Dear Dr van Schoubroeck

Re: Rural and Remote Mental Health and Wellbeing Action Plan Response

The Queensland Branch of the Royal Australian and New Zealand College of Psychiatrists (QLD Branch) welcomes the opportunity to provide a response to the discussion paper, ‘Towards a Queensland Rural and Remote Mental Health and Wellbeing Action Plan’.

Like the Queensland Mental Health Commission, the QLD Branch is concerned with improving the mental health and wellbeing of people living in rural and remote Queensland.

The QLD Branch has prepared a response to the discussion paper overleaf and would like to highlight the following recommendations for improving rural and remote mental health, specifically the need to:

- develop targeted rural and remote, and Aboriginal and Torres Strait Islander mental health campaigns
- expand and invest in telehealth services and technology
- recognise the importance of face-to-face clinical assessment and treatment by psychiatrists
- encourage medical student interest in psychiatry
- address the low number of addiction specialists in Queensland
- use sustainable solutions to attract and retain mental health workers.

The QLD Branch would like to refer the Commission to its recent submission on the ‘Queensland Medical Workforce Whitepaper’, which also details the QLD Branch’s concerns for the rural and regional medical workforce, and is provided at the end of the response.

To discuss any matters raised in the response please do not hesitate to contact the QLD Branch Policy Officer, Judith Johnston on (07) 3852 2977 or on ranzcp.qld@ranzcp.org.

Yours sincerely

Dr Agnew Alexander
Chair, RANZCP QLD Branch
Response to discussion paper

1. Promoting good mental health, wellbeing and community resilience

Queensland is Australia's second largest state and its third most populous, which presents challenges to providing equal levels of health care to all Queenslanders.

In rural and remote Queensland, the challenge of providing mental health services is complicated and magnified by geographical distance and unique community characteristics including: rapid growth due to resource and mining development, ageing population, low population density, Aboriginal and Torres Strait Islander population, limited and ageing infrastructure, and higher costs associated with health care delivery (Queensland Health, 2013). In addition to these unique community characteristics, there are other challenges that affect a remote and rural person’s mental health including natural disasters, financial hardship, lack of or inaccessibility to health services, and geographical and social isolation.

Aboriginal and Torres Strait Islander mental health and rural and remote mental health share similar challenges due to the majority of Queensland’s Aboriginal and Torres Strait Islander population (73%) living outside the Capital City area (ABS, 2011). Both vulnerable population groups should have targeted mental health campaigns that focus on early intervention, prevention, promotion and awareness. Such campaigns have the potential to help both population groups become more aware of mental illness, address problems with stigma, recognise signs of mental illness and encourage people to seek help.

The QLD Branch recommends that targeted rural and remote, and Aboriginal and Torres Strait Islander mental health campaigns that focus on early intervention, prevention, promotion and awareness should be developed.

2. Access to high quality, timely, relevant, integrated services

Across Australia, access to psychiatrists is currently very limited for Aboriginal and Torres Strait Islander peoples and those living in remote and rural locations due to the maldistribution of the workforce. For example, Australian urban centres have approximately 16.3 full time equivalent (FTE) employed psychiatrists per 100,000 population, whereas Australian inner regional areas have 6 FTE and remote areas have 3 FTE (AIHW, 2016).

The role of rural and remote hospitals has changed significantly over the last 15 years. While larger rural communities are generally able to support a traditional hospital and specialised service models, increasing remoteness and diminishing population size and density demands innovative service model options, such as telehealth. Queensland has one of the largest managed telehealth networks in Australia. There is significant opportunity to further embed telehealth in future planning and provision of public and private health services across Queensland (Queensland Health, 2013).

In order to continue to support the mental health workforce servicing rural and remote areas, the QLD Branch considers that there should be continued and increased investment in telehealth. This includes investing in teleconferencing and web conferencing technology so that psychiatrists can support consumers across distances, as well as provide supervision and consultation with mental health professionals located in these areas, who would otherwise have very little access to professional supports and who are vulnerable to burnout (RANZCP, 2015).
The QLD Branch recommends expanding telehealth services and providing more investment in teleconferencing and web conferencing technology to further enable telehealth.

Notwithstanding the strengths of telehealth, face-to-face clinical treatment is still relevant and necessary in some cases. Financial assistance and practical travel arrangements should be available for psychiatrists visiting rural areas via outreach programs in communities where there are unmet needs and an inability to employ a resident psychiatrist (RANZCP, 2015).

The QLD Branch recommends that the Queensland Mental Health Commission recognise and support properly facilitated face-to-face clinical assessment and treatment by psychiatrists.

3. Attracting and retaining a skilled workforce

There is likely to be an increased demand in Queensland for healthcare due to population growth, ageing population and health related risk behaviours, such as issues around alcohol and illicit substance use. Mental health issues are likely to be a significant proportion of this increased health care demand, especially as one in five Australians suffer from a mental disorder.

The QLD Branch considers that - on a national level - there is a need to increase the mental health medical workforce. On a local and state level, focus should be directed towards encouraging training and employment in mental health specialties with workforce shortages, and rural and regional centres. This could be enhanced by added incentives or by providing extra support.

The QLD Branch is also greatly concerned about the low level of interest in the psychiatry specialisation amongst medical students. The ‘Queensland Medical Workforce Whitepaper’ (Queensland Health, 2015) reports how in 2014 only 2% of domestic graduates indicated they would choose psychiatry as a future specialty in training. This has the potential to maintain or worsen the workforce shortage in the field of psychiatry. The medical workforce profiles contained in the Whitepaper’s Appendix reports how the psychiatry workforce is perceived to be in current shortage with predicted demand in the next decade surpassing predicted supply.

The QLD Branch considers that the reasons why medical students steer away from psychiatry include: stigma attached to mental health and the mental health workforce; current community attitudes towards ‘ice’ and other drugs; inadequate incentives; psychiatry is a high risk specialty.

The QLD Branch recommends to encourage student interest in psychiatry, Hospital and Health Services (HHSs) should provide more incentives (particularly for rural locations), and develop management strategies to address the high risk nature of psychiatry as a specialty.

There is also a significant reliance on International Medical Graduates (IMGs) to address the workforce shortages in psychiatry, this is more evident in the regional and rural areas. There are more IMGs practicing medicine in Queensland than in other states or territories, as Queensland has 29% of all IMGs in Australia. The HHSs that have higher than average IMG cohorts include Wide Bay, Central Queensland, Mackay, Cairns and Hinterland, Townsville, North West and Sunshine Coast (Queensland Health, 2015). Queensland also has the highest number of Area of Need declarations in ‘regional, rural and remote’ Australia with 35% of all national declarations belonging to Queensland (Queensland Health, 2015).
The QLD Branch would also like to express its concern about the low number of addiction medicine specialists in Queensland. The Whitepaper (2015) reports how there was only one addiction medicine trainee out of 1780 trainees in Queensland in 2010. This has barely increased - as in 2014 - there were four addiction medicine trainees compared to 2634 trainees (p. 85). Similarly, there were only 25 addiction medicine specialists in Queensland in 2013 (p. 49). Considering the current ‘war on drugs’ and ‘ice epidemic’, and the government’s pledge to address these problems, there is a marked lack of addiction medicine specialists available to address the number of patients with addiction problems.

The QLD Branch recommends that the insufficient number of addiction specialists, including psychiatrists to attend to patients with addiction problems, should be addressed immediately.

The QLD Branch considers that for regional and rural services with a significant medical school and continuing student presence (e.g. James Cook University), the ‘grow your own’ approach offers a sustainable solution. This is where students remain and work in the regional and rural area where they have trained. This approach captures an audience that has already experienced and enjoyed a regional or rural health service and lifestyle. As indicated in the Whitepaper (2015), there is a positive interaction between rural backgrounds and clinical training in enhancing the probability of rural training (p.26). Encouraging universities to continue to have and expand on training in rural and regional areas will help towards the shortage problem.

The QLD Branch recommends the ‘grow your own approach’ as a sustainable solution to attracting and retaining mental health workers.

In terms of psychiatry, the QLD Branch considers that regional and rural training would benefit from the following:

- funding to support a medical education psychiatrist/registrar position in regional and rural services to facilitate support programs and increase psychiatry conversion rate
- supporting for regional and rural services to negotiate within their HHSs to increase the numbers of interns and RMOs allocated to psychiatry
- communicating with universities to ensure that the size of medical student cohorts has to in some way be moderated to ensure the quality of their training and experiences in all specialties is maintained
- providing scholarships for regional and rural based medical students to attend psychiatric conferences and workshops
- targeting Specialist Training Program expansion of training in rural and regional areas to allow trainees to complete all their training at these sites would assist in recruitment and retention of doctors
- increasing focus on curriculum and rotations in psychiatry for medical students and prevocational doctors.
Bibliography


