professionals. We have also emphasised the need for the development of new workforces comprising community members and including those with personal experience of mental illness.

To achieve these tasks, we have recommended the promotion, implementation and evaluation of regional recruitment mechanisms to engage people in both generalist and specialist mental health career pathways in regional, rural and remote Australia, targeting areas and communities that need it most, such as socioeconomically disadvantaged areas that are underserviced by the current system, and where there is evidence to suggest the efficacy and sustainability of recruitment and retention strategies. (Suggestion 18)

We have also recommended the expansion of the Rural Health Continuing Education Stream 2 (RHCE2) to include a focus on supporting the generalist workforce to mental health emergencies as well as working with people with co-morbidities (Suggestion 19). The augmenting of other similar training and continual education programs could also be considered.

Further to ensure professionals working throughout regional, rural and remote Australia have access via a one-stop-shop to credible sources of information regarding evidence-based approaches to treatment, care, support and service development, we have recommended the collaborative development of a national mental health e-learning portal by existing national organisations with a relevant remit. (Suggestion 20)
1.8 Models of care in mental health and approaches to address challenges for regional, rural and remote communities

An overarching conclusion of this report is for the development of a nationally agreed conceptual framework to guide mental health service delivery in regional, rural and remote Australia and its governance, which promotes the development, implementation and evaluation of regionally and locally relevant models and pathways for stepped and integrated care (Suggestion 6).

Approaches based on integration of mental health services with community based approaches that confront issues relevant to underlying disadvantage are likely to be useful to address factors contributing to inequity.

Integrated approaches and community based initiatives leveraging local resources are likely to improve inequity of access to mental health services in the long term, combined with innovative use of technology.

Development of effective evaluation and measurement frameworks, and testing practice based models within these frameworks are needed to identify and change factors related to inequity of service usage.

To enable governments and service providers to do things differently we have recommended the piloting of new funding and administrative approaches in a number of regional, rural and remote communities to enable integrated service delivery for people experiencing mental illness. (Suggestion 7)

1.9 Practical ways to minimise factors inhibiting access, and improve service provision and access within current fiscal limits

Some key priorities for reducing inequity in mental health service access and outcomes include:

- Working with communities experiencing high levels of adversity and distress to build their capacity to assist those most vulnerable and at risk (Suggestions 1 & 2);
The targeting of incentives and support for co-located and multidisciplinary practices within primary health care networks. (Suggestion 14);

Supporting and promoting mental health champions through a regional, rural and remote mental health leadership initiative (Suggestion 3);

A renewed or strengthened focus on suicide prevention in rural and remote areas building on program development over recent years including for example initiatives such as Farm-Link (Suggestion 4);

Renewed national leadership in promotion, prevention and early intervention with a particular focus on rural and remote communities (Suggestion 5); and

Better and more targeted access to Commonwealth funded mental health services through Better Access and Medicare Benefits Schedule (MBS) Items (Suggestion 12).

A further recommendation is the continued roll out of a suite of sub-acute mental health services that support stepped prevention and recovery care with a focus on regional, rural and remote areas of high need. (Suggestion 15)

Importantly, we urge the continuation and augmentation of Commonwealth funded community-based mental health support programs, including for example Partners in Recovery, the Personal Helpers and Mentors service (PHaMs), Day2Day Living, Support for Families and Carers, until the overlap between these services and the new NDIS-based services is established. (Suggestion 16)

The suggestions seek to ensure that over time mental health service access and outcomes are improved by setting in place systems of stepped and integrated professional assistance. Services would commence with less intense options such as telephone support and information lines and e-mental health services. There would then be progression to mental health services available through GPs, health clinics and non-government mental health organisations. Finally, and where needed, there would be access to more intense specialist services available through sub-acute services, clinical community mental health services, recovery support and psychosocial rehabilitation services, hospitals and acute mental health facilities –
locally, regionally and more distantly. An emphasis on support for self-management and a contributing life would be present at all stages of the stepped care continuum.
This section provides an inventory of suggested actions for minimising factors inhibiting access, and improving service provision and access within current fiscal limits in regional, rural and remote Australia. Each suggestion is discussed in more detail in the body of this report.

Targeted community capacity building via the Australian Government Department of Social Services funded Community Capacity Building Projects and Strengthening Communities Activities. (Suggestion 1)

Targeted community capacity building via existing organisations and networks involved with strengthening social cohesion in rural and remote areas experiencing significant levels of adversity. (Suggestion 2)

A regional, rural and remote mental health leadership initiative via the Australian Government Potential Leadership in Local Communities and the Healthy Communities Initiative. (Suggestion 3)

A renewed or strengthened focus on suicide prevention in rural and remote areas building on program development over recent years including for example evidence-based initiatives such as Farm-Link as well as targeted research to better understand how rural and remote cultural paradigms affect help seeking and suicidal behaviours particularly during heightened times of personal, social, economic and/or climatic adversity (Suggestion 4).

Renewed national leadership in promotion, prevention and early intervention in rural and remote communities including a focus on stigma reduction. (Suggestion 5)

The development of a nationally agreed conceptual framework to guide mental health service delivery in regional, rural and remote Australia and its governance, which promotes the development, implementation and evaluation of regionally and locally relevant models and pathways for stepped and integrated care. (Suggestion 6)
The piloting of new funding and administrative approaches in a number of regional, rural and remote communities to enable integrated service delivery for people experiencing mental illness. (Suggestion 7)

Nationally coordinated promotion throughout regional, rural and remote communities of available telephone-based help and counselling services that includes an emphasis on targeting people with literacy needs. (Suggestion 8)

Promotion nationally of e-mental health services with a particular focus on targeting regional, rural and remote communities. (Suggestion 9)

Leadership nationally through the Australian Government E-Mental Health Support Service to embed the use of e-mental health services as a routine form of treatment, recovery support and referral pathways through the upskilling and training of all primary health, allied health and specialist mental health professionals with a particular focus on regional, rural and remote Australia. (Suggestion 10)

National leadership (possibly under the auspice of the Australian Health Minister’s Advisory Committee) to ensure national coverage of telepsychiatry and other telemental health services and to develop nationally agreed guidelines for the use of these services. (Suggestion 11)

Better and more targeted access to Commonwealth funded mental health services through Better Access and Medicare Benefits Schedule (MBS) Items and other programs including:

- Chronic Disease Management under Medicare Benefits Scheme
- Mental Health Services in Rural and Remote Areas
- Mental Health Nurse Incentive Program (MHNIP)
- Access to Allied Psychological Services (ATAPS)
- ATAPS Child Mental Health Focused Service (CMHS)
- The visiting psychiatric services through the Medical Specialist Outreach Assistance Program (MSOAP)
- MBS item numbers for telepsychiatry (Suggestion 12)
National leadership (possibly through AHMAC or other national entity) is recommended to facilitate the development of a national primary care strategy for mental health service delivery in remote areas and in rural towns where there is a limited specialist capacity. (Suggestion 13)

The targeting of incentives and support for co-located and multidisciplinary practices within primary health care networks. (Suggestion 14)

The continued roll out and evaluation of a suite of sub-acute mental health services that support stepped prevention and recovery care is recommended with a focus on regional, rural and remote areas of high need. (Suggestion 15)

The continuation and augmentation of Commonwealth funded community-based mental health support programs, including for example Partners in Recovery, the Personal Helpers and Mentors service (PHaMs), Day2Day Living, Support for Families and Carers, until the overlap between these services and the new NDIS-based services is established. (Suggestion 16)

The new primary health organisations be tasked with coordinating initiatives to improve the physical health outcomes of people with mental illness including for example:

- integrated, multi-disciplinary approaches – new models and ways of thinking, funding and working;
- tailored prevention and early intervention strategies;
- building linkages between mental health and primary and sub-acute/acute care; and
- making improvements in referrals (with an emphasis on supported referral) and other aspects of service coordination. (Suggestion 17)

Promote, implement and evaluate regional recruitment mechanisms to engage people in mental health career pathways in regional, rural and remote Australia, targeting areas and communities that need it most, such as socioeconomically disadvantaged areas that are underserviced by the current system, and where there
is evidence to suggest the efficacy and sustainability of recruitment and retention strategies. Included would be the trailing of creative solutions such as:

- workforce incentives for recruitment and/or relocation;
- packages to support the relocation and settling in of families;
- rural allied health scholarships;
- workforce development support – e.g. funding for position back fill while attending professional development, leave or other workplace requirements.

(Suggestion 18)

The Rural Health Continuing Education Stream 2 (RHCE2) program be expanded to include a focus on supporting the response of the generalist workforce to mental health emergencies as well as their response to people with co-morbidities.

(Suggestion 19)

A national mental health e-learning portal be developed by existing national organisations with a relevant remit to provide a one-stop shop for current and credible sources of information regarding evidence-based approaches to treatment, care, support and service development.

(Suggestion 20)

As per the recommendation made by Health Workforce Australia (2014), the development of a national mental health peer worker definition, dataset, data collection and public reporting approach across employment sectors to measure progress and support evaluation is required.

(Suggestion 21)

That Australian research and evaluation be encouraged and supported with a view to building the evidence base of the contribution of the peer workforce with a particular focus on the roles that might be played in regional, rural and remote areas where there is a critical mental health workforce short fall.

(Suggestion 22)

That research be encouraged and resourced to enable:

i. a more precise understanding of the distribution and determinants of mental health and wellbeing in regional, rural and remote populations in Australia;

ii. more precise information about what models and approaches to care and service delivery work, where, with whom and for what reasons; and
iii. the development and evaluation of outcome-oriented project, program, and place-based indicators, to in turn, support more robust and meaningful frameworks suited to mental health service provision across diverse regional, rural and remote communities. (Suggestion 23)
3 INTRODUCTION

Location matters for the mental health of approximately thirty per cent of Australians who live outside our major cities. In some states the proportion is higher, with forty five per cent of Queenslanders living outside of metropolitan areas (CRRMHQ, 2011). Despite the numbers of Australians potentially affected, we are without a systematic approach nationally to mental health service delivery in regional, rural and remote areas.

This advice paper provides a summary of our findings concerning inequity of access to mental health services and supports between metropolitan areas, and regional, rural and remote areas. A synthesis is then provided of major current, emerging and potential challenges for regional, rural and remote Australians who require or seek to access mental health programs and services. One such challenge arises from the need or tendency to clump regional, rural and remote areas together, despite the complexity of their diversity, for the purposes of service planning and delivery.

This paper then concludes with a number of practical ways to minimise factors inhibiting access, and to improve service provision and outcomes within current fiscal limits in regional, rural and remote Australia.

Importantly, this paper concludes that access to the advice of specialist mental health professionals in emergency situations, 24-hours a day, 7 days a week and year round, is now possible – no matter how remotely a person might live. Suggestions are outlined for achieving this goal.

This advice should be read in conjunction with an accompanying technical report, entitled, Regional, rural and remote mental health services: challenges, inequities and opportunities, that provides a review of the available data and a review of the research and literature.
4 THE CRUX OF THE INEQUTY FOR REGIONAL, RURAL AND REMOTE AUSTRALIANS

People living in regional, rural and remote locations are thought to experience mental illness at about the same prevalence as city dwellers (ABS, 2012). However, such published data generally measure only the occasions of health care service recorded as specifically related to mental health. There are likely to be numerous reasons why people with mental health conditions do not seek or obtain mental health services. The extent to which such reasons are common in city and regional, rural and remote areas will determine the degree to which the published data about the similarity of prevalence of mental illness are reliable (National Rural Health Alliance, 2014).

In regional, rural and remote areas, unlike the major cities, the reasons for not accessing services will include the fact that no appropriate mental health services are readily available, affordable or otherwise accessible (National Rural Health Alliance, 2014). This means that people presenting with serious mental illness and/or high levels of acute distress are frequently dealt with by de-facto ‘mental health services’, including through police and law enforcement agencies and/or through expensive and often traumatising emergency evacuation, often by air (NSW Mental Health Commission, 2013).

Even if the prevalence of mental illness in regional, rural and remote areas is no different from that in the major cities, the greater challenges non-city people face in accessing the necessary support and services heighten the consequences of mental ill health and frequently associated comorbidities.

The consequences are further compounded by fear of stigma and discrimination as well as cultural values including self-reliance, resilience and ‘toughing it out’. These longstanding social attitudes combined with the perception and/or reality that it is less easy to access the services and supports in sparsely populated areas act as barriers to seeking help (National Rural Health Alliance, 2014).
Discussed in turn are a number of threads key to locational and geographic inequity for Australians experiencing mental health problems:

- Social isolation and adversity; poorer physical health and greater injury;
- Higher risk of prolonged stress, distress and suicide;
- Fewer specialist mental health professionals and services coupled with less social infrastructure; and
- Accumulative social disadvantage including lowers levels of disposable household income, employment and completion of education.

4.1 Social isolation, adversity and rapid change

Many people in regional, rural and remote Australia are socially isolated, with less face-to-face contact with family, friends and other support networks (Living is for Everyone, Fact Sheet 18). This can lead to loneliness and depression, and can contribute to suicidal behaviour (SPA, 2008). Social fragmentation and an ageing population have accompanied the gradual de-population of rural and remote communities (National Rural Health Alliance, 2009). The closure, restructuring and withdrawal of essential services such as banking, schools, hospitals, government offices, public and/or private train and bus services and publicly funded employment services has significantly contributed to a declining quality of life in many rural communities (National Rural Health Alliance, 2014; AHMAC Standing Council on Health, 2012).

As towns decrease in size, local councils, the lifeblood and hub of many communities, begin to lose their viability. The trend of amalgamating local councils into super councils has carried over into the size of administrative regions for publicly funded services as well as for private services and utilities (Urana Shire Council, 2012).

The trend to ever larger governance structures has left many people feeling powerless, without a voice and disconnected from decisions made about their lives and welfare.
The National Rural Health Alliance (2014) notes there is a large body of evidence showing that a lack of control over one's life is associated with poorer health. A larger proportion of the workforce in rural and remote communities than in the major cities find themselves in a situation in which their economic security and returns are affected by circumstances entirely beyond their control. Farm incomes and businesses linked to them are influenced by quite uncontrollable and unpredictable weather and climatic circumstances (e.g. floods, fires, drought and cyclones), variations in commodity and fuel prices, and exchange rate changes (Berry et al., 2008).

People living in regional, rural and remote areas are likely to feel the brunt of extreme adverse and economic and social changes. Within these areas, people experiencing socio-economic disadvantage are among the first and are perhaps, the most profoundly affected.

Resulting housing stress, bankruptcy, unemployment, financial difficulties, relocation and dislocation from community, family and friends can contribute to increased levels of anxiety and depression, social isolation, the misuse of alcohol and other drugs and relationship problems. There is also an increased risk of suicide (Kolves et al., 2012).

In some communities structural adjustment has been rapid. The mining boom has led to displacement, people leaving their usual jobs for jobs in the mines, spiralling housing prices and high costs of living (National Rural Health Alliance, 2014). In some areas a two-tiered economy is in place. Socially, long-term residents can feel strangers in their own communities whilst fly-in/fly out workers or new residents can feel unaccepted and/or unwelcome (Barclay et al., 2013).

Vulnerability is increased for those who already feel alienated or not accepted including for example Indigenous people, immigrants, people with disability, lesbian, gay, bi-sexual, transgender and intersex people and fly-in/fly-out workers (ICCWA, 2006). Young people who have stayed in their communities rather than migrating to
the cities are also at risk of heightened vulnerability. The resilience of people and communities who have previously experienced significant losses might be lessened by consequent waves of further adverse life events (AHMAC Standing Council on Health, 2012).

People living with low prevalence mental illness such as psychotic conditions are thought to be among those profoundly affected by adverse weather events, natural disasters and economic decline and population decline (Berry et al., 2008).

4.2 Poorer physical health and greater injury

Australians living in regional and remote areas generally experience poorer health compared with people living in major cities (AHMAC Standing Council on Health, 2012). They have higher levels of mortality, morbidity and health risk factors than those who live in major metropolitan areas particularly for Indigenous Australians. Disability is also higher among men (AHMAC Standing Council on Health, 2012). Outside of city areas there are also higher rates of child deaths and low birth weight babies (AHMAC Standing Council on Health, 2012).

People living outside major cities are more likely to have a longer wait time to see a GP, are more likely to delay seeing a GP because of cost, and are more likely to be hospitalised with preventable conditions (AHMAC Standing Council on Health, 2012).

Higher rates of smoking, excessive and risky alcohol drinking levels, substance misuse and more sedentary lifestyles also feature in a poorer health profile for non-city dwellers (AIHW 2011, National Drug Strategy Household Survey of 2010). Access to fresh fruit and vegetables is affected by significantly higher costs of food as well as lower incomes than is the case in major cities (AHMAC Standing Council on Health, 2012).

Rural and remote Australians are also exposed to greater physical risks (AHMAC Standing Council on Health, 2012). Apart from dangerous occupations such as farming, fishing and forestry, other physical risks (e.g. road accident) are greater and
retrieval times are longer should they experience health difficulties. Death due to injury is up to 1-3 times higher in regional and remote areas (AHMAC Standing Council on Health, 2012).

In the absence of affordable and regular health checks, people with severe mental illness particularly psychotic illnesses in non-city areas, are thought to be of heightened risk of medication-related metabolic syndrome and other adverse health impacts (National Rural Health Alliance 2014; Nankivell et al., 2013).

4.3 Higher risk of stress, distress and suicide

People living in regional, rural or remote locations are subject to a number of cumulative pressures that are not experienced as frequently by their metropolitan counterparts (Vines, 2011). These pressures feature alongside a number of key mental health issues that result in higher risk of distress including comorbid mental health and alcohol and other drug disorders, higher levels of attempted and completed suicide, unique stressors amongst farming communities, and Indigenous mental health issues (Cheug et al., 2012; Kolves et al., 2012).

Suicide rates in rural and remote areas of Australia are significantly higher than the national average and very remote regions have suicide rates more than double that of major capital cities (Australian Government Department of Health and Ageing, 2008). At higher risk are male farmers, Indigenous communities, older men, young people, and gay, lesbian, bisexual or transgender people (National Rural Health Alliance, 2009).

Rural women in remote areas are more exposed to violence in personal relationships than urban women and many are isolated without public transport (AHMAC Standing Council on Health, 2012).

While rates of substance abuse are higher outside the major cities, the availability of remedial alcohol and drug services is particularly limited in rural and rural areas (National Rural Health Alliance, 2014). These services include withdrawal assistance such as methadone programs and detoxification services, and needle and syringe programs that can make drug use safer. Rural and remote residents may also be
more reluctant to disclose their drug use to local healthcare professionals, given the fact that there is a greater chance of them being personally known to each other (AIHW 2011, National Drug Strategy Household Survey of 2010).

4.4 Educational and literacy levels in regional, rural and remote areas

The role of education and its interaction with mental illness is an area discussed with many stakeholders and highlighted as a foundational issue. It was seen as an underlying driver in that lower education often related to less favorable employment and income outcomes within communities. Education was also seen as important in that it contributed to people’s ability to understand and seek effective treatment for mental illness. A recent report for the Commonwealth Department of Education, Employment and Workplace Relations (Hancock et al., 2013), highlighted the interaction with socio-economic status (Rothman, 2001) and established that levels of school attendance contributed significantly to educational outcomes. This data and report therefore established the systemic nature of this issue.

4.5 Fewer mental health professionals and services in regional, rural and remote communities

There are far fewer specialist mental health professionals and specialist services available in regional, rural and remote areas (AIHW, 2013).

The limited supply of specialist professional and services means that, even given the will to do so, it is harder for rural people to know about, locate and access professional services (National Rural Health Alliance, 2014).

Therefore it is often the case that diagnosis and intervention that could alleviate mental illness are hampered and delayed. Fewer GPs, allied health professionals and community supports can make it harder for people with mental health problems to get on with their daily lives (National Rural Health Alliance, 2014). This results in greater personal, family and community impacts. It also results in significant
economic costs through avoidable hospitalisations and transfers out of areas and longer periods out of work as well as loss of employment (Jelinek et al., 2011).

People in rural and remote areas are disadvantaged in access to mental health services funded or subsidised by Medicare, almost certainly because of the maldistribution of GPs and other relevant health professionals and their shortage or absence in more remote areas. This means that the effectiveness of one of the standard policy responses to mental health challenges and other health matters that can make an early difference (i.e. providing Medicare rebates through targeted Item numbers, largely for GPs) is reduced with increasing levels of remoteness or thinness of population (National Rural Health Alliance, 2014).

Another of the responses in the standard suite of mental health services that can effectively assist people in crisis or in heightened distress are services provided through the Internet or with telephone information, help and crisis lines. These services are thought to be particularly valuable for rural and remote people, especially given their greater exposure to and sensitivity towards stigma and privacy concerns (Wade et al., 2012). However, poorer Internet connectivity and telephony in rural and remote areas might be reducing their potential effectiveness (Wood et al., 2012).

More precise information is needed about which particular approaches to online and telephone services work most effectively, for people who are already isolated by their geographical location and placed at higher risk by events and circumstances that unequally impact the lives of non-city dwellers.

Reduced health and community service infrastructure results in a lack of promotion, prevention, early intervention and a further lack of a myriad of upstream and intermediate services that can prevent mental health issues from escalating (Humphreys & Wakeman, 2010 & 2011). This means that appropriate professional assistance is often provided later and might be delayed until after a serious crisis has occurred.
Although the evidence is not clearly available, it is likely that specialist mental health intervention and management is also delayed and deficient for people with acute and severe mental health issues, including psychotic illnesses (National Rural health Alliance, 2014). The fear is that many people affected by mental illness may not be adequately recognised or supported by the health and community care systems in rural and remote areas (National Rural Health Alliance, 2014). Issues relating to the access to medication and professional pharmacy services, and personal transport, may also pose particular challenges for people in more remote areas who have a mental illness (CRRMHQ, 2011).

### 4.6 Accumulative disadvantage

Also featuring in the greater complexity of mental health problems in rural and remote areas, are factors referred to as the social determinants of health and wellbeing. For non-city dwellers these include lower levels of completed education, lower levels of literacy and numeracy, lower income and fewer employment opportunities and less secure employment (NCOSS, 2013; Inder et al., 2011; National Rural Health Alliance, 2013).

Housing stress (the situation in which housing costs are 30 per cent or more of household income) is also more prevalent in rural and remote areas (AHMAC Standing Council on Health, 2012). Despite cheaper housing costs overall in rural areas, stocks of good housing are low, the risk of homelessness is increased due to lower incomes, and there are few emergency housing and accommodation services, all making it difficult for those with lower and more insecure incomes in rural and remote areas to escape their predicament (National Rural Health Alliance, 2013). Homeless people are also disproportionality affected (National Rural Health Alliance, 2014; AHMAC Standing Council on Health, 2012).

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Greater social disadvantage and fewer mental health services and fewer community supports combine to increase the consequences of mental illness and its impacts.
Though the presence of this link between mental health and socio-economic disadvantage is accepted, it appears to be quite variable across Australia (McLachlan et al., 2013). More precise information is required so that integrated community wide responses can be targeted at key locally significant aspects of social disadvantage that are impeding mental health and recovery (National Rural Health Alliance, 2014).

For many people in regional, rural and remote areas, improved mental health and sustained wellness will require supports and services outside of the traditional mental health service system.

4.7 Summary of the metropolitan/regional, rural and remote inequity

Metropolitan-rural-remote inequity is expressed statistically in the following ways:

- Perceived higher levels of stigma and concerns about privacy acting as barriers to seeking help for mental health problems (Handley et al., 2014);
- Lower life expectancy (COAG Reform Council, 2014);
- Access to Medicare-funded services diminishing with increasing remoteness (AIHW, 2013);
- Reduced health workforce distribution (AIHW, 2013);
- Lower rates of mental health service access, with access to psychological services significantly less than in major cities (AIHW, 2013);
- Poorer health status and increased health risk factors (ABS, 2008);
- Reduced effectiveness in health promotion (AHMAC Standing Council on Health, 2012);
- Reduced survival rates once diagnosed with a health problem (COAG Reform Council, 2014);
- Lower levels of education and educational outcomes (AHMAC Standing Council on Health, 2012; National Rural Health Alliance, 2013);
- Lower levels of literacy (AHMAC Standing Council on Health, 2012) and
- Reduced access to infrastructure; communications and cost to access services (AHMAC Standing Council on Health, 2012; National Rural Health Alliance, 2013).

To complicate matters, physical illness commonly coexists with mental health problems in the form of dual diagnosis and co-morbidities (Centre for Rural and Remote Mental Health QLD, 2011).

*In summary, living outside the major cities presents a number of additional risks to health and mental health; a fact which underlines the need for governments to improve access and services to people living in rural and remote Australia.*
5 Specific challenges

Though regional, rural and remote communities can face significant hardship, they report higher levels of satisfaction with life than their city counterparts (McShane et al., 2014). This pattern possibly reflects the resilience and strengths that are found in non-urban Australia. A challenge in closing the gap in mental health service access and outcomes is to harness the resilience, innovation, creativity and social capital that reside within regional, rural and remote communities (Bourke et al., 2010).

A number of further specific challenges are now discussed including:

- Finding solutions given the diversity of regional, rural and remote communities – figuring out what works where;
- Addressing the multifaceted nature of inequity of mental health service access and outcomes including lower educational and literacy levels;
- Maximising local access and thereby freeing up resources;
- Tackling barriers to seeking help for mental health issues; and
- Building and sustaining fit for purpose workforces centred on the capabilities required as against professional groupings.

Each of these challenges is discussed in turn.

5.1 Diversity of regional, rural and remote communities and figuring out what works best where and for whom

Regional, rural and remote Australian communities are diverse. There is no single culture, no typical community profile and no single definitive description that aptly describes a regional community, a rural community or a remote community. It is clear from this diversity as well as the sheer size of the geographical area covered by areas designated regional, rural and remote, that a ‘one size fits all’ solution will not work (South Australian Health Performance Council, 2013).

Further complications arise from the varying and sometimes overlapping roles and responsibilities of our three levels of government as well as the boundaries between public, private and non-government community managed service sectors.
Whilst it is also apparent that many of the urban models designed in our capital cities do not work sufficiently in non-city areas, there is need for precise information about the differences in what works and doesn't work between urban and non-urban areas as well as different kinds of regional, rural and remote areas.

A challenge then, is to design, deliver and support rural and remote mental health services using more flexible, innovative, and locally appropriate solutions, without compromising the quality and safety of care. This also requires due consideration to issues associated with low client volumes, which can impact the viability and the quality, and safety of services (CRRMHQ, 2011).

Some of the requisite learning will come from regional, rural and remote communities themselves. This points to the need for new health and community service governance frameworks that prioritise the voice of community leaders and people with experience of mental illness themselves. Also required is a capacity for local planning that integrates formal services with the assistance of community members and organisations who are frequently at the front-line in crises and during circumstances such as drought and other adverse events.

5.2 Addressing the multifaceted nature of inequity of service access and outcomes including lower educational and literacy levels

Inequity in regional, rural and remote areas is multifaceted and variable. Some regional, rural and remote areas are relatively well off, have a good sense of community and social cohesion whilst other communities are in decline and engulfed by a sense of hopelessness (National Rural Health Alliance, 2014). There is a need for more precise information to enable targeted responses that are place-based and relevant to local need and able to simultaneously address physical health, mental health and associated comorbidities as well as social impediments to getting better and staying well including isolation, poverty, unemployment,
unstable or lack of affordable and appropriate housing and lack of transport (Australian Senate Community Affairs References Committee, 2010).

Improving the mental health and wellbeing in regional, rural and remote communities will require funding and policy frameworks which enable integrated responses to health, mental health, community service and justice sectors, at all levels of government including local government.

*Improving access and service outcomes will also require action to address social impediments to health and wellbeing.*

Even if there is a will to seek professional help and to increase mental health self-management skills, education levels and concomitant health literacy can deter people from following through.

*To close the gap between health and mental health access and outcomes the lower educational and literacy levels of non-city dwellers must be tackled.*

Coordination and collaboration will also be required with business and industry sectors, service organisations and other voluntary groups to improve both mental health service access and opportunities for social connection, education, training, employment and recreation.

5.3 Maximising local access and thereby freeing up resources through reduced costs

Enabling people experiencing high prevalence mental health conditions (such as depression, anxiety, trauma, grief and loss) to access services earlier and locally will improve both health and personal outcomes. Early access will reduce the level of interruptions to people’s lives and will enable them to remain in school, complete their education and training or return to work.
Much of the help people living with more severe mental illness require to remain at home and to stay in their communities lies outside of the specialist mental health system and includes support focussed on relationships, housing, training, employment and community participation. Savings made from reducing the need for hospitalisation and transfer out of area could be utilised to scale up existing community support and capacity building programs.

### 5.4 Tackling barriers to seeking help for mental health issues

As discussed above the ethos of self reliance, self sufficiency and resilience appears to deter people in non-city areas from seeking help for problems that may be associated with some sort of social stigma; as is the case with mental health issues. Social issues are particularly important in small centres where everyone knows everyone else, and where medical and health professionals are part of the community. If people seek help, it may often be at an advanced stage after an acute episode or crisis (CRRMHQ, 2011).

Barriers to seeking help from formal services when feeling stressed and anxious in rural and remote communities have been reported to include:

- A preference to seek help from friends and family;
- Limited acceptability of mental health care and stigma around mental illness;
- Limited accessibility of formal health providers and services in rural and remote areas; and
- The perceived helpfulness of a local GP or health service (Judd et al., 2007).

Rural and remote Australians, both men and women, face an increasing and elevated burden of death due to suicide. Research suggests that this higher suicide rate in farming communities is not easily explained by an elevated rate of mental health problems; a combination of adversity, personality, gender and social attitudes...
appear to come into play (Judd et al., 2007; Kolves et al., 2012). Reducing suicide in regional, rural and remote areas will require greater understanding and recognition of the potential stressors associated with living and working in these areas by all levels of governments and across health, community and industry sectors (Kolves et al., 2012).

Better understanding of how rural and remote cultural paradigms affect help seeking and suicidal behaviours particularly during heightened times of personal, social, economic and/or climatic adversity can lead to the development of appropriate and effective suicide prevention strategies. In this way, people most vulnerable can be encouraged to seek help and be protected from the tragedy of suicide.

5.5 Building and sustaining fit for purpose workforces

Workforce issues have always been a challenge in all types of health care delivery in rural and remote areas, but the shortfall is particularly evident in the mental health care field. The most recent statistics (2011) suggest that only approximately around 12% of psychiatrists, 18% of practising psychologists and 27% of mental health nurses are practising in places outside of the major cities in Australia (AIHW 2013). There are also workforce gaps for services providing counselling for alcohol and drug misuse, family support, women’s issues, sexual abuse and crisis support. It is the generalist primary care worker who is called upon to fill the breach in rural and remote areas (AHMAC Standing Council on Health, 2012). Unfortunately, GPs are also underrepresented in rural and remote areas with around 9% working in outer regional areas and only 3.5 to 4% in remote/very remote areas (AIHW, 2013).
The prevalence of people presenting with co-occurring alcohol and other drug abuse and mental illness (dual diagnosis) is high in both mental health and drug and alcohol treatment settings (CRRMHQ, 2011). Despite the significant number of individuals with co-occurring conditions, many regional, rural and remote health professionals have limited preparation and experience in dealing with clinical diagnosis and management issues (CRRMHQ, 2011). In fact, health professionals themselves are often stressed and frustrated in their attempt to understand people’s ongoing drug misuse despite its impacts and consequences (CRRMHQ, 2011). Certainly there is a case for improved professional development opportunities and collaborative care in ameliorating this situation (Deans & Soar, 2005; QLD Health, 2005; Barnes & Rudge, 2003).

Workforce problems in rural and remote regions are not isolated to the health context. Over the years rural incentive programs for professionals have had limited success. Regional, rural and remote areas remain unattractive for people to move to for numerous reasons including limitations in educational facilities, opportunities for partner employment, inferior housing, social issues and privacy considerations (CRRMHQ, 2011). Extreme physical environments and the general tyranny of distance also takes a toll. There have been some successful community generated initiatives in various areas, but on the whole workforce problems need addressing with some creative solutions (AHMAC Standing Council on Health 2012). Solutions might include:

- workforce incentives for recruitment and/or relocation;
- packages to support the relocation and settling in of families;
- rural allied health scholarships;
- workforce development support – eg funding for position back fill while attending professional development, leave or other workplace requirements

While it is important to emphasise the need for continued effort to increase the presence of specialised mental health professionals and services in rural and remote areas, little change from the current workforce pattern for mental health care can be expected quickly (CRRMHQ, 2011). Much of the initial presentation of mental health
conditions and the ongoing care will continue to be managed by GPs, nurses, psychologists and other allied health professionals, pharmacists and Aboriginal and Torres Strait Island Health workers - including for emergency presentations (National Rural Health Alliance, 2014).

There are also numerous professionals including practice nurses, nurse practitioners, midwives, nutritionists, dieticians, sport and exercise physiologists, health science, health promotion and health management professionals, employment advisers and rehabilitation workers, who though not traditionally viewed as mental health clinicians, are increasing their presence in regional, rural and remote areas.

Therefore, a strengthened focus is required on leveraging and upskilling these local professionals many of them are under-deployed, or despite having left their professions have much to offer.

There is also potential to develop a health promotion, recovery support and peer workforce by skilling up local community members (National Rural Health Alliance, 2014; QLD Mental Health Commission, 2014). Their life experience, expertise and local knowledge could be utilised to promote mental health literacy, assist with suicide prevention and provide support to help people get on with their everyday lives.

Developing a peer education program could also provide a constructive way of assisting people with both mental health and drug and alcohol issues and encouraging use of formal specialist services.

The skills of wider health and community workforces as well as community members could also contribute significantly to improved health, personal and social outcomes and complement the capacity to provide whole of life and integrated service offerings for people living with mental illness that are locally relevant, sustainable, and hence, fit for purpose.
6 Practical steps

Supporting communities to pull together in the face of adversity and doing what they can to support those who are most vulnerable and at risk are among the suggestions detailed in this section. Other suggestions include the following.

- Supporting communities to harness their strengths, resourcefulness, resilience, patience and courage to improve local wellbeing through a range of community development and capacity building activities.
- Community members including those with personal experience of mental health issues skilled up to reach out to people who are struggling or in crisis.
- Deploying skilled up and trained community members to supplement and complement specialist mental health professionals and to support people to build on skills that will enable them to take greater control and personal responsibility.
- Ending siloed service systems by trialling integrated service delivery approaches for physical health and mental health needs as well as co-morbidities.
- Cross government and community wide action to address social and economic impediments to good mental health including:
  - fewer young people completing education and training; and
  - lack of jobs, affordable and appropriate housing, transport and opportunities for recreation and participation.

Suggestions including these actions can assist to improve the mental health of regional, rural and remote communities. Wherever possible, some examples of relevant programs and initiatives are provided.

Other key suggestions seek to build on the current efforts of Australian governments to skill up and put all Australians ‘in the know’ – so that no matter how remotely they live or work, they know the basics of mental health: early warning signs; what helps; how they can help themselves as well as others; what professional help is available; and how it might be accessed.
The suggestions also seek to ensure that over time mental health service access and outcomes are improved by setting in place models and systems for stepped care.

Finally, the suggestions provided below seek to ensure that when specialist mental health and recovery support professionals and services cannot be present on the ground, the necessary assistance and interventions can be provided in real time via telephone or over the internet via computers, iPads and other hand-held devices. The goal is to achieve 24-hour coverage, seven days a week.

6.1 Supporting local communities to take action – making mental health everyone’s business

Regional, rural and remote communities are resilient, resourceful and innovative. Community members of all ages and walks of life are often de-facto mental health workers (NSW Mental Health Commission, 2013). Their local knowledge and resources could be better and more systematically harnessed to assist to improve mental health and wellbeing. There are numerous programs across Australian government portfolios that could be potentially strengthened and used to help regional, rural and remote communities to make mental health everyone’s business.

6.1.1 Community capacity building to address social impediments to mental health and to promote wellbeing in regional, rural and remote communities

Several authors (Handley et al., 2012, Hossain et al., 2013, Kelly et al., 2011; and National Rural Health Alliance, 2014) have noted the importance of mental health approaches being accompanied by broadly based action to support community cohesion and capacity building, particularly in rural and remote areas experiencing adversity and rapid change.

Target groups of the Australian Government Department of Social Services funded Community Capacity Building Projects and Strengthening Communities Activities currently include people with mental health issues and individuals or communities who are vulnerable or at risk of social inclusion. These programs potentially provide mechanisms for enabling local communities to take action to promote hope, mental health and wellbeing. Consideration could be given as to how Commonwealth
programs such as these could target communities where mental health and social wellbeing are being negatively impacted by socio-economic trends and/or adversity.

Example – More than just a garden – Ravenshoe Community Garden

Ravenshoe was affected by the flooding following Cyclone Yasi in 2011. A community garden on a derelict basketball court at the community centre, which FRRR funded through its Repair-Restore-Renew program, is just one example of a successful community disaster recovery project as well as an example of community action to promote community wellbeing during tough times.

The Ravenshoe Community Garden has 20 members who meet regularly to work on the gardens, which include raised garden beds at a suitable height for wheelchair gardening, irrigation, fencing around the gardens and bird netting. The members particularly enjoy the knowledge and skills exchange, and they have a lot of support through donations from the wider community.


Suggestion 1.

Targeted community capacity building via the Australian Government Department of Social Services funded Community Capacity Building Projects and Strengthening Communities Activities.

Similarly, the National Rural Health Alliance 2014 argued that there are opportunities for partnerships with organisations such as the Foundation for Rural and Regional Renewal, Heads Up, Mens Sheds Australia, Country Women’s Association, RSL Australia, service clubs and organisations (e.g. Rotary and Red Cross) and industry and sporting groups, might be explored with a view to enabling local leadership, community directed action and the engagement of all sectors of the community in making mental health everyone’s business.

Suggestion 2.

Targeted community capacity building via existing organisations and networks that are already working to strengthen social cohesion in rural and remote areas experiencing significant levels of adversity.
6.1.2 Regional, rural and remote community mental health leadership initiative

The Queensland Ministerial Roundtable on Rural and Remote Mental Health (2014) and Wakeman et al. (2009) discussed the importance to effective mental health service delivery of influential families and community leaders. Collaboration with local governments in regional, rural and remote communities can identify community members of all ages who are already perceived as “natural” helpers and who have an interest in promoting mental health and to support people experiencing mental health issues. Training and mentoring could be made available similar to that provided through the new National Mental Health Leaders initiative (initiated by the National Mental Health Commission in collaboration with the Mental Health Council of Australia, and with the support of the National Mental Health Consumer and Carer Forum).

A leadership program of this nature might be located within or linked to a number of existing Australian government initiatives including the Potential Leadership in Local Communities Initiative (the Stronger Families Fund Initiative) and the Healthy Communities Initiative. Links with beyondblue’s Ambassadors, the Heads Up Mentally Health Workforce Initiative and Rotary Youth Leadership program and other similar initiatives might also be made.

**Suggestion Three.**

*Supporting regional, rural and remote mental health leadership initiative via the Australian Government Potential Leadership in Local Communities Initiative and the Healthy Communities Initiative.*

6.1.3 Nationally coordinated community based mental health promotion, anti-stigma and suicide prevention

Key informants argued that there is a need for continued diligence in preventing suicide in rural and remote communities. Key informants noted that whilst a vast amount of good work is occurring in the space of suicide prevention, a lack of coordination results in a perception that little is being done. Despite building a sound
evidence base for their effectiveness, many of these projects and initiatives, established through time limited project funding, are faced with closure. Farm-Link, described below, is one such initiative.

A further reason for renewed or strengthened focus in rural and remote areas is that programs designed and tools in major cities do not necessarily translate into effective resources in non-urban areas (Tasmanian Statewide and Mental Health Services Department of Health and Human Services, 2010).

**Example: Farm-Link**

The Farm-link Program (now the Rural Adversity Mental Health Program) was an application of a suicide prevention model. It involved educating and equipping front-line community members likely to interact with ‘at-risk’ population groups (in this case drought-affected farmers) in mental health and mental health first aid practices. The aim was improve access and responsiveness of mental health services to the needs of people who live and work on farms. Networks and pathways to care consistent with suicide prevention principles were established. The program also contributed to the identification and establishment of mental health service development interventions in target communities (Perceval et al., 2011).

One key attribute of the model involved leverage of existing community-based resources to develop intervention and treatment strategies. This was especially importance given the particular help-seeking behaviour of the rural communities that emphasised self-reliance and stoicism. Another key attribute was the establishment of cross-agency networks and links with community organisations that allowed integration of approaches.

Communities facing particular adversity and difficulties as well as vulnerable groups could be targeted with a further promotion and/or roll out of National Suicide Prevention Program resources including LIFE information resources, LifeForce Suicide Prevention Training Program, LivingWorks Applied Suicide prevention and Training (ASIST), LIFE Communications, SPA Communities Matter tool kit and Small Towns Resource Network, Mental Health First Aid and similar training and Access to Allied Psychological Services (ATAPS) Suicide Prevention project etc.
### Suggestion 4.

A renewed or strengthened focus on suicide prevention in rural and remote areas. A renewed or strengthened focus on suicide prevention in rural and remote areas building on program development over recent years including for example evidence-based initiatives such as Farm-Link as well as targeted research to better understand how rural and remote cultural paradigms affect help seeking and suicidal behaviours particularly during heightened times of personal, social, economic and/or climatic adversity.

Research of this nature can lead to the development of appropriate and effective suicide prevention strategies. In this way, people most vulnerable can be encouraged to seek help and be protected from the tragedy of suicide.

### 6.1.4 Ensuring a focus on anti-stigma, mental health promotion, prevention and early intervention in regional, rural and remote Australia

The WA Mental Health Commission 2013 and the Centre for Rural and Remote Mental Health Queensland (CRRMHQ) 2011 noted the importance of ongoing anti-stigma and mental health promotion, prevention and early intervention activities in rural and remote communities. Key informants noted the lapsing of the National...
Action Plan for promotion, prevention and early intervention for mental health (2000) and the declining emphasis given to these activities in recent times.

The Australasian Centre for Rural and Remote Mental Health (ACRRMH) in its submission to the Inquiry into the Development of Northern Australia cited documentation of a strong economic case for evidence-based prevention and early intervention initiatives with regard to mental health. An example provided from the Health Program of the European Union (Matrix Insight 2012) asserted that for every euro invested in mental health prevention, between €.81 and €13.62 could be saved. The Centre reported that evidence-based promotion, prevention and early intervention programs have a demonstrated capacity to improve the mental health of targeted communities and groups and to reduce pressures on health and social welfare systems, employers, and the economy as a whole by assisting people to access specialist help earlier and thereby reducing unnecessary hospitalisation and disruption to a person’s education, training employment and productivity. Reachout.com (2014) argues further that programs such as these can save lives.

The new primary health organisations with relevant Australian Government funded national mental health organisations could potentially provide renewed national leadership in mental health promotion, prevention and early intervention. A specific focus could be the targeting of rural and remote communities and could include strengthened emphases on increasing the mental health literacy and the capacity of rural and remote communities to assist people experiencing mental health issues.

**Suggestion 5.**

*Renewed national leadership in promotion, prevention and early intervention in rural and remote communities including a focus on stigma reduction.*

### 6.2 Maximising benefit from finite resources

Greater consistency of approach nationally as well as removing barriers to integrated service delivery will assist to address current inequities faced by regional, rural and remote Australians who experience mental health issues.
6.2.1 A nationally agreed conceptual framework for mental health service delivery in regional, rural and remote Australia and its governance

Given that so many Australians live in regional, rural and remote communities, the porous nature of our state and territory borders and the need for action across all levels of government, a number of key informants argued that a nationally agreed conceptual framework for mental health service delivery in regional, rural and remote Australia and its governance is long overdue.

A nationally agreed conceptual framework will require guiding principles that acknowledge the diversity of regional, rural and remote communities and the need for flexibility given that no one size fits all approach will be possible.

The guiding principles will also need to acknowledge the diversity of regional, rural and remote communities and the need for flexibility given that no one size fits all approach will be possible. The framework itself would emphasise the need for more complete information about regional, rural and remote communities and areas: their health, mental health and risk profiles, socio-economic trends, resources and strengths, social issues and current events or changes that are possibly impacting mental health service access and outcomes.

We are not without significant guidance as State and Territory governments and researchers have sought to more clearly articulate what might work where and with whom and how.
Example: A framework for mental health service delivery in rural and remote Australia
(Centre for Rural and Remote Mental Health QLD, May 2011)

Provides a review of the literature, research and evidence, and makes observations and recommendation regarding: the effective use of telepsychiatry, telehealth and telecare, e-mental health programs; categories of effective mental health care and service delivery in rural and remote communities; typologies of rural and remote primary health care-based mental health service delivery models along the rural-remote continuum; enablers and requirements of sustainable rural and remote primary health care services; a conceptual framework for mental health service delivery in regional, rural and remote Australia.

Figure 1 is based on the model proposed by the Centre for Rural and Remote Mental Health Queensland and has been adapted by drawing on our research, review of submissions and synthesis of stakeholder consultations to provide an example of what a possible conceptual framework for mental health service delivery in regional, rural and remote Australia might look like. Key components are likely to include the following.

- A source of coordination (if not a new agency, a role within an existing agency) with the authority to work across all levels of government and across public, private and non-government mental health sectors as well as across a range of health and community sectors.
- Governance models that define responsibilities, coordinate funding and projects, resource and empower key people, consult systematically and routinely, achieve buy-in from all professional and cross-sectoral groups in communities and ensure open lines of communication.
- Sufficient autonomy at regional levels to enable place-based approaches and to ensure relevance locally and the utilisation of local resources and facilities.
- Strong community engagement, consultation and representation in governance structures.
- Action to address social disadvantage, to build social cohesion and to alleviate identified local area impediments to good mental health.
- Stepped care pathways commencing with the least intensive interventions and enabling people to step up or down according to changing needs and in response to treatment.
- Primary mental health services provided by local generalists staff in remote and rural towns and supported by specialist mental health professionals from hubs on both a visiting basis and through telemental health.
- A strong focus on self-management skills and recovery support.
- Sub acute alternatives to hospitalisation and to out of area transfers.
- Hub and spoke models with outreach services covering prevention, promotion, early intervention, primary health and acute care services supplemented by e-mental health and telemental health services.
- The building of a critical mass of specialist mental health professionals in larger regional centres that are more attractive for professionals to live in.

Service delivery models would seek to optimise the use of human and financial resources through multi-disciplinary and inter-sectoral models utilising both formal and informal community networks, particularly sectors outside of health.

A key emphasis would be on setting in place over time approaches and pathways for systems of stepped professional assistance that range from less intense options such as telephone support and information lines and e-mental health services, mental health services available through GPs and health clinics including instruction in self-management skills more intense specialist services available through hospitals and acute mental health facilities.

Systems of effective stepped care that:
- are non-stigmatising and culturally acceptable in rural and remote settings;
- provide assistance early and include a focus on promotion and prevention;
- people are willing to use;
- equip people and communities with the knowledge and skills to use the full range of options if necessary; and
- are both affordable and accessible.
will not only reduce inequity in mental health service access and outcomes but will also reduce the need for the most disruptive and expensive interventions, namely preventable hospitalisations and out of area medical evacuations.

A stepped-care model is likely to be cost effective because people will receive the least intensive intervention for their need. If a less intensive intervention is able to deliver the desired positive service-user outcome, this limits the burden of disease and the costs associated with more intensive treatment.

**Suggestion 6.**

_The development of a nationally agreed conceptual framework to guide mental health service delivery in regional, rural and remote Australia and its governance and which promotes the development, implementation and evaluation of regionally and locally relevant models and pathways for integrated and stepped care._
Figure 1: Components of a possible framework for mental health service delivery in regional, rural and remote Australia (adapted from Centre for Rural and Remote Mental Health QLD 2011, p. 28)
6.2.2 Piloting smarter funding approaches, service delivery models and governance frameworks

Integration of mental health and primary and allied health care service would enable a focus on the provision of holistic and coordinated care, liaison and advice, and the development of clinical pathways between and across a range of agencies and service sectors including accommodation, education, employment, legal, families, ambulance, police, and criminal justice (CRRMHQ, 2011). As such, the focus of integrated care at a systems level is at the interface between health service providers and the creation of client care pathways, including entry, transition and exit (CRRMHQ, 2011). However, existing funding and administrative structures do not readily facilitate integrated service delivery.

Key informants suggested that there are unique opportunities in regional, rural and remote areas for the piloting of new funding and administrative approaches to enable service delivery innovation and to break down rigid service sector boundaries and silos.

It is likely that the new primary health organisations, just as Medicare Locals and Divisions of General Practice have done, will have a key role to play in working toward a more integrated approach. One might expect a similar focus in Partners in Recovery programs should they continue (National Rural Health Alliance, 2014).

Pilots of new funding approaches and administrative structures could investigate how best to ensure integrated and coordinated care, support and treatment for people with both high and low prevalence mental health conditions as remoteness increases. At the service delivery level there appears to be a need for a single body (a primary health care organisation or mental health consortium) that is authorised and resourced to work across all levels of government as well as public, private and NGO health, mental health and relevant community service sectors within delineated local or regional areas.

Possible models for trialing include the following:
A headspace style funding model for adult mental health service consortiums/primary mental health consultation services - enabling the co-location of GPs and allied health professionals who are self funded through their billings against the MBS.

An ‘alternate optimal and coordinated care funding scheme’ for people with psychotic disorders which focuses on the provision of fewer hospitalisations and the avoidance of out of area transfers in conjunction with needs-based, stepped-care mental health treatment and recovery support including sub-acute and other community-based alternatives to hospitalisation, consultations with GPs and other primary health care consultants, clinical community mental health services and locally coordinated recovery support services.

Pooled or blended funding within a geographic area or service network – Commonwealth, state and local government and private and public, private and NGO.

Cashing in of funds and infrastructure grants.

Funding mental health services within a particular area/region on the basis of a weighted, or risk adjusted, capitation formula based on empirical analysis in an attempt to fund regions and services in a more efficient and equitable manner.

Discrete service entities remaining but entering into co-location and shared, coordinated and integrated care arrangements.

A clustering approach in existing mental health service catchments that are not self sufficient and not able to provide or sustain certain service elements. Instead, people living in that area would still be able to access all necessary service elements through the clustering of their local service provider with other providers, who as a group or consortium could sustainably operate higher cost, lower volume service components.

Funding requirements would include:

- An adequate budget to cover salaries and infrastructure, indexed to meet all operational costs;
Sustainable and flexible financing to ensure the delivery of appropriate care;

The facility to pool funds in order to maximise service efficiencies and economies and to respond flexibly to changing health needs;

An agreement between all funders, service providers, service users and the community that details funding amount, financing mechanism, agreed objectives, performance indicators and consolidated reporting requirements (CRRMH QLD, 2011, p. 17).

Whilst pilots are in the establishment phase, it will be important for transitional arrangements to be made whereby people currently receiving services do not lose those services.

The trials will also by necessity need to pilot new arrangements for governance, management and leadership.

Also included in the trials would be new information management/information technology systems appropriate to the service, its catchment population (particularly in areas of high population mobility), and its monitoring, evaluation and reporting needs.

**Suggestion 7.**

*The piloting of new funding and administrative approaches in a number of regional, rural and remote communities to enable integrated service delivery for people experiencing mental illness.*

**6.3 Keeping people in their communities by leveraging low cost interventions as early as possible**

This section provides a series of suggestions modelled on a stepped care approach to keeping people in their communities and supporting them to get on with their lives with the least possible interruption.

The following suggestions are outlined and discussed in turn.

- Promotion of telephone helplines and e-mental health programs and resources and incorporation into practice
- National leadership to ensure national coverage of telepsychiatry and other telemental health services
- Better and more targeted access to Commonwealth funded mental health services through Better Access and Medicare Benefits Schedule (MBS) Items and other programs
- Better utilisation of existing on the ground health and allied health professionals
- Identifying areas suited to recruitment drives, relocation incentives and retention strategies
- Increased availability of safe sub-acute care and other alternatives to hospitalisation
- A focus on the development of self-management skills
- Locally coordinated care and support for people with severe mental illness
- Supporting self help and mutual support by incorporating models from other areas of health and community care

For these suggestions to result in fit-for-purpose mental health services and responses for rural and remote areas, close collaboration and communication with local health consumers, families and carers, clinicians and community services is required.

6.3.1 Promotion and ongoing development of telephone helplines and e-mental health services and incorporation into practice

The National Rural Health Alliance reports that considerable use is made in Australia of telephone counselling services such as Lifeline, Kids Helpline and beyondblue.

*These can be of particular use to people living in areas where few or no mental health professionals are available. This of course assumes that their particular area has good telephony connections (National Rural Health Alliance, 2014, p. 24)*

Telephone-based help and counselling services are an important first step and a pathway to both crisis support and then more specialised and/or intensive professional assistance. They are particularly helpful for people with lower levels of education and concomitant lower levels of literacy. Key informants argued that
telephone-based help and counselling services also play an important role in assisting to reduce unnecessary presentations to hospitals and their emergency departments in regional, rural and remote Australia.

The National Rural Health Alliance reported that research presented at the 12th National Rural Health Conference identified lack of awareness of telephone support services (79%) and confusion regarding the different types of support services available (71%) as major barriers to accessing mental health telephone support for rural and remote communities (National Rural Health Alliance 2014 citing Le Gresley, Darling & Reddy, 2013). A number of key informants concurred with the Alliance’s recommendation for promotion nationally throughout regional, rural and remote communities of available telephone-based help and counselling services. This recommendation appears substantiated and warranted.

**Suggestion 8**

*Coordinated promotion nationally throughout regional, rural and remote communities of available telephone-based help and counselling services that includes a focus on targeting people with literacy needs.*

Based on growing evidence about their effectiveness and costs benefits, the Australian Government has provided national leadership in promoting the development and implementation of E-Mental Health services. The *National E-mental health strategy for Australia* was launched in June 2012 (Australian Government Department of Health and Ageing, 2012). E-mental health services involve the delivery of mental health services by telephone, mobile phone and through online applications to extend the reach of mental health service support. E-mental health services can range from provision of health information, self-driven virtual therapy programs, and real time interaction via telephone or online with clinicians trained to assist people experiencing mental disorders.

E-mental health services provide an alternative, and an adjunct, to face-to-face mental health care. They are known to be both popular and effective, especially in the treatment of high prevalence, mild to moderate disorders such as anxiety and depression. They can be used anonymously and privately, 24 hours a day, from
anywhere in Australia and more widely around the world (Australian Government Department of Health and Ageing, 2012).

**Examples**

**OnTrack** aims to support mental and physical health and wellbeing by the provision of free online mental health, alcohol and drug information, programs and tools prepared by psychologists.

**headspace** (the National Youth Mental Health Foundation) has developed eheadspace to address the needs of young people in rural and remote areas. eheadspace is a confidential, free and secure online space developed for young people aged 12 to 25 years or their family to contact a qualified youth mental health professional via chat, email or telephone. Headspace is also expanding their use of telepsychiatry to complement their web based services.

**The Australian Government’s e-Mental Health Portal** – mindhealthconnect – provides a gateway for people to improve access to quality online services and information that they can trust.

**e-hub Assist** is a portal of resources for people who use e-hub services and e-facilitators who support others to use e-hub’s online self-help programs. It can be used by many people including mental health professionals, other health professionals, teachers, youth workers, carers and support workers.

**e-hub Self Help Program for Mental Health and Wellbeing**’s suite of online self-help services is based on the best available evidence and evaluated through high quality research (e.g. BluePages, Ecouch, MoodGYM, beacon and Blue Board).

A number of online Virtual Clinics to provide evidence based CBT are also commencing.

Schrader et al., 2014 recently reported on a trial of an eHealth system for the management of chronic conditions in a rural setting in South Australian. An online management program was developed which incorporated content from the Flinders Chronic Condition Management Program (Flinders Program) and used an existing
software platform (goACT), which is accessible by patients and health care workers using either Web-enabled mobile phone or Internet, enabling communication between patients and clinicians (Schrader et al., 2014). The impact of this eHealth system was analysed using qualitative and simple quantitative methods. The eHealth system was piloted with recently hospitalised patients from rural areas, average age 63 (SD 9) years, each with an average of 5 chronic conditions and high level of psychological distress with an average K10 score of 32.20 (SD 5.81). Study participants interacted with the eHealth system (Schrader et al., 2014). The average number of logins to the eHealth system by the study participants was 26.4 (SD 23.5) over 29 weeks. The researchers concluded that:

*The pilot demonstrated the feasibility of implementing and delivering a chronic disease management program using a Web-based patient-clinician application. A qualitative analysis revealed burden of illness and low levels of information technology literacy as barriers to patient engagement (Schrader et al., 2014).*

According to the National Rural Health Alliance, the Australasian Centre for Rural and Remote Mental Health and a number of key informants, there are two priorities:

1. the ongoing promotion of the availability of e-mental health services; and
2. the embedding of their use as a routine form of treatment and referral pathways through the upskilling and training of all primary health, allied health and specialist mental health professionals in the use and incorporation of e-mental health services into daily practice and to support people to use these resources effectively.

It is suggested that the Australian Government E-Mental Health Support Service (the Support Service) can potentially play a key role in the coordination nationally of the promotion of e-mental health services and as well as their adoption by the specialist mental health and primary health care sector with a particular focus on regional, rural and remote communities.

*Suggestion 9.*

*Promotion nationally of e-mental health services with a particular focus on targeting regional, rural and remote communities.*
Suggestion 10.

Leadership nationally through the Australian Government E-Mental Health Support Service (the Support Service) to embed the use of e-mental health services as a routine form of treatment and referral pathways through the upskilling and training of all primary health, allied health and specialist mental health professionals with a particular focus on regional, rural and remote Australia.

6.3.2 National leadership to ensure national coverage of telepsychiatry and other telemental health services

‘Telepsychiatry’ is the ‘use of communication technology to provide psychiatric services from a distance” (RANZCP, 1999). There is also the more general term “telemental health’, which may include a range of mental health services from professionals other than psychiatrists, and utilises different forms of telecommunications such as email, fax, telephone, internet, still images and videoconferencing. The term ‘telecare’ refers to care delivered in the home via telecommunications. Telemental health can be categorised into three areas: patient care; educational and workforce support; and administrative activities (Millar, 2009).

The Queensland Parliament’s Health and Community Services Committee recently conducted an inquiry into telehealth services (including mental health) throughout the state. The Committee’s definition of telehealth encompasses the delivery of health-related services and information via telecommunication technologies, and includes:

- live, audio and/or video interactive links for clinical consultations and educational purposes
- store-and-forward telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists
- telehealth services and equipment to monitor people in their home (QLD Parliament Health and Community Services Committee, 2014)
The Royal Australian and New Zealand College of Psychiatry Position Statement on Telepsychiatry summarises its evidence base (RANZCP 2009, p. 2) and provides the following conclusions.

- Telepsychiatry can be a very effective means of improving rural and remote community access to specialist psychiatric resources by facilitating timely, cost effective and responsive psychiatry services.
- Telepsychiatry options enable support to be provided to local health care providers, and most significantly the mental health workers and the general practitioners in the care of psychiatric patients in their local community.
- Research has demonstrated that the psychiatric interviews conducted over videoconferencing are reliable for diagnostic assessment and treatment and as effective as face-to-face consultations in achieving improved health outcomes.
- Patient and referrer satisfaction has consistently shown that this mode of clinical service delivery is widely accepted.
- Patients have been found to be: satisfied with the service; happy to use telepsychiatry again; and in preference of telepsychiatry over travelling to a larger centre for face-to-face consultations.
- Telepsychiatry decreases unnecessary referrals, reduces the need for patient transfer, and increases opportunities for local treatment and/or early release.

Activity in telehealth in most Australian jurisdictions commenced in the mid to late 1990s, encouraged by project funding provided by the Australian Government to health departments in the states and territories.

Encouragement of telehealth activities in Australia was, in general, a response to the need to improve access to health services for people in rural and remote areas. More recently, issues of cost effective delivery of services and improved monitoring of chronic conditions have also become arguments for the expansion of telehealth activity (QLD Parliament Health and Community Services Committee, 2014).
The Queensland Parliament Health and Community Services Committee’s report provides a review of the evidence base of the effectiveness of telehealth as well as the barriers to its efficient and effective statewide use. The Committee concluded that the most significant benefits of delivering services by telehealth accrue to patients. Improved access to health services, particularly timely specialist and emergency advice, can in turn lead to improved health outcomes. The Committee argued that telehealth can in many instances, relieve the unreasonable burden of travel on patients as well as its costs.

Example: Mental Health Emergency Care Rural Access Project (New South Wales)

The Mental Health Emergency Care Rural Access Project aims to improve access to emergency mental health services and treatment in rural and remote hospitals emergency departments across western NSW. A specialist team at Bloomfield Hospital in Orange provides assessments for mental health clients in remote and rural hospitals via videoconference 24 hours a day, 365 days a year.

With the support of the expert team, people who needed to travel hundreds of kilometres to receive expert clinical assessment, can often be cared for in their local hospital. The team also provides training and specialist advice to local clinicians, providing them with the skills to confidently manage mental health presentations.

A major challenge identified by the Committee to delivering health services by telehealth is the need for health professionals, health service providers and health administrators to think differently about the way they work, and to focus on delivering patient-centred care. Clinician engagement emerged as an important factor in overcoming the barriers to the greater use of telehealth.

The challenges of implementing telehealth are not unique to Queensland. Reflecting the project funding basis of trials and pilots, the use, reach, management, and coordination of telehealth in mental health service delivery varies across Australian jurisdictions. In some it is centrally coordinated and in others it is managed by primary care providers or hospitals or supported by regional ‘alliances’ (Blywood et al., 2013). As a result of this patchwork process of development, telehealth is yet to
be viewed an integral component of mental health service delivery and is yet to be embedded in mainstream service nationally (QLD Parliament Health and Community Services Committee, 2014).

A number of key informants argued strongly that the current rollout of the National Broadband Network (NBN) provides an opportunity to extend the reach and effectiveness of telemental health services into the remotest or most distressed rural Australian community. The NSW Mental Health Commission (2014) identified the need for national leadership to ensure co-ordinated action across all levels of government as well as across borders and across a range of health and community sectors. National leadership would also assist to reduce duplication.

This work might potentially proceed under the auspice of the Australian Health Minister’s Advisory Committee. Key issues would include:

- how national coverage might be achieved, particularly in relation to responding in a timely manner to mental health emergencies in the most remote areas of Australia and/or in areas where mental health workforce shortages are most critical;
- guidelines and protocols for supporting the delivery of telehealth to people experiencing mental health and alcohol and drug conditions;
- improvements that can be made in each state and territory to support high quality access in rural and remote areas to telehealth services for mental health and/or alcohol and other drugs;
- how telemental health services can be used to reduce the need for hospitalisations and out of area health care transfers; and
- workforce training required to embed telemental health into practice.

**Suggestion 11.**

*National leadership to ensure national coverage of telepsychiatry and other telemental health services and to develop nationally agreed guidelines for the use of these services.*
6.3.3 Better and more targeted access to Commonwealth funded mental health services through Better Access and Medicare Benefits Schedule (MBS) Items and other programs

Morley et al., reporting on their review of 51 rural Access to Allied Psychological Services projects, funded under the Better Outcomes in Mental Health Care program, concluded:

the findings suggest that the rural projects have the potential to improve access to mental health care for rural residents with depression and anxiety, by enabling GPs to refer them to allied health professionals (Morley et al., 2007, p. 304).

Drawing on the work of Morley et al., this section makes a number of suggestions for improving access to mental health services for people in rural and remote areas through the following schemes and provisions:

- Chronic Disease Management under Medicare Benefits Scheme
- Mental Health Services in Rural and Remote Areas
- Mental Health Nurse Incentive Program (MHNIP)
- Access to Allied Psychological Services (ATAPS)
- ATAPS Child Mental Health Focused Service (CMHS)
- The visiting psychiatric services through the Medical Specialist Outreach Assistance Program (MSOAP)
- MBS item numbers for telepsychiatry

Chronic Disease Management under Medicare Benefits Scheme - Currently, the MBS includes a number of chronic disease management items designed to support multidisciplinary care for patients with chronic conditions, such as diabetes or ischaemic heart disease. The General Practice Management Plan (GPMP) (Item 721) allows for an extended GP consultation and plan for the management of a chronic medical condition (defined as one that has been or is likely to be present for at least six months).

A corollary item, the Coordination of Team Care Arrangements (TCA) (Item 723) supports a multidisciplinary approach (a team of at least three health or care
providers including the GP) for the treatment of diabetes, for example, where a diabetes educator, podiatrist and general practitioner may provide (MBS rebated) services to the patient under the TCA.

The Victorian Ministerial Advisory Council on Mental Health (MAC) noted there are several limitations to the utility of these MBS items in respect to adequately supporting health care for people with enduring mental illness (2011). The MAC argued that total number of allied health services (five) allowed per calendar year is too few to support good health for this client group; the rebate is insufficient as an incentive for providers and inadequate for patients if they cannot meet gap payments; and the organisation and paperwork for the GPMP and TCA must be undertaken by busy GPs who find this a disincentive to co-ordinating care. Consequently, and anecdotally, the MAC argued that few GPs use these items to arrange care for their patients with a mental illness.

The MAC recommended that the Victorian Government advocate to the Australian Government to:

- Introduce an MBS item for an annual GP physical assessment of patients with a severe mental health illness as a minimum requirement.
- Implement an adequately funded ‘voluntary enrolled’ GP population approach for people with severe mental illness on the basis of the degree of health inequality experienced by this population group.
- Reduce or eliminate ‘gap’ fees for people with severe and enduring mental illness who are economically disadvantaged.
- Provide ‘block funding’ to selected GP clinics, including Community Health Services, to ensure the prioritisation of access for people with severe and enduring mental illness.
- Consideration block funding for credentialed nurses to ‘fill the gap’ where GPs are unable or unwilling to provide physical health care to this patient group.
- Review, expand and tailor the existing MBS Chronic Disease Management items (particularly the under the Team Care Arrangement) to provide
additional and more affordable allied health services to people with severe mental illness.

- Review and make the current diabetes Lifestyle Modification Program openly available to, and appropriate for, people with severe mental illness referred through general practice.
- Investigate the tailoring of existing health promotion and lifestyle programs, currently delivered through general practice to patients with chronic disease, to the needs of people with a severe mental illness.

These recommendations retain currency and appear relevant to the Commission’s current review. Priority could be given to targeting these changes to rural and remote communities with greatest need and most critical mental health service workforce shortfalls and barriers.

**Mental Health Services in Rural and Remote Areas (MHSRRA)** – The Mental Health Services in Rural and Remote Areas (MHSRRA), A COAG Mental Health initiative, aims to provide greater access to mental health services for those living with a mild to moderate mental illness in rural and remote Australia.

The Australian Government provides funding of up to $125 million from 2006-07 to 2014-15 under the Program, including $32 million over two years from 1 July 2011 to 30 June 2013 (Source: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-rural). To achieve its outcomes, the program funds Aboriginal Medical Services, Medicare Locals and the Royal Flying Doctor Service to engage allied and/or nursing mental health professionals limited to:

- Aboriginal Health Workers;
- Aboriginal Mental Health Workers;
- Clinical Psychologists/Psychologists;
- Mental Health Nurses;
- Occupational Therapists; and
- Social Workers.

The Program provides funding for participants to engage mental health professionals in communities that would otherwise have little or no access to mental health
services. The Program aims to address inequities in access to the Medicare Benefits Schedule (MBS) by targeting areas where access to MBS subsidised mental health services is low. The MHSRRA program also seeks to address workforce shortage issues by providing flexible employment models suited to local needs and conditions.

An evaluation of the program, conducted by PricewaterhouseCoopers (PwC) in 2011, found that the MHSRRA Program has provided a service to rural and communities and has demonstrated how a program of this nature can be successful.

The key ingredients of this success include implementation and management of the services provided via local organisations and sufficient flexibility within the Program guidelines to be able to tailor services to local needs (PWC 2011, p. 17).

The evaluation report advised that the ongoing success of the Program is dependent on a number of factors including capitalising on what has worked well, addressing challenges and ensuring continuous improvement of mental health services for rural and remote Australians.

The appropriateness, effectiveness and efficiency with which the Program has been implemented provide a strong foundation for the ongoing benefits realisation and the sustainability of the program (PWC 2011, pp. 17-18).

PwC also concluded that there is potential to capitalise on the accomplishments of the MHSRRA Program and broaden the reach of the Program.

The implementation of the recommendations will only serve to strengthen the Program and achieve the overall aim to provide greater access to mental health services for those living in rural and remote areas of Australia (2011, p. 18).

Key among PwC’s recommendations were:

- an increased focus on mental health prevention, promotion and education;
- increased focus and service offerings for children and young people with mental illness living in rural and remote areas;
- review of the program’s workforce guidelines for eligibility of mental health professionals employed under the Program and consideration of new workforce models such as support workers and internships;
- review of the appropriateness of referral guidelines and referral sources based on access to GPs in rural and remote communities; and
- investigation of the provision of support services and education for families and carers in rural and remote areas.

PwC’s final recommendation was that the Department of Health and Ageing consider providing continued funding for the MHSRRA Program and thereby enabling continued provision and expansion of mental health services in rural and remote areas.

These recommendations retain their currency and appear relevant to the Commission’s current review. Consideration could be given to the adoption and implementation of these PwC recommendations.

**Mental Health Nurse Incentive Program** - The Mental Health Nurse Incentive Program (MHNIP) provides a non-MBS incentive payment to community based general practices, private psychiatrist services, Medicare Locals and Aboriginal and Torres Strait Islander Primary Health Care Services who engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders.

Under the program, Mental Health Nurses may deliver case-management, counselling and appropriate medication administration as required. Amongst many benefits, the capacity to follow up patients who do not attend medical appointments and encourage regular medical attendance was considered to be a noteworthy strength of this program (HMA 2012).

The holistic approach to care delivered through this service model ensures that the patient can be managed systemically and in conjunction with the GP for any physical health concerns. Opportunistic intervention is facilitated by the co-location of the Mental Health Nurse with the GP. Patients have been enthusiastic about this program because it is fully funded (no cost to the patient) and there is less stigma associated with attending a mental health nurse in a GP clinic (HMA 2012).

The program was evaluated by HMA in 2012. Key findings included the following.
MHNIP is providing support to a sizeable group in the community – people with severe and persistent mental health illness who are primarily reliant for their treatment on GPs and psychiatrists in the private sector (around 0.6% of the adult population).

The model of care involving clinical treatment and support provided by credentialed mental health nurses working with eligible medical practitioners received strong endorsement.

Patients receiving treatment and support under the program benefitted from improved levels of care due to greater continuity of care, greater follow-up, timely access to support, and increased compliance with treatment plans.

There is evidence of an overall reduction in average hospital admission rates while patients were being cared for, and reduced hospital lengths of stay where admissions did occur.

There is also evidence that patients supported by MHNIP had increased levels of employment, at least in a voluntary capacity, and improved family and community connections.

MHNIP has had a positive impact on medical practitioner workloads by increasing their time available to treat other patients and improve patient throughput.

The Evaluation reported that based on the de-identified patient data provided by case study organisations (N= 267 patients), the cost analysis suggests that savings on hospital admissions attributable to MHNIP were on average around $2,600 per patient per annum. This is roughly equivalent to the average direct subsidy levels of providing MHNIP, which ranged from an average of $2,674 for patients in metropolitan areas to $3,343 in non-metropolitan areas.

HMA also concluded that:

there are a large number of uncosted and intangible benefits associated with MHNIP, including the impacts of improved patient outcomes, enhanced relationships with carers and family members, and the effects on carer social security outlays. The evaluation findings suggest a comprehensive economic analysis would find these benefits to be positive (2012, p. vii).
Although the model of care underpinning MHNIP is well regarded and has positive outcomes, HMA argued that certain design features of the program could be re-examined. Included here are the current purchasing arrangements. These provide limited capacity to manage demand in line with program resource allocations and do not enable growth to be targeted at geographic areas of greatest need.

The evaluation report also highlighted the need to address the uneven geographic spread of MHNIP services, the lack of control over program expenditure, and the need to strengthen operational guidelines and improve data collection (HMA, 2012).

The VIC MAC noted that the MHNIP practice guidelines restricts Mental Health Nurses working in GP clinics from seeing patients who are clients of specialist mental health services (2010). The MAC noted that at least two Victorian Medicare Locals have arrangements with their local Area Mental Health Service to “lease” Mental Health Nurses to work for several sessions per week in local general practices whilst remaining employed by the Area Mental Health Service. The MAC argued that this model provides excellent continuity of care to patients once they are engaged with general practice and supports the Area Mental Health service discharge planning. This model is thought to also ensure that the GP’s patients have timely access to acute care when needed (Victorian Ministerial Advisory Committee on Mental Health, 2010).

The MAC argued that significant opportunity exists to strengthen the interface between Mental Health Nurses in GP and other primary health service settings and the specialist mental health services. The MAC recommended that the Victorian Government advocate to the Australian Government to:

- expand the Mental Health Nurse Incentive Program and mandate this program to include the physical health of people with severe and enduring mental illness;
- expand the sub-contractual model of employment of Mental Health Nurses in general practice through Divisions of General Practice (Medicare Locals) and Area Mental Health Services; and
- develop of a team-based approach between both service sectors to support the patient to access timely GP care and improve the management of chronic physical disease.

These recommendations require the expanding of the health role for Mental Health Nurses to include support to the specialist mental health clinicians to undertake, review and monitor physical health assessments.

To address inequity of access to the scheme across rural and remote Australia, other changes that could be considered and could be piloted initially in areas with high mental health need and an acute shortage of mental health professionals include:

- incentive loading whereby the base-hourly rate is increased in acknowledgement of the additional costs of rural and remote practice as well as problems associated with sustaining financially viable positions;
- Increased service allocations (i.e., the number of sessions) for existing service providers;
- additional but targeted allocations of MHNIP service provider organisations.

**Better Access and the Access to Allied Psychological Services (ATAPS)** - Both the relatively small Access to Allied Psychological Services program (ATAPS) and the larger Better Access programs enables GPs, psychologists and other mental health professionals to contribute to mental health care. Under both Better Access and the Access to Allied Psychological Services schemes, GPs can initiate sessions with psychologists and other mental health professionals. The ATAPS has demonstrated a capacity to flexibly deliver psychological services with the involvement of GPs to people with complex mental health care needs (National Rural Health Alliance 2014).

However, the proportion of people who receive a mental health service funded or subsidised by Medicare has been shown to fall off dramatically with increasing remoteness. In Major Cities, over 75 per 1,000 head of population benefit from an MBS-subsidised consultation with a mental health provider, compared with 18 per 1,000 in Very Remote areas (National Rural Health Alliance, 2014). A key factor in both Better Access and ATAPs having had reduced application in more remote areas, is the shortage of GPs and psychologists in those areas (National Rural Health Alliance, 2014).
In this way, the shortage or absence of GPs in rural and remote communities acts as a barrier or block to accessing psychological services.

If a person living in a rural or remote community could have a limited number of sessions with a psychologist or another mental health professional reimbursed by Medicare before requiring the referral from the GP, this barrier would be alleviated.

This provision is currently available through the ATAPS Child Mental Health Focussed Service (CMHS) program but it is not available for adults (National Rural Health Alliance, 2014).

The fine tuning of Better Access and ATAPS in this way would be welcomed by people in rural and remote areas but it must include flexible funding and straightforward guidelines that enable appropriate programs to be tailored to meet the needs of a particular community or individual (National Rural Health Alliance, 2014). Consideration could be given to initially piloting this change in a number of high needs rural and remote areas.

**ATAPS Child Mental Health Focussed Service (CMHFS)** - ATAPS Child Mental Health Focused Services (CMHS) for children from birth to 11 years allows for a Provisional Referral from School Counsellors and Principals to psychologists. This means that psychologists in a remote location can provide up to three sessions to the child before requiring a Mental Health Care Plan (MHCP) from a GP. Though welcoming this provision, key informants noted that three sessions are insufficient to many situations presenting in rural and remote areas where access to GPs is limited by distance and affordability (National Rural Health Alliance, 2014). Counseling and therapy that has only just commenced is stopped and delayed until a GP referral can be obtained.

Increasing the number of sessions from three to six under the Provisional Referral provisions and incorporating CMHFS into the Telehealth Benefits scheme would greatly assist the efficiency and effectiveness of care.

**Medical Specialist Outreach Assistance Program (MSOAP)** - The Medical Specialist Outreach Assistance Program (MSOAP) improves access to psychiatrists (and other
medical specialists) in rural and remote communities. The Program has proven to be most successful when implemented in consultation with local communities and with local health professionals working in the area (National Rural Health Alliance 2014).

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

**Incentives for Telehealth** – Currently certain health providers are eligible for Telehealth Medicare Benefits Schedule (MBS) items. This scheme enables consultations facilitated by Consultant Psychiatrists, GPs, nurse practitioners, midwives, practice nurses and Aboriginal Health Workers to be reimbursed through Medicare for their clients living in rural and remote areas to participate in a videoconference with a specialised psychiatry service. Mental health professionals such as psychologists, mental health nurses, occupational therapists and social workers and Allied Health Professionals are ineligible for this scheme (Medicare Benefits Schedule — Allied Health Services 1 March 2014, http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/2F8294726E8247C8CA257C70001292AD/$File/201403-Allied.pdf).

For a number of years an additional scheme, the Telehealth Financial Incentives Program, provided incentives to encourage change in the way in which services are provided. Incentive payments recognised that incorporating telehealth into everyday workflows can represent a significant change to traditional practice that will affect billing and scheduling systems, IT systems, staff training, and capital improvements to establish telehealth-appropriate rooms at a practice.

The Queensland Mental Health Commission argues that restrictions on the Telehealth MBS items act as disincentive for rural and remote mental health service provision and inhibits access to specialist clinical mental health services for people in
rural and remote areas experiencing mental illness and extreme psychological distress (QLD Mental Health Commission, April 2014).

As a means of ensuring 24 hour emergency access to the services and advice of specialist mental health professions in rural and remote areas, consideration should be given to:

- enabling GPs in certain circumstances to bill for their interaction via telehealth with public sector specialists;
- including under the Telehealth MBS Items all professional groupings currently recognised as ‘mental health professionals’ under Medicare in addition to GPs, nurse practitioners, practice nurses and Aboriginal Health Workers;
- ensuring that areas eligible for Telehealth MBS include those rural and remote areas of greatest mental health need as well those facing severe mental health workforce shortage

Additionally, and as means of reducing the rates of hospitalisation and out of area hospital transfers, consideration could be given to a pilot of telemental health incentives targeting allied health professionals who can assist people living with and recovering form comorbid health, mental health needs and alcohol and drug conditions to return and stay in their homes and communities.

**Suggestion 12.**

*Better and more targeted access to Commonwealth funded mental health services through Better Access and Medicare Benefits Schedule (MBS) Items and other programs.*

These would include:

- Chronic Disease Management under Medicare Benefits Scheme
- Mental Health Services in Rural and Remote Areas
- Mental Health Nurse Incentive Program (MHNIP)
- Access to Allied Psychological Services (ATAPS)
- ATAPS Child Mental Health Focussed Service (CMHS)
- The visiting psychiatric services through the Medical Specialist Outreach Assistance Program (MSOAP)
- MBS item numbers for telepsychiatry)
6.3.4 Better utilisation of existing on the ground health and allied health professionals – a best-fit-for-needs approach

This section outlines suggestions for enabling a ‘best-fit-for-needs’ approach by utilising on the ground health and allied professionals and by systematically embedding primary mental health services in local multi-disciplinary primary care networks.

Primary care approaches to the delivery of primary mental health services –
Several authors (Campbell, 2005; Nagle, et al., 2011; Lewis, 2012; Fuller et al., 2011; and Perkins et al, 2006) provide evidence of the effectiveness of numerous and differing trials of delivering primary mental health services through GPs, nurses and other generalist primary health care professionals who are living within remote areas and rural towns. Medicare Locals have also been making significant progress in establishing primary health care-based models suited to particular geographical areas (Australian Medicare Local Alliance, 2014). Key informants suggest that much of this largely project-based service development might be lost.

The Royal College of General Practitioners (2014) argues that a primary care strategy is of critical importance to providing mental health services in rural and remote Australia (2011). The Centre for Rural and Remote Mental Health Queensland concludes similarly:

Integration of mental health into the primary health care service enables a focus on the provision of holistic and coordinated care, liaison and advice, and the development of clinical pathways between and across a range of agencies. As such, the focus of integrated care at a systems level is at the interface between health service providers and the creation of client care pathways, including entry, transition and exit. Examples of where clinical pathways can be developed across service systems that may be involved in a client’s care include accommodation, legal, families, ambulance, police, and criminal justice (CRRMHQ, 2011, p. 14).

The Royal Australian College of Practitioners, the Australian Medicare Local Alliance and National Rural Health Alliance and other key informants argued for a systematic approach to utilising GPs, practice nurses, nurse practitioners, registered nurses and
other nurse specialities including midwives to provide primary mental health services. A number of key informants suggest that nurses as a professional grouping are under-deployed and under-employed in rural and remote areas and could assist with both health and mental health care needs of people across the life span. This suggestion is also supported by the research and published literature (Hanrahan & Hartley, 2008; Ellis & Phillips 2010).

National leadership (possibly through AHMAC) is recommended to facilitate the development of a national primary care strategy for mental health service delivery in remote areas and in rural towns where there is a limited specialist capacity. This strategy would build on and augment progress to date as well as enabling the development and implementation of further approaches that are place-based, suited to local need and have the capacity to utilize and upskill on the ground generalists.

**Suggestion 13.**

*National leadership through AHMAC (or other national entity) is recommended to facilitate the development of a national primary care strategy for mental health service delivery in remote areas and in rural towns where there is a limited specialist mental health service capacity.*

Promotion of multi-disciplinary and co-located approaches within primary care networks that are delivering primary mental health services and responses – A number of researchers (Humphreys & Wakerman, 2010; Jelinek et al., 2011; Nagel et al., 2011; Lewis, 2012; Fuller et al., 2011; Allenby et al., 2005; Perkins et al., 2006) have discussed the contribution that multi-disciplinary and co-located approaches can make to enabling sustainable primary mental health services in rural and remote areas.

Key informants recommend the targeting of incentives and support for co-located and multidisciplinary practices within primary health care networks. Professional groups in additional to social workers, OTs, psychologists and mental health nurses who could collectively assist a holistic approach as well improved quality of life include physiotherapists, exercise and sport physiologists, nutritionists and dieticians, health science, health promotion and health management professionals,
employment advisers and rehabilitation workers etc. These additional professional
groups, though not traditionally viewed as mental health clinicians, are increasing
their presence in regional, rural and remote areas (Sources: State and Territory
unpublished community mental health care data Private Mental Health Alliance
unpublished Centralised Data Management Service data; Department of Health and
Ageing unpublished MBS Statistics; Department of Veterans’ Affairs unpublished
Treatment Account System data; Australian Bureau of Statistics unpublished)
Estimated Residential Population, 30 June 2010). These professional groupings could
support more rapid and sustained recovery and return to everyday roles and
responsibilities including education, training and employment (Jelinek et al., 2011).

Suggestion 14.

The targeting of incentives and support for co-located and multidisciplinary practices within
primary health care networks.

6.3.5 Increased availability of safe sub-acute care and other alternatives to
hospitalisation

Under the National Partnerships Sub Acute Projects (2009/10 to 2014-2015), state
and territory governments have been developing a range of sub-acute care mental
health services. Some services have been located within public mental health
services whilst others have been developed in partnership with non-government
providers. The purpose of these services is to avert crisis, prevent relapse, promote
recovery and enable the consumer to return to their usual wellness state and living
environment. In South Australia, by way of example, the following have been
developed.

- **Supported sub-acute accommodation** – individually tailored and short-term
psychosocial and rehabilitation support service for 80 people including at
least 15 places for youth and 15 places for Aboriginal and Torres Strait
Islander people.
- **A 10-bed forensic mental health step-down facility**, adjacent to James Nash
House, to provide community rehabilitation support to consumers
transitioning back into the community.
- **Crisis Respite facility-based** - 24 new sub-acute crisis respite beds provided across three sites in the metropolitan area (8 in each metropolitan area).

- **Crisis Respite in the home** - 10 new community bed equivalent packages provided by clinical staff and non-government organisations to people in crisis in their own home (operating on a 24 hours a day, 5-7 days a week basis) with programs located in a number of rural and remote centres – Whyalla/Port Augusta, Mt Gambier, Port Lincoln and Kangaroo Island.

- **Youth sub-acute inpatient unit** - a Statewide 15-bed youth sub-acute mental health residential unit, in a community setting, for youth and young adults aged between 16-24 years old with emerging serious mental illness.

- **Country Community Rehabilitation Centres** - Two purpose built country Community Rehabilitation Centres in Whyalla and Mount Gambier – accommodation consisting of 10 self-contained, independent living units, with single bedrooms and ensuites with the purpose of supporting adults with a primary diagnosis of mental illness who have high and complex needs and who require a combination of clinical and non-clinical care and rehabilitation in a supportive, residential environment. (SA Health website).

A similar range of sub-acute services have been established in regional, rural and remote centres around Australia. Some examples are:

- **Far West Mental Health Recovery Centre at Broken Hill** - 10 bed centre operated by Neami National (a non-government organisation) in partnership with the Far West Mental Health and Drug and Alcohol Service, providing early intervention for people who are becoming unwell in the community (step up) and for those in the early stages of recovery from an acute episode in the inpatient unit (step down) to strengthen and consolidate gains from the inpatient setting;

- FSG, non-government organisation operates a peer-run crisis support and respite accommodation program on the Sunshine Coast; and

- **Prevention and Recovery Care (PARC) Services** – provided by SNAP Gippsland (a NGO) and operating at Latrobe, is a short-term (7-28 days), residential treatment service located in the community that provides recovery oriented
support required to avoid admission to acute mental health facilities and to develop strategies to cope better at home and continue the recovery journey.

Whilst information could not be found about the effectiveness of sub-acute services in regional, rural and remote areas, Thomas et al., (2013) conducted a systematic review of the literature to identify studies that have evaluated the clinical effectiveness, user satisfaction, or cost-effectiveness of acute or subacute residential treatments. Outcome data were extracted from quantitative studies, and themes relevant to service satisfaction were extracted from qualitative studies. The researchers provided the following conclusions.

Acute residential mental health services offer treatment outcomes equivalent to those of inpatient units, with users reporting high satisfaction. Acute residential services offer a cost-effective alternative to inpatient services. Further research is needed to determine client groups that will benefit most from these alternative services (2013, p. 1140).

The Australian Government National Health and Hospitals Reform Commission (2009) concluded that mental health sub-acute services have demonstrated a capacity to provide alternatives to hospitalisation, reduce unnecessary hospitalisation, facilitate appropriate professional assistance at an earlier point and avert out of area transfers.

For those that are admitted and discharged from a hospital, there is concern that they are left largely unsupported and at risk of relapsing. If going home isn’t possible straight away, the system should offer the same suite of clinical and non-clinical services as well as access to short- to medium-term accommodation options (step-down care). The same suite of community-based services should be available to manage the care of people before they become acutely unwell and require hospitalisation (step-up care) (2009, p. 252).

The Commission recommended that the prevention and recovery care model should be adopted more broadly to improve health outcomes for this vulnerable group and ensure that people receive the right care in the right setting.
This recommend retains currency and is apposite to the task of improving mental health service access and outcomes in regional, rural and remote Australia.

**Suggestion 15.**

*The continued roll out and evaluation of a suite of sub-acute mental health services that support stepped prevention and recovery care is recommended with a focus on regional, rural and remote areas of high need.*

### 6.3.6 Locally coordinated care and recovery support for people with severe mental illness

**Local recovery support services** – Evidence received and examined during this project points to the need for the continuation and augmentation of Commonwealth funded community-based mental health support programs, including for example Partners in Recovery, the Personal Helpers and Mentors service (PHaMs), Day2Day Living, Support for Families and Carers, while the overlap between these services and the new NDIS-based services is established.

The problems are both administrative and legislative. One hundred per cent of the PHaMs, 70% Partners in Recovery, 50% Mental Health Respite for Carers and 35% Support for Day to Day Living in Community funds are to be rolled over into the NDIS (Maher, 2014). However, the definitions of disability and criteria for eligibility provided in the National Disability Insurance Scheme Act 2013, will result in large numbers of people currently receiving Commonwealth funded services not being eligible for services under the NDIS.

The situation is further complicated by some states and territories rolling over into the NDIS, funding they currently provide to non-government organisations for recovery support services. However, not all of the services currently funded by states and territories are provided by the NDIS. So services including residential support, supported accommodation, sub-acute services, peer support, advocacy and centre-based recreational and therapeutic programs will be unfunded (VICSERV, 2014).

Further, as a consequence of a switch from block funding packages of care based on various hourly rates, it is likely that many non-government organisations who are
currently providing recovery support services for people living with severe mental illness and who have built up considerable expertise, will find they are not able to sustain viable and sustainable business models (VICSERV, 2014). In rural and remote towns, agencies such as these are often the only organisations with expertise in recovery support and psychosocial rehabilitation. Many have also become an oasis of resources that communities have come to rely upon.

Key informants argued that the continuation of these programs is required until it is known how many people with severe mental illness who are currently receiving a service will be eligible for the NDIS. It will also be important to establish where these people are living and whether there are any other services available locally.

The PHaMs program is useful starting point for discussion. As far as can be ascertained here there are currently 216 PHaMs sites providing services to around 15,066 people. At least 80 sites are in non-metropolitan sites and a further 14 in remoter communities. Initial advice from the Hunter trial points to between 70-80% of PhaMHS participants not being eligible for NDIS (MHCC, June 2014).

Upon reviewing available information and interviewing key informants, we have reached a number of conclusions. Firstly, the guiding principle for the next here years should be:

**no one with severe mental illness currently receiving a service loses that service.**

Secondly, it seems unrealistic to expect that the NDIS is a one-stop solution for the needs of all people living with disability as well as impairment arising from health conditions including mental illness. The NDIS is rightly targeted at people with permanent disability. Mental health recovery support and psychosocial rehabilitation services are rightly targeted at people whose mental illness significantly impairs their capacity to do the things they need to do on daily basis. This level of impairment will vary both in intensity and duration. For some it will be episodic, whilst for others there will be ongoing impairment but the level of impairment for this group will vary from time to time and from person to person.
Thirdly, the cost-effectiveness of the NDIS program for people with severe mental illness will be undermined if there are not services such as those currently funded by the Commonwealth for people to step down into. Further, the existing Commonwealth funded community mental health services have the capacity to play a preventative role. The recovery-orientation of these services will result in higher proportions of people recovering and not requiring the services of the NDIS.

Fourthly, once it is known what proportion of people with severe mental illness who are currently receiving a service are eligible for the NDIS, the criteria and targeting of the existing Commonwealth funded programs could be adjusted to include those with co-morbidities, particularly those with both mental illness and drug and alcohol disorders and those who are at risk of progressing from moderate impairment to severe.

**Suggestion 16.**

*There is a need for the continuation and augmentation of Commonwealth funded community-based mental health support programs, including for example Partners in Recovery, the Personal Helpers and Mentors service (PHaMs), Day2Day Living, Support for Families and Carers, until the overlap between these services and the new NDIS-based services is established.*

**Ensuring a continued focus on physical health care needs** – People living with mental illness, as a group are known to have poorer health than the general population. VICESRV (2008) summarises the evidence:

- People living with severe mental illness have an overall health status that is far lower than that of the mainstream population, resulting in significant health inequalities.
- The death rate of people with severe mental illness is 2.5 times greater than that of the general population, which is equivalent to a life expectancy of 50 - 59.
- People with schizophrenia have a mortality rate that is up to three times higher than that of the general population.
- People with mental illness have a higher death rate across each of the main physical causes, with heart disease causing the highest number of ‘excess’ deaths.
The death rate from heart disease has not declined for this group in recent years, in stark contrast to the general population and has actually increased substantially for women with mental illness.

The number of deaths in people with severe mental illness, due to main physical causes, far exceeds the number of hospital admissions for related conditions. Conditions such as heart disease are not being picked up or treated until it is too late.

Whilst the incidence of cancer appears to be no different for people with a mental illness and the general population, people with mental illness are 30.0% more likely to die from a cancer diagnosis.

Whether and how mortality and morbidity rates for people with mental illness differ across geographic areas and across states is not known. Factors giving rise to poorer health outcomes are likely to be numerous. Key factors possibly include:

- Poor inter-sectoral collaboration, knowledge transfer and resource sharing between the mental health service sector and primary care and (non-psychiatric) acute care sectors;
- A tendency (likelihood) for specialist mental health, clinical and recovery support workers to overlook and/or under-address the physical health issues of their patients/clients; and
- Reluctance on the part of other health providers to engage and treat people whose behaviours are affected by mental illness (VICSERV, 2008).

A further key factor is that people living with severe mental illness might frequently ‘fall between the cracks’ of service systems leaving a range of physical conditions ignored and untreated, resulting in tragic health outcomes.

In recent years, public, private and non-government health services have collaborated to improve health outcomes.

The establishment of the new primary health organisations provides an opportunity for a nationally coordinated effort to improve the health outcomes of people with mental illness. Opportunities include: integrated, multi-disciplinary approaches – new models and ways of thinking, funding and working; tailored prevention and
early intervention strategies; building linkages between mental health and primary and sub-acute/acute care; and making improvements in referrals (with an emphasis on supported referral) and other aspects of service coordination.

### A Rural Example South East SA GP-Access Pilot, Uniting Care Wesley, Port Adelaide

GP Access Pilot is to support patients self management of their mental illness/health and to support the links between GP’s and other health providers in the region. GP Access provides, based on self management principles, recovery focused care planning and psychosocial rehabilitation utilising the Flinders Model of Chronic Condition Self Management Model as developed by the Flinders University Human Behaviour and Health Research Unit.

The target group broadly were patients who do not access Community Mental Health (Public) for their clinical case management, have a diagnosed mental disorder and who require a short-term intervention to support their self management. It was also envisaged that the patient engages in clinical support from primarily one GP.

GPs who referred to the Project were from a geographical area bounded by Naracoorte, Millicent and Mount Gambier referred to the Pilot.

The pilot demonstrated both improved health and mental health outcomes and was well received by GPs, people with mental illness themselves, other local health services and community organisations.

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**Suggestion 17.**

*The establishment of the new primary health organisations be tasked with coordinating initiatives to improve the health outcomes of people with mental illness.*

### 6.4 Building and skilling up workforces

#### 6.4.1 Identifying areas suited to recruitment drives and retention strategies

A number of key informants advised that some locations, particularly regional centres with proximity to major urban areas, might lend themselves to a drive to recruit, train, support and retain specialist mental health professionals including psychiatrists, mental health nurses and psychologists. An example provided during
the key informant interviews is the Ballarat Health Services Psychiatrists Training Program, a structured program of support for overseas recruits that has been operating for over ten years. The program provides intensive acculturation, on-going professional development and support as the new psychiatrists work towards their Royal Australian and New Zealand College of Psychiatrist Fellowship exams (http://www.health.vic.gov.au/healthvictoria/may10/overseas.htm). The program is reported to be succeeding in retaining psychiatrists both locally and in other rural Victorian towns (personal communication Dr Abdul Khalid, 2014).

The National Mental Health Workforce Strategy and Plan, endorsed by the Australian Health Ministers’ Conference in September 2011, envisaged strategies of this nature.

**Suggestion 18.**

*Promote, implement and evaluate regional recruitment mechanisms to engage people in mental health career pathways in regional, rural and remote Australia, targeting areas and communities that need it most, such as socioeconomically disadvantaged areas that are underserviced by the current system, and where there is evidence to suggest the efficacy and sustainability of recruitment and retention strategies. Included would be the trailing of creative solutions such as:*

- workforce incentives for recruitment and/or relocation;
- packages to support the relocation and settling in of families;
- rural allied health scholarships;
- workforce development support – e.g. funding for position back fill while attending professional development, leave or other workplace requirements.

**6.4.2 Consolidating roles and competencies for existing health, allied health and community professionals inclusive of training and professional development**

It is important that efforts are continued to upskill GPs, other primary health and allied health professionals. The National Rural Health Alliance argues that an expanded program to provide continuing professional development in mental health
for rural GPs, nurses, Aboriginal Health Workers and allied health workers is urgently needed.

"It could be modelled on the successful Rural Health Continuing Education Stream 2 (RHCE2) program managed for the Commonwealth by the Alliance, which has been consistently oversubscribed and which has been very positively reviewed. Such training and support should include a focus on the means by which the generalist workforce can respond to mental health emergencies (2014, pp. 30-31)."

The Alliance further argues that providing continuing education of this nature will support local communities to 'grow their own' mental health care network.

"This will provide the local healthcare team with stronger capacity to understand patients’ needs and be able to provide more continuity of care locally for at least some of those with mental health problems (Ibid, p.30)"

**Suggestion 19.**

*The Rural Health Continuing Education Stream 2 (RHCE2) program be expanded to include a focus on supporting the generalist workforce to mental health emergencies as well as working with people with co-morbidities.*

There is an extensive array of online training platforms and resources that could be better utilised by professionals working in regional, rural and remote areas. The Mental Health Professional Online Development (MHPOD) is one example. Webinars conducted by the Australian Mental Health Professionals Network are accessed throughout rural and remote Australia. Other recently developed resources include: National Perinatal Depression Initiative tools and resources, numerous Suicide Prevention resources, Emergency Mental Health, Alcohol and Drug Program Training Programs (EMHAD), ACMHN eLearning Chronic Disease and Mental Health Program, and mental health in primary care training resources.

There is a need for a national mental health e-learning portal where all mental health workers, whether private, public or non-government, can access a one-stop shop for current and credible sources of information regarding evidence-based approaches to treatment, care, support and service development. This portal could
be developed through collaboration between existing national organisations/initiatives with a relevant remit including for example: MHPOD, MHPN, Australian Government E-Mental Health Support Service and beyondblue.

**Suggestion 20.**

*A national mental health e-learning portal be developed by existing national organisations with a relevant remit to provide a one-stop shop for current and credible sources of information regarding evidence-based approaches to treatment, care, support and service development.*

6.4.3 **Utilising new and untapped workforces – peers and other relevantly experienced and skilled community members**

Peer workers are people who have lived experience of mental illness, often directly, or within their family, and are employed specifically to share this experience and knowledge to help other people and families experiencing mental ill-health. Peer workers are employed around the country, but in a range of different ways. Roles may include peer support, advocacy, health promotion, coordination or education. Peer workers may be employed in outreach services, inpatient units, day programs, and telephone services, amongst other service types.

The distribution of the peer workforce across city and non-city areas is unknown. There is evidence that the workforce is growing and services in the public, private and non government sector appear willing to engage peer workers in mental health programs. Little is known however about city and non-city differentials in this trend.

**Suggestion 21.**

*As per the recommendation made by Health Workforce Australia (2014), the development of a national mental health peer worker definition, dataset, data collection and public reporting approach across employment sectors to measure progress and support evaluation is required.*

The National Mental Health Commission in its *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*, recommended a range of actions relevant to the peer workforce, including:
- the expansion of service approaches that provide early intervention and support an alternative path to a hospital admission; and
- multi-skilled teams that collaborate to provide integrated and effective support, care and treatment for people living with a mental health difficulty, and their families and support people

HWA, concurring with the Commission, reported that peer workers have been identified as being able to contribute to better health outcomes, and are employed in significant numbers in countries similar to Australia (2014, p.9). There is evidence to suggest that peer workers offer a number of benefits, and can reduce the rate of hospital admissions for the service users with whom they work (Trachtenberg et al 2013, Lawn et al 2008). HWA also suggested that the development of the peer workforce could ably supplement rural and remote generalist and specialist mental health workforce.

HWA noted the need to further build the evidence base concerning differences in outcomes when peer workers are included as partners on mental health service delivery teams and whether there are any city/not city differentials. A further suggestion made by HWA was for research and evaluation activities that provide empirically grounded learning to assist mental health services and teams in successfully developing and using the peer workforce.

**Suggestion 22.**

*That Australian research and evaluation be encouraged and supported with a view to building the evidence base of the contribution of the peer workforce with a particular focus on the roles that might be played in regional, rural and remote areas where there is a critical mental health workforce short fall.*

### 6.5 Research, development and evaluation

Accurate data on the distribution and determinants of mental health and wellbeing in regional, rural and remote populations in Australia is still largely unavailable. Also lacking is precise information about what models and approaches to care and service delivery work, where, with whom and for what reasons.
The health and place literature provides a framework for a more comprehensive approach mental health service development in rural and remote locations (Fraser et al., 2005; Macintyre, Ellaway & Cummins, 2002). Evidence-based research of this nature is needed to assist in better planning and service delivery for rural and remote populations and to overcome the obstacles of distance, gather local input to priority areas and for ensuring the recognition and understanding of cultural factors and beliefs about mental illness.

Indicators of integration of mental health services with other local service provision to reflect a systemic framework would be beneficial to understanding access in regional, rural and remote communities.

**Suggestion 23.**

That research be encouraged and resourced to enable:

i. a more precise understanding of the distribution and determinants of mental health and wellbeing in regional, rural and remote populations in Australia;

ii. more precise information about what models and approaches to care and service delivery work, where, with whom and for what reasons; and

iii. the development and evaluation of outcome-oriented project, program, and place-based indicators, to in turn, support more robust and meaningful frameworks suited to mental health service provision across diverse regional, rural and remote communities.

### 6.6 Conclusion

Some key priorities for reducing inequity in mental health service access and outcomes include the following:

- Continued upskilling of communities to promote mental health literacy and local capacity to support and include people living with mental health issues and their families;

- Supporting and resourcing communities experiencing high levels of adversity and distress to build their capacity to assist those most vulnerable and at risk;
Development of an agreed framework for service planning, delivery and evaluation suited to the diversity of situations in regional, rural and remote Australia;

Promotion and ongoing development of helplines and e-mental health programs as well as their incorporation into the practice of health, mental health community professionals;

Nationally agreed guidelines for telemental health services;

Incentives for the establishment of multi-disciplinary primary health clinics;

Establishing co-morbidity communities of practice;

Piloting different approaches to funding, administering and delivering integrated health, mental health and community support services and programs; and

The ongoing upskilling of GPs, other primary health and allied health professionals as well as the development of new workforces comprising community members and including those with personal experience of mental illness.

Also important is the continuation and improved targeting of existing Commonwealth funded community mental health programs.

Finally, addressing the gaps in the current data and evidence base must continue to be prioritised.
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## INTERVIEWS WITH STAKEHOLDERS

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<td>John Feneley, Commissioner, NSW Mental Health Commission</td>
<td>10 September 2014</td>
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<tr>
<td>Jackie Crowe, Commissioner National Mental Health Commission &amp; Family Consultant, Ballarat Health Services</td>
<td>14 August 2014</td>
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<td>Dr Abdul Khalid, Director of Clinical Services Ballarat Mental Health Services</td>
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<td>Prof Russell Robert, National Rural and Remote Mental Health Alliance Representatives, National Rural and Remote Mental Health Alliance</td>
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<td>Frank Quinlan, Josh Fear, Mental Health Council of Australia</td>
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<td>Geoff Harris, Community Mental Health Australia</td>
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<td>Phil Jones, Program Manager North</td>
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<td>Prof Brian Kelly</td>
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<td>Prof Jane Pirkis</td>
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<td>3rd September 2014</td>
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<td>Anne Buck</td>
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<tr>
<td>Peter Brown</td>
<td>Manager, Australian Journal of Rural Health, National Rural Health Alliance</td>
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<td>Russell Roberts</td>
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<tr>
<td>Jem Mills</td>
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<tr>
<td>Pam Rutledge</td>
<td>Chief Executive, Richmond PRA, Sydney</td>
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<tr>
<td>Jan O’Connor</td>
<td>Carer, Northern NSW, Carer of the Year,</td>
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<tr>
<td>Bronwyn Hendry</td>
<td>Director of Mental Health, Department of Health and Families, Darwin</td>
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<tr>
<td>Carolyn Griffin</td>
<td>Senior Indigenous Research Officer, Mental Health, Wellbeing and Chronic Disease, Menzies School of</td>
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<tr>
<td>Tim Carey</td>
<td>Clinician, Associate Professor, Alice Springs</td>
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<tr>
<td>John Reilly</td>
<td>Clinical Director, Qld Health, Rural Mental Health Services, Townsville..</td>
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<tr>
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<td>CEO, Australasian Centre for Rural and Remote Mental Health, Cairns</td>
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<tr>
<td>Steve Carrig</td>
<td>Consultant Advisor to Australasian Centre for Rural and Remote Mental Health, Cairns</td>
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<td>Tania Hancock</td>
<td>Consumer Consultant, North Qld, Cairns.</td>
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<td>Executive Director, Mental Health Country Health SA, Local Health Network, Adelaide</td>
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<tr>
<td>Jeff Fuller</td>
<td>Professor of Nursing, Flinders University, Adelaide.</td>
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<tr>
<td>Lee Martinez</td>
<td>Country Health SA / Spencer Gulf Rural Health School, Mental Health Academic / Manager Knowledge Brokerage, Translation &amp; Exchange, Whyalla.</td>
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<tr>
<td>Geoff Harris</td>
<td>Chief Executive, Mental Health Coalition, South Australia</td>
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<tr>
<td>Lyn English</td>
<td>Experts by Experience Development Office, Adelaide</td>
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<td>Jorg, Storbel</td>
<td>Clinical Director, Mental Health, Country Health District.</td>
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<tr>
<td>Satvir Singh</td>
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<td>Samantha Splatt</td>
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<td>Ian McMichael</td>
<td>President, Rural Alive &amp; Well Inc.</td>
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<td>Ben Elijah</td>
<td>Clinical Director, Northern Mental Health, DHHS, Launceston</td>
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<td>Keith Sutton</td>
<td>Monash University, Dept of Rural &amp; Indigenous Health, Moe.</td>
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<td>Jason Graham</td>
<td>Advertising Executive, Wiley-Blackwell, Melbourne,</td>
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<tr>
<td>Vic Tripp</td>
<td>Director of Nursing, Psychiatric Services, Bendigo</td>
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<td>Leigh Williams</td>
<td>Business Development Executive, Wiley-Blackwell, Melbourne</td>
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</tbody>
</table>
| Assoc Prof Neerag Gill | Director of Clinical Services  
Division of Mental Health, Alcohol and Other Drugs  
Darling Downs Hospital and Health Service  
Associate Professor of Rural Psychiatry,  
School of Medicine- Rural Clinical School,  
University of Queensland | Vic   |
<p>| Cath Murphy           | General Manager, Murray Mallee Family Care, Mildura                                                                                                                                                                                                                                                                                      | Vic   |
| John Hermans          | Nurse Manager, Echuca, Swan Hill, Horsham                                                                                                                                                                                                                                                                                               | Vic   |
| Liz Carr              | Consumer Representative, VMIAC, Northern Region                                                                                                                                                                                                                                                                                          | Vic   |</p>
<table>
<thead>
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<tr>
<td>Richard Menasse</td>
<td>Area Director, Mental Health, WA Country Health Service,</td>
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