RACP submission to the inquiry into the accessibility and quality of mental health services in rural and remote Australia
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The Royal Australasian College of Physicians (RACP) welcomes the opportunity to contribute a submission to the Community Affairs Reference Committee inquiry into the accessibility and quality of mental health services in rural and remote Australia.

The RACP connects, trains and represents 17,000 physicians and 7,500 trainee physicians, across Australia and New Zealand. In developing this response, we consulted widely across our membership, and the following insights and concerns were raised on each of the terms of reference of this inquiry.

(a) The nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate

The underlying cause for the unequal access to mental health services in rural and remote Australia is the existing inequitable distribution of these services and, in particular, specialised mental health care. For instance, in 2015 the clinical full time equivalent (FTE) numbers per 100,000 of the population for psychiatrists as a percentage of those in major cities ranged from as low as 14.4 per cent in very remote areas to 37.1 per cent in inner regional areas. The equivalent percentages for clinical FTE numbers per 100,000 of the population for mental health nurses were as low as 35.2 per cent in very remote areas to 88.7 per cent in inner regional areas, while for psychologists the range was from 24.2 per cent to 63.3 per cent.

One of the primary aims of the World Health Organization (WHO) Mental Health Action Plan 2013-2020 is to provide comprehensive, integrated, and responsive mental health and social care services in community-based settings. WHO recommends a ratio of 10 psychiatrists per 100,000 people. However, as an example, there are currently 7.3 per 100,000 people in the Northern Territory, of which 5.8 per 100,000 are clinical FTE.

Responsibility for local mental health service delivery currently rests with Primary Health Networks (PHNs) and Local Hospital Networks (LHNs). Existing inequities of distribution could be better addressed if there was an overarching governance arrangement to ensure that the efforts of the PHNs and LHNs are underpinned by a national strategy for mental health services. Therefore, we endorse a recommendation made by the National Rural Health Alliance that the Council of Australian Governments (COAG) Health Council should develop a national rural mental health strategy, to be informed by the National Mental Health Commission. The Commission would be tasked with investigating PHN service mapping in rural and remote areas and other key data that can identify shortfalls in mental health services.

(b) The higher rate of suicide in rural and remote Australia

Timely diagnosis, treatment and ongoing management of a mental health condition in rural and remote areas is essential to appropriate management of suicide risk. This means that the inequitable distribution of mental health services noted previously may hamper attempts at timely diagnosis and may result in insufficient access to mental health services, thereby compounding mental health

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1 Table WK.4 of Mental Health Workforce Table, AIHW Mental Health Services in Australia (published 3 May 2018).
2 Tables WK.12 and WK.20 of Mental Health Workforce Table, AIHW Mental Health Services in Australia (published 3 May 2018).
6 Email communication from CEO of National Rural Health Alliance.
problems, which ultimately result in suicide. For example, in 2015 only 42.4 per cent of Australian Government funded Indigenous primary health care organisations (and within this group only 39.1 per cent of ACCHOs) had on site psychiatrist services. Even within the sub-group of these organisations which were already funded to provide mental health and social and emotional wellbeing services (which is roughly a quarter of the 203 organisations surveyed), 56.7 per still reported service gaps for these services in 2015.

The 2016 report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) has a recommendation for the use of gatekeeper training as a primary prevention measure against suicide risk. This approach has already been implemented and studied in many populations including military personnel, public school staff and Indigenous people. It involves teaching specific groups of people in the community how to identify and support individuals at high risk of suicide and has been evaluated in several systematic studies cited by the ATSISPEP. We recommend that this approach has general application to rural and remote communities, including but not restricted to, Indigenous communities given the importance of timely interventions including diagnosis, treatment and management to manage suicide risk.

(c) The nature of the mental health workforce

The provision of culturally appropriate mental health training is critical. This applies to the mental health context as well as in more general health service delivery. For instance, in New Zealand cultural competence is already recognised as a key professional skill required to address health disparities for Māori, as enshrined in legislation through the Health Practitioner’s Competition Assurance Act 2003. Such training should be provided to physicians, general practitioners and allied health when there is no psychiatrist or psychologist available in the region. Cultural competence entails recognising and ameliorating the impact that our own beliefs, assumptions and behaviours have on others; and, for health care practitioners, recognising the serious adverse impacts on patients and family of practicing in a culturally unsafe way. Cultural competence requires awareness of cultural diversity, understanding of issues faced by different populations, and the skills to function effectively and respectfully when working with people of different cultural backgrounds.

As there are areas of unmet need, a significant number of International Medical Graduates (IMGs) are employed in rural and remote settings. This can introduce additional cultural and language issues, which accentuates and reinforces the need for cultural competence training.

(d) The challenges of delivering mental health services in the regions

There is a relationship between physical and mental health as indicated in the rate of comorbidity of mental disorders and physical condition. For instance, according to the most recent Australian Institute of Health and Welfare (AIHW) statistics, 12 per cent of Australians aged 16-85 had a mental disorder and a physical condition at the same time; the most common comorbidity being anxiety

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8 Table 5.2 of Australian Institute of Health and Welfare 2016. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2014–15. Aboriginal and Torres Strait Islander health services report No. 7. IHW 168. Canberra: AIHW
9 School of Indigenous Studies, University of Western Australia, for the Department of the Prime Minister and Cabinet 2016, Solutions that work - What the evidence and our people tell us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) report.
10 School of Indigenous Studies, University of Western Australia, for the Department of the Prime Minister and Cabinet 2016, Solutions that work - What the evidence and our people tell us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) report.
disorder combined with a physical condition. In rural and remote areas, given the larger percentage share of preventable and unrecognised physical illness in the population, this is bound to also negatively impact on mental health.

Another prominent area of comorbidity is the linkage between mental health and musculoskeletal conditions. For instance, based on 2007 patient population figures (which are the most recent available for this sort of calculation), there were 470,000 more Australians who had both a musculoskeletal condition and a mental disorder than would be expected if the two conditions were independent of one another, with the research suggesting that the causation tends to run from musculoskeletal pain to mental health conditions rather than the reverse. This suggests an important role to be played by other kinds of healthcare specialists such as occupational and environmental health physicians and rheumatologists in addressing potential mental health problems.

In addition, there are some illnesses that require inherent shared physical and mental health management, e.g. anorexia nervosa. Shortages, or lack of particular services, in some regions reflecting more general shortages in the psychiatry workforce may therefore exacerbate the difficulties associated with detecting or treating such illnesses. For example, even though paediatricians have an important role to play in managing child mental health issues, in the absence of psychiatrists there is a risk that they will have to extend their roles beyond their usual scope of practice, and vice versa for psychiatrists. While only a relatively small proportion of patients may fall into this category, this still requires careful planning to facilitate better collaboration between physicians and psychiatrists on many of these health problems.

These examples underline the point that access to both physical and mental health services is essential as they have complementary roles to play, along with the need for early identification of patients at risk, an organised system of referral and more holistic models of care including integrated care. The RACP has been a prominent proponent of integrated care, which includes incorporating more patient-centred approaches to care, promoting a cross-sector, cross profession approach, and better supporting primary healthcare as the main portal through which communities access care.

The increased recognition of a reciprocal relationship between more severe and persistent mental illness and poor physical health, including cardiovascular disease and diabetes, also supports the need for better integrated care in the primary health sector. For instance, mental health factors contribute to obesity in children, adolescents and adults. The Productivity Commission (PC) has also recently discussed how Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) are well placed to develop localised collaborative approaches to integrated health needs, responding to the health profile of their communities.

The College believes that these approaches for facilitating more collaborative and integrated models of care are worthy of further investigation. They would be of particular benefit in the regions where better integration and collaboration can leverage the existing health workforce to better serve a population with high rates of chronic disease and multimorbidities.

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15 AIHW Australia’s health 2016
18 The Royal Australasian College of Physicians (2018) Integrated Care: Physicians supporting better patient outcomes
(e) Attitudes towards mental health services

One significant challenge faced in delivering mental health services is the attitude or stigma in small communities surrounding seeking help from a psychologist or psychiatrist. It is well documented, for instance, that the reluctance to seek treatment for mental health issues is reinforced by 'rural stoicism'.\textsuperscript{22} Some additional indirect evidence for this is provided by the documented pattern of relatively higher rates of general practitioner attendance for mental health problems compared with similar attendance patterns in metropolitan centres\textsuperscript{23} because consulting a general practitioner for mental health issues may ensure more privacy than if a patient openly seeks the advice of a mental health professional.

As stated in the previous section, the College advocates for more integrated care approaches to health service delivery. This has additional merit where mental health services are concerned, in part, because more comprehensive and holistic care can help to overcome some of the stigma patients may experience in accessing mental health services.

(f) Opportunities that technology presents for improved service delivery

Telehealth offers an opportunity to provide access and support to those working in rural and remote Australia not only in delivering mental health services but also in delivering related GP and specialist services that manage physical comorbidities. Telehealth can also facilitate early identification and triage of mental health issues including suicide risks. An obvious technical barrier to the greater use of telehealth is access to reliable broadband internet, which was still ranked as a number two priority in the 2016 AMA Rural Health Issues Survey\textsuperscript{24}. Although this situation may be improved with the rollout of the National Broadband Network. In addition, technology is only effective in effectively trained hands. Therefore, it is essential that training be required for both practitioners and consumers to ensure familiarity with the types of technical solutions available for rural and remote consultations.

(g) Any other related matters – opportunities for improvement

According to feedback provided by the RACP’s Faculty of Occupational and Environmental Health Medicine, mental health strategies have been developed for remote mine workers in Pilbara, Western Australia, which employ a triage process to improve the design and delivery of mental health services. This approach comprises the following components:

- education of leaders and supervisors for early identification of mental health issues;
- wellness programs that incorporate mental health strategies;
- peer support programs that encourage workers to share issues with co-workers who have received specific peer-support training;
- free access to psychologists through employee assistance programs;
- intermittent site visits by psychologists to specific areas in need;
- training of emergency services in triage, assessment and referral;
- specific ‘Mental Health Transport Guidelines’ to assess when, how and where to transfer cases off-site;


\textsuperscript{23} Perkins D, Fuller J, Kelly BJ, Lewin TJ, et al. Factors associated with reported service use for mental health problems by residents of rural and remote communities: cross-sectional findings from a baseline survey. BMC Health Serv Res. 2013 Apr 30;13:157

• referral of complex/challenging cases; and
• referral of specific cases to psychiatrists, including for alcohol or drug issues.