The Royal Australian & New Zealand College of Psychiatrists

Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales – November 2020

Improving the mental health of the community

Introduction

NSW Branch ('Branch') of the Royal Australian and New Zealand College of Psychiatrists ('RANZCP') welcomes the opportunity to make this submission to the *Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW ('inquiry')*.

RANZCP is a membership organisation that trains doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. It has almost 6000 members bi-nationally, including more than 4000 qualified psychiatrists and around 1400 members who are training to be psychiatrists. RANZCP NSW Branch (NSW Branch) represents more than 1200 Fellows and 400 trainees.

As mental health specialists, psychiatrists are well positioned to provide constructive input into improving outcomes for people with mental health conditions.

About our submission

In preparing our submission, the Branch consulted with psychiatrists who have extensive expertise in mental health issues affecting people living in rural communities, and in the planning of and delivery of mental health services to people with mental health conditions living in these communities.

We have chosen to focus our submission on terms of reference (a) to (g) which deal specifically with issues concerning health outcomes, access to health services, workforce, patient experience, and planning processes. We have opted not to address questions regarding access to cancer treatment and palliative care despite their having a mental health dimension to them. In our view these are best addressed by health experts who work and/or study in this area of healthcare.

Importantly, our submission offers several key suggestions to address the complex challenges facing mental healthcare in rural communities. While many of these recommendations rely on making better use of existing resources and implementing significant cultural change across all parts of the health care system, others will not. There will need to be significant ongoing investment by government to address the social determinants of mental illness and gaps in service provision.

Our submission presents statistical data on a range of mental health indicators, such as hospitalisation, self-harm, and suicide to highlight the prevalence of and differences between mental healthcare in rural communities and city/metropolitan areas.

We define 'rural' to mean geographical locations whose Local Health Districts fall outside major cities but fall within inner regional, rural, remote and very remote areas. This includes:

- Central Coast
- Far West
- Hunter New England
- Illawarra Shoalhaven
- Mid North Coast
- Murrumbidgee
- Nepean Blue Mountains
- Northern NSW
- Southern NSW
- Western NSW

Summary of recommendations

Recommendation 1

Considering the issues raised in relation to access to mental health services in rural areas, quality of care, and outcomes in this submission, the NSW Branch recommends the development of a rural and remote mental health strategy which:

- Targets investment to groups who are at risk of harm from mental health conditions including those who live in rural and remote communities. These groups include:
  - Aboriginal and Torres Strait Islander people
  - Children and adolescents
  - People with alcohol and drug addiction
- Fund and develop targeted programs to focus on prevention of suicide and continuity of care to people with mental health conditions living in rural communities
- Fund and support systems for telepsychiatry, including upgrades to technology and enhanced referral systems
- Expand treatment and recovery services for alcohol and other drugs in rural areas
- Sufficiently fund the full suite of mental health services, including prevention and early intervention, community support, acute and crisis services targeting children and adolescents with mental health conditions.

Strategies targeting Aboriginal and Torres Strait peoples need to be culturally appropriate, ideally developed and run by Aboriginal and Torres Strait Islander people, and take a trauma-informed care approach to address underlying causes such as transgenerational trauma.

Recommendation 2

To support Recommendation 1, the NSW Branch recommends the government's rural mental health strategy consider population growth and acute care needs of the community which must be met with a reliable and sustainable workforce.

Recommendation 3

In light of the issues described regarding funding of mental health services, the NSW Branch believes funding reform that is equitable across rural LHDs and accounts for the unique requirements of each in providing effective and timely mental health services across a range of geographical and remote regions in urgently needed. Such considerations in the calculation of service funding, but pivotal in providing effective and efficient mental health services, need to include:

- Population growth and socioeconomic advantage and disadvantage
- At risk populations, including Aboriginal and Torres Strait Islander peoples, young people and people of refugee backgrounds. These need to be delivered in a culturally appropriate way.
- Unmet demand allowing for recognition of shortfalls in current service provision
- Distance and access to transport between communities and services

- Investment in physical, capital and technological rural health infrastructure to improve the availability of quality services and the capacity of rural doctors to provide mental health care

Recommendation 4

NSW Health, with input from our Branch, is working on a psychiatry workforce plan to support a sustainable psychiatry workforce and to meet the needs of people living with a mental illness and their families. We should like to recommend that the Committee note this work and support its implementation once completed.

General comments

We have set out below some general statements about mental healthcare in rural communities. We make these statements as the basis of our recommendations and guiding principles for the development of policy solutions to current situation facing mental healthcare for rural communities. In no way are they comprehensive. We acknowledge there have been numerous governmental inquiries in the past about this issue and that the findings and recommendations of these are likely to still be relevant today. We encourage the Committee to refer to these reports as part of their deliberations on the matter at hand.

With this in mind, we submit the following:

- People living in rural areas should receive equitable access to services that meet their needs. These services should be affordable and ensure ongoing continuity of care in the community and at the local hospital.
- Care should be provided as close to home as practicable. This may involve innovations such as telehealth, specialist support of local services, creative solutions to facilitate access (addressing transport and digital barriers).
- Aboriginal and Torres Strait Islander people need to be provided with culturally safe and appropriate mental health services if we are to make inroads into addressing their entrenched disadvantage. With some 55% of the NSW Aboriginal population living in inner regional, rural and remote communities, these services need to build on existing successful approaches and ensure they are developed and led by Aboriginal people and organisations as far as possible 1. Furthermore, it is important to recognise and acknowledge intergenerational trauma, therefore care provision must be trauma-informed.
- Finally, the Branch submits it is critically important health services including those for people with mental health conditions, are well-planned and established long-before populations reach their limit. In our view, the mental health system has not benefitted from consistent and integrated service planning.

Overview of mental health in NSW

Before addressing the terms of reference for this inquiry, we wish to provide an overview of the challenges facing mental healthcare in rural areas of NSW.

It is estimated that one in five people living in NSW will experience some level of mental ill-health this year. This equates to around 1.6 million people 2. Based on 2016 ABS census data, approximately one in four (or 2 million) people live in regional, rural and remote areas of NSW 3. On these figures, it is estimated that around 400,000 people living in locations outside of major cities has experienced or will experience mental illness this year.

[1] NSW Aboriginal Affairs. Key data – NSW Aboriginal people September 2020 [cited 9 November 2020] available from aboriginalaffairs.nsw.gov.au/media/website_pages/new-knowledge/facts-and-figures/KEY-DATA-ABORIGINAL-PEOPLE-SEP-2020.pdf

[2] NSW population is estimated to be 8.1 million as at June 2020. [Cited 4 November 2020]- http://www.population.net.au/population-of-new-south-wales/

[3] HealthStats NSW. Population by remoteness from service centres. [Cited 4 November 2020] available at http://www.healthstats.nsw.gov.au/Indicator/dem_pop_aria

In 2017-19, 33% of people living in inner regional, rural and remote areas experienced high to very high-level psychological distress 4. This equates to around 80,000 people and includes:

- 12,800 aged 17 years and under
- 52,000 aged 18-64 years
- 16,000 aged 65 years and over 5.

As the Committee is likely to hear repeatedly during this inquiry, the mental health of Aboriginal and Torres Strait Islander peoples warrants attention. Aboriginal and Torres Strait Islander peoples in NSW:

- Are twice as likely as non-Aboriginal people to experience high or very high levels of distress
- Are 3 times as likely as non-Aboriginal people to be hospitalised for intentional self-harm
- Have a suicide-rate that is two times higher than non-Aboriginal people in NSW 6. Among 15-24 year-olds it is three times higher (See Table 1).

TABLE 1 - Suicide by Aboriginality 15-24 years and all persons NSW 2014-2018[7]

2014-2018	Aboriginal	15-24 years	10.8	21.0	15.8	27.4
		All ages	39.6	17.7	15.0	20.6
	Non-Aboriginal	15-24 years	95.0	9.9	9.1	10.9
		All ages	808.4	10.5	10.2	10.9
	Total	15-24 years	108.8	10.7	9.9	11.7
		All ages	862.0	11.0	10.6	11.3

The Branch submits the health inequities for all rural people including Aboriginal and Torres Strait Islander people living in NSW are unfair and largely preventable. They are primarily the result of isolation, socio-economic disadvantage, lack of healthcare providers and barriers to service access.

The Branch further submits that one of the reasons for lower engagement with mental health services is the lack of services and specialists physically available in rural and remote communities. Targeted strategies and funding are needed to improve access and reduce barriers to mental health services for rural and remote people in NSW.

Productivity Commission ('Commission') inquiry into mental health

RANZCP, the NSW Branch and other sections of the college made several submissions and follow-up reports to the Productivity Commission inquiry into mental health.

[4] NSW Ministry of Health. Centre for Epidemiology and Evidence. 2017-19 NSW Population Health Survey (SAPHaRI) Psychological distress by Kessler 10 categories. [Cited 5 November 2020]. Available http://www.healthstats.nsw.gov.au/Indicator/men_distr_type/men_distr_type_aria_trend

[5] NSW Government submission. Senate Community Affairs References Committee. Accessibility and quality of mental health services in rural and remote Australia July 2018. [Cited 9 November 2020].

[6] NSW Mental Health Commission Aboriginal Communities September 2014. [Cited 16 November 2020] available at https://nswmentalhealthcommission.com.au/mental-health-and/aboriginal-communities

[7] NSW Health HealthStats NSW Suicide by Aboriginality, persons of all ages and 15-24 years, NSW 2006-2010 to 2014-2018. [Cited 18 November 2020]

Our submission and reports drew attention to several problems with the structure and delivery of mental health services to people with mental health conditions many of which are amplified for people living in rural area. For instance, it noted:

- The current system of mental health is fragmented, complex, and difficult to navigate, and because of this, people with mental illness can often face significant barriers to seeking and receiving quality mental healthcare
- Obstacles to patient journeys abound and include lack of resources, lack of clarity about how to access resources if they exist, lack of clarity about what service delivers which intervention, and inevitable duplication
- Under the current system, there is no clear and efficient 'care journey' for individuals with mental illness. The 'care journey' and its navigation are affected by several key issues, including governance, funding frameworks, and out-of-pocket costs.
- Due to the complex funding arrangements, and the mix of public and private services within the Australian healthcare system, people with mental illnesses can incur several direct and indirect costs of care. These out-of-pocket costs can be a significant barrier to accessing services, particularly for certain vulnerable groups within the population.

We believe many of the recommendations made in our submission and in the Commission's reports should be considered by this Committee in its analysis and reporting of health issues impacting rural communities. We have, where relevant, referred to these recommendations in this submission.

Inquiry's terms of reference

(a) Health outcomes for people living in rural, regional and remote NSW

(b) A comparison of outcomes for patients living in rural, regional and remote NSW compared to other local health districts across metropolitan NSW

Higher rate of suicide and self-harm in rural and remote NSW

While the prevalence of mental illness in rural areas throughout NSW appears relatively comparable to that of people living in metropolitan areas, rates of suicide, self-harm and psychological distress are higher in remote and rural areas and increase with degree of remoteness as the data in the tables presented in this submission show.

As shown in the appended tables (2, 3 4 and A) suicide rates per 100,000 population are consistently higher, and in some years, (for example 2016) almost double in areas outside major cities, for example, Hunter New England.

TABLE 2 - Suicide, Major cities v rest of NSW, NSW 2009 to 2018[8]

Year	State comparison	Number	Rate per 100,000 population
2009	Major cities	460	8.7
	Rest of NSW	172	9.7
	Total NSW	632	8.8
2010	Major cities	464	8.6
	Rest of NSW	193	10.8
	Total NSW	657	9.1
2011	Major cities	440	8.0
	Rest of NSW	187	10.4

[8] NSW Health. HealthStats NSW. Suicide [Cited 24 November 2020] http://www.healthstats.nsw.gov.au/Indicator/men_suidth/men_suidth_aria_trend

	Total NSW	627	8.5
2012	Major cities	498	9.0
	Rest of NSW	264	14.8
	Total NSW	762	10.3
2013	Major cities	475	8.3
	Rest of NSW	230	12.3
	Total NSW	705	9.3
2014	Major cities	560	9.8
	Rest of NSW	265	14.4
	Total NSW	825	10.8
2015	Major cities	550	9.5
	Rest of NSW	292	15.5
	Total NSW	842	11.0
2016	Major cities	493	8.3
	Rest of NSW	317	17.1
	Total NSW	810	10.3
2017	Major cities	612	10.1
	Rest of NSW	326	17.0
	Total NSW	938	11.7
2018	Major cities	607	9.9
	Rest of NSW	288	16.6
	Total NSW	895	11.0

TABLE 3 - Suicide by remoteness from service centres, persons NSW 2018[9]

Rural and remote	Number	Rate per 100,000 population
Major cities	607	9.9
Inner regional	208	14.9
Outer regional & remote*	79	16.7
Total	895	11.0

Rates of intentional self-harm also increase with remoteness with young people (aged 15-24 years) having significantly higher rates (67%) of self-harm than their peers in city areas (see Table 4). A similar level exists for all-persons (58%) living in rural areas.

TABLE 4 - Intentional self-harm hospitalisations by remoteness from service centres, persons of all ages and 15-24 years NSW 2018-19[10]

Remoteness	15-24		All ages	
Rural and remote	**Number**	**Rate per 100,000 population**	**Number**	**Rate per 100,000 population**
Major cities	1,551	197.6	4,788	80.4
Inner regional	569	329.0	1,650	127.1
Outer regional & remote*	144	282.5	470	119.3
Total	2,288	225.9	7,018	90.7

[9] NSW Health HealthStats NSW Suicide by remoteness. [Cited 24 November 2020] available at http://www.healthstats.nsw.gov.au/Indicator/men_suidth/men_suidth_aria_trend

[10] NSW Health HealthStats NSW Intentional self-harm [Cited 24 November 2020] available at http://www.healthstats.nsw.gov.au/Indicator/men_suihos/men_suihos_aria_trend

While data indicates significant differences in the rates of hospitalisation in rural and remote NSW compared with major cities, it also reveals significant variation within regions; the rates of hospitalisation in some communities can be significantly higher than for other communities of the same level of remoteness, for example Hunter New England and Illawarra Shoalhaven (18,994 and 8,253 hospital admissions respectively for mental health disorders – see Table A in appendix).

The 2017-19 NSW Population Health Survey found higher levels of psychological stress for adults living in inner regional (17.5/100,000) and outer rural and remote areas (15.5/100,000) compared with major cities (15.2/100,000). For Aboriginal and Torres Strait Islander people, levels were significantly higher (23.5) though this figure is for all of NSW as data by remoteness is not available for this cohort (see Table 6). We can only assume Aboriginal and Torres Strait Islander people living in rural areas experience proportionally higher levels of psychological stress than non-Aboriginal people given their higher rates of suicide, self-harm and alcohol and drug problems and prevalence of Aboriginal and Torres Strait Islander living outside major cities. The lack of specific data on this health indicator warrants further research in our view.

TABLE 6 - Psychological distress by Kessler 10 categories – all persons [11]

	Psychological distress	Number of Respondents	Per cent
Major city 2017-2019	Low level of psych distress	13,871	57.3
	Moderate level of psych distress	13,871	26.5
	High level of psych distress	13,871	11.4
	Very high level of psych distress	13,871	4.8
Inner regional 2017-2019	Low level of psych distress	7,668	57.0
	Moderate level of psych distress	7,668	25.5
	High level of psych distress	7,668	11.2
	Very high level of psych distress	7,668	6.3
Outer regional-remote 2017-2019	Low level of psych distress	3,762	61.7
	Moderate level of psych distress	3,762	22.8
	High level of psych distress	3,762	11.8
	Very high level of psych distress	3,762	3.7
Aboriginal and Torres Strait Islander 2017-2019 ALL NSW	Low level of psych distress	648	50.8
	Moderate level of psych distress	648	25.7
	High level of psych distress	648	13.2
	Very high level of psych distress	648	10.3

Our members noted that several factors are involved in exacerbating mental health acuity and heightening the risk of suicide for people living in rural areas. This includes poor access to primary and acute care, limited numbers of mental health services and mental health professionals, reluctance to seek help, concerns about stigma, distance and cost, and cultural barriers in service access.

Social determinants can also adversely impact mental health. At a population level, there are clear associations between problem mental illness and poverty, disadvantage and social marginalisation, which extend into health and social outcomes. Reducing social disadvantage has the potential to reduce the propensity for people to develop mental illness

[11] NSW HealthStats. Psychological distress by Kessler 10 categories [cited 6 November 2020] available at http://www.healthstats.nsw.gov.au/Indicator/men_distr_type/men_distr_type_aria

by ensuring those at risk have access to basic social needs such as affordable and stable housing, a job, access to education and training, and access to affordable healthcare. For this to be realised, all parts of the community services sector which includes education, community services, and justice, need to work together in a coordinated and flexible manner to intervene at all 'touch points' to prevent further escalation of mental ill-health. These services also need to be sustainably funded.

Aboriginal and Torres Strait Islander peoples

We heard from our Fellows that Aboriginal and Torres Strait Islander peoples have a significantly higher risk of being exposed to potentially traumatic events leading to higher rates of stress, self-harm and suicide. This is borne out in the data presented in the tables presented in this submission (see Tables 1 and 6). Factors such as discrimination and racism, grief and loss, child removals and unresolved trauma, life stress, social exclusion, economic and social disadvantage, incarceration, child removal by care and protection orders, violence, family violence, substance use and physical health problems have been linked to social and emotional wellbeing concerns for Aboriginal and Torres Strait Islander people. Some experts argue that there is a lack of 'fit' between Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing and mainstream concepts of mental health and illness which have informed mental health service provision.

The NSW Branch believes strongly in the need for models of care that are culturally safe and appropriate. The application of strategies for respectful engagement and communication are key to bolstering clinical practice when working with Aboriginal and Torres Strait Islander peoples. Partnerships and service delivery with Aboriginal community-controlled health organisations is fundamental.

Alcohol and other drugs (AOD)

Our Fellows told us drug and alcohol addiction was often comorbid with mental health issues. We heard people living in remote areas were more likely to smoke, drink at risky levels and use illicit drugs such as methamphetamines and that there are massive challenges faced by rural and remote communities with regard to seeking help for alcohol and other drug use. We know from the 2016 National Drug Strategy Household Survey that people in remote and very remote areas were 2.5 times as likely to use meth/amphetamines and 1.5 times to consumer five or more drinks on a monthly as those in major cities 12.

We also heard that the AOD service sector in rural areas is not supported and resourced to meet the specific and complex needs of vulnerable groups, for example, Aboriginal and Torres Strait Islander people and those experiencing intersecting issues such as mental illness. These can have a significant flow on impact on general health, employment and social integration. Further, we heard these AOD services are often not equipped or resourced to respond for these intersecting needs and there is limited continuity of support for people transitioning back into the community following AOD treatment. This means that without adequate support, some people are at higher risk of experiencing homelessness, compounding health issues or coming into contact with the justice system, which further entrenches the cycle of disadvantage.

In our view, the AOD service sector in needs more support and resources to meet demand for treatment and bed shortages, particularly in rural and remote NSW where services are limited. Services in these areas need more funding and investment not only to meet

[12] Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2016: detailed findings. [Cited 24 November 2020] available at https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2016-detailed/contents/table-of-contents.

demand, but also reduce the need for clients to travel long distances to metropolitan or larger regional cent res to access treatment.

Child and adolescent services

The NSW Branch recently reported to the NSW Minister for Mental Health an escalation of presentations to emergency departments and hospitalisation of children and adolescents with serious mental health conditions such as eating disorders and suicide ideation. We believe much of this rise is COVID related as young people and their families struggle to cope with changes in personal and family circumstances such as unemployment, domestic violence, abuse, isolation and dislocation from friends.

As shown in appended Tables C and D, there has been a 40 to 50% increase in emergency department presentations of 12-17 year-olds with serious mental health issues to tertiary facilities and 0-11 year-olds with self-harm and suicide ideation in regional areas such as the Far West and Hunter New England. We are told increased young people are presenting with new onset of severe and complex mental illness, while those with existing disorders are experiencing high rates of relapse, also increasing demand for specialist Child and Adolescent Mental Health Services and inpatient and community care.

As recommended to the Minister, there is a need for the development of a short and long-term action plan that sees an immediate injection of funds to create assertive outreach services in high demand areas to work in emergency departments and the community providing step-up and step-down care, increasing the number of acute beds to provide observation, and in the medium to long term, providing additional resources for community youth and mental health services and funding services based on population levels. We strongly encourage the Committee to recommend the development of this plan in its report.

(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services

We heard from our Fellows that people living in rural areas do not have anywhere near the level of access to mental health services as people in living major cities. We heard this happens for a range of well-recognised reasons including lack of access to appropriate and affordable mental health services. We heard this also happens because:

- There may be few, if any, mental health professionals and services within a local area
- The services that do exist may not be appropriate to the patient or the mental health issue and may not be joined up with other necessary health, social and community services
- Telehealth services may be more difficult to access, particularly where connectivity and data speeds are an issue
- Fly-in fly-out and drive-in drive-out services, though an important mechanism to fill critical gaps, are not available to all communities. Where provided, they can only deliver limited face-to-face contact with mental health professionals and may not be available at times of crisis.
- The cost of services, both financial and other, may be an issue. People from rural and remote areas often have to travel long distances to see health professionals incurring travel and accommodation expenses as well as those associated with time away from employment.
- People fear being stigmatised. In small rural communities, privacy and confidentiality are difficult to maintain.

Many of these issues are evident in Medicare subsidised mental health services data which shows rates of access to psychiatric and psychological services decreasing by remoteness. As shown in Table 7, there are significant differences in the number of psychiatrists, psychologists and mental health nurses in inner region, rural and remote areas (Australia wide) compared to major cities. Psychiatrists in these areas number 450 or 15% of those employed in mental health services (3441) across Australia 13. This pattern was consistent across health provider types and could be a result of the increased stigma and limited access to a mental health workforce in rural and remote areas.

TABLE 7 - Mental health workforce data 2018[14]

	Psychiatrists			Psychologists			Nurses		
	Number(	Clinical FTE	Clinical FTE per 100,000 population	Number	FTE per 100,000 population	Clinical FTE per 100,000 population)	Number	FTE per 100,000 population	Clinical FTE per 100,000 population
Major cities	2,981	2,398.1	13.3	22,528	106.5	77.5	17,697	93.2	86.2
Inner regional	319	265.0	6.0	3,274	62.5	48.9	4,021	85.6	79.0
Outer regional	113	100.4	4.9	1,044	45.6	34.5	1,135	54.1	49.5
Remote	18	16.5	5.7	122	38.3	27.6	157	56.1	51.2
Very remote	6	5.1	2.5	52	25.5	18.8	70	36.1	32.9
Total	**3,441**	**2,788.6**	**11.2**	**27,027**	**92.3**	**67.9**	**23,083**	**87.8**	**81.1**

Our Fellows reported rural communities have chronic shortages of services and health professionals to staff them. They stated that access to comprehensive management and continuous care are limited once you step out of major cities and major regional centres: psychiatrists are in short supply and general practitioners and nurses are underprepared for growing problems such as dual diagnosis. Further, they stated that community support services to help people with complex mental health needs are underdeveloped compared with other areas. Pressure and isolation encourage high staff turnover, militating against continuity in care.

The Branch acknowledges that all people in NSW should be able to access adequate and appropriate mental health services in line with their needs, and there is a critical need to provide greater and more specialised support for at-risk groups in rural and remote areas. This is reflected in the statistics around suicide rates in certain groups. With this in mind, the NSW Branch recommends:

(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW

Our Fellows told us a major problem for many people with severe mental health conditions living in rural areas is a lack of appropriate 24 hour supports services particularly acute at night. They reported that it is not uncommon for seriously mentally ill people having to wait overnight (e.g. psychotic and/or suicidal) for a specialist to return on duty to be seen for an assessment and treatment. They noted that waiting to be seen leads to increased distress and behavioural problems which can result in more restrictive practices being implement.

[13] For an overview of psychiatrists employed in NSW, see section (g) of this submission.

[14] Australian Institute of Health and Welfare. Mental Health Services in Australia November 2020. [Cited 25 November 2020] available at https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce/interactive-data

Long wait times were reported for initial assessment appointments and follow-up treatment appointments among a range of services, such as psychologists, psychiatrists, counselling and support services for family.

In recent years, our members have consistently reported to government that people with mental illness who present to emergency departments disproportionately experience unacceptably long lengths of stay while they wait for admission to specialist inpatient care. They report there is inadequate prioritisation of and resourcing for mental health in hospitals.

Finally, we heard that despite evidence early intervention for young people can make a big difference to their lives, and prevent mental illness escalating, waiting lists in rural areas are apparently so long that some young people are not receiving help until they age out of CAMHS and become eligible for adult services.

Recommendation 1

Considering the issues raised in relation to access to mental health services in rural areas, quality of care, and outcomes, the NSW Branch recommends the development of a rural and remote mental health strategy which:

- Targets investment to groups who are at risk of harm from mental health conditions including those who live in rural and remote communities. These groups include:
  - Aboriginal and Torres Strait Islander people
  - Children and adolescents
  - People with alcohol and drug addiction
- Fund and develop targeted programs to focus on prevention of suicide and continuity of care to people with mental health conditions living in rural communities
- Fund and support systems for telepsychiatry, including upgrades to technology and enhanced referral systems
- Expand treatment and recovery services for alcohol and other drugs in rural areas
- Sufficiently fund the full suite of mental health services, including prevention and early intervention, community support, acute and crisis services targeting children and adolescents with mental health conditions

Strategies targeting Aboriginal and Torres Strait peoples need to be culturally appropriate, ideally developed and run by Aboriginal and Torres Strait Islander people, and take a trauma-informed care approach to address underlying causes such as transgenerational trauma.

(e) an analysis of the planning systems and projections that are used by NSW Health in determining the provision of health services that are to be made available to meet the needs of residents living in rural, regional and remote NSW

The Productivity Commission's final report on mental health noted that Australia's mental health system needs 'redesigning with local planning to meet local needs'15 so that it can become person-centred and address unmet need. In its draft and final reports, the

[15] Productivity Commission. Inquiry Report Mental Health volume 1. No.95 June 2020. [Cited 26 November 2020]

Commission noted several instances of poor planning leading to poor service design, resources being misallocated, service duplication and poor outcomes for consumers.

When we spoke to our Fellows about how mental health services are planned for in rural communities, they said it is extremely haphazard and tends to only happen when a crisis eventuates. A good example of this is what we are seeing with the delivery of mental health services to children and adolescents; we have resources playing catch up to an ever-increasing crisis that the sector had long forecasted.

As clinicians with extensive expertise in acute and community mental healthcare, we know all too well that poor planning of mental health services only leads to poorer health outcomes for affected individuals and communities and adverse flow-on effects to other parts of the healthcare system. In our view, the mental health system has not benefitted from consistent, integrated and sophisticated service planning, rather it is characterised by limited demand forecasting, fragmented planning across districts, poor infrastructure planning and piecemeal approaches to previous reforms. Again, the Productivity Commission said as much.

We submit that NSW does not systematically apply a planning model that links service responses to prevalence of mental health problems across defined areas. Nor does it link benchmarked levels of provision to expected benefits at a population level. This results in some unevenness in service capacity across the state, particularly for certain rural areas. It also results in many people falling through gaps between services.

In our view, service planning is critical to preparing for the range of variables that influence service systems, such as changing and growing demand, and demographic changes. Effective planning is needed to build the evidence base to demonstrate where funding and resources are required.

Recommendation 2

To support Recommendation 1, the NSW Branch recommends the government's rural mental health strategy consider population growth and acute care needs of the community which must be met with a reliable and sustainable workforce.

(f) an analysis of the capital and recurrent health expenditure in rural, regional and remote NSW in comparison to population growth and relative to metropolitan NSW;

We see from the data presented in Table 8 below and E in the appendix that per capita expenditure on mental health services decreases significantly as rurality increases with differences varying by 700% (e.g. city vs very remote in 2018/19). Despite per capita spending in rural areas increasing over time, funding levels remain grossly unequal and need to be addressed as a matter of urgency.

TABLE 8 - Australian Government Medicare expenditure on mental health-specific services per capita ($), constant prices, by provider type, remoteness area, 2006–07 to 2018–19 – All providers

Remoteness area	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19	Ave annual change (per cent) 2014/15 to 2018–19
Major cities	24.7	36.0	40.6	43.8	47.7	46.4	47.3	48.7	50.8	52.8	53.9	55.0	55.3	2.2
Inner regional	14.8	25.1	29.7	33.1	36.3	34.6	36.0	37.2	40.3	43.5	44.6	45.5	46.2	3.5
Outer regional	7.3	13.0	16.3	18.6	20.1	20.0	20.8	23.4	26.3	29.2	30.0	30.6	31.6	4.7
Remote	3. 9	6.6	8.1	9.4	10.3	9.8	10.1	11.1	12.9	14.1	15.	17.3	18.5	10.5
Very remote	2.0	3.9	4.2	5.0	5.4	5.3	5.2	6.2	6.8	8.0	8.5	8.1	8.8	6.8

We heard from our Fellows that current funding arrangements do not take account of the higher operating costs associated with providing mental health services in rural communities. We heard that outreach services incur higher costs because of the cost of travelling across larger geographical areas to reach dispersed populations. Similar costs are borne by consumers and families needing to travel to services.

Our members in consultation said that although significant strides have been made in the past 30 years, mental health care in NSW is still characterised by siloed funding streams and short-term funding arrangements that create service fragmentation and uncertainty among mental health service providers impacting on their capacity to engage in long term planning and provide employment certainty for staff.

We hear anecdotally that growth funding for mental health services is not allocated on a proportional basis of total spend on mental health in NSW (that is, 10% of health's budget) and that such growth funding gets absorbed into other parts of the health system that are unrelated to mental health. We believe the Committee should recommend further examination of this issue to establish whether this is true or not.

Our members in consultation also expressed concern about consumers being treated in mental health facilities that are in poor condition and unsuitable for delivering best practice treatment, care and support.

Recommendation 3

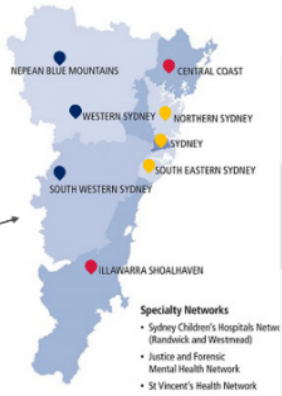
In light of the issues described regarding funding of mental health services, the NSW Branch believes funding reform that is equitable across rural LHDs and accounts for the unique requirements of each in providing effective and timely mental health services across a range of geographical and remote regions in urgently needed. Such considerations in the calculation of service funding, but pivotal in providing effective and efficient mental health services, need to include:

- Population growth and socioeconomic advantage and disadvantage
- At risk populations, including Aboriginal and Torres Strait Islander peoples, young people and people of refugee backgrounds. These need to be delivered in a culturally appropriate way.

- Unmet demand allowing for recognition of shortfalls in current service provision
- Distance and access to transport between communities and services
- Investing in physical, capital and technological rural health infrastructure to improve the availability of quality services and the capacity of rural doctors to provide mental health care

(g) an examination of the staffing challenges and allocations that exist in rural, regional and remote NSW hospitals and the current strategies and initiatives that NSW Health is undertaking to address them

The profile of the mental health workforce in rural and remote NSW is far different from that in major cities. As shown in Table 7 (in part c), the distribution of mental health professionals decreases rapidly with remoteness, with psychiatrists being roughly six times less prevalent in rural areas, psychologists roughly five times less prevalent and mental health nurses roughly three times less prevalent than in major cities. Prevalence for these professions in regional/rural areas are about a third to two thirds what they are in major cities.



Location	Number of Psychiatrists	Hours worked by setting
Sydney (Northern Sydney, South Eastern Sydney, Sydney LHDs)	**1 psychiatrist per 4,102 population**, equating to approximately 24.3 FTE per 100,000 population	**600 psychiatrists**, working 3936 hours in the inpatient setting, working 2360 hours in the outpatient setting
Outer Sydney (Nepean Blue Mountains, South Western Sydney and Western Sydney LHDs).	**1 psychiatrist per 12,311 population,** equating to approximately **8.1 FTE per 100,000 population**	**186 psychiatrists,** working 2315 hours in the inpatient setting, working 1223 hours in the outpatient setting
Regional/rural (Central Coast, Far West, Hunter New England, Illawarra Shoalhaven, Mid North Coast, Murrumbidgee, Albury Wodonga Health Service, Northern NSW, Southern NSW, Western NSW LHDs)	**1 psychiatrist per 13,518 population,** equating to approximately 7.4 FTE per 100,000 population	**222 psychiatrists,** working 2147 hours in the inpatient setting, working 1456 hours in the outpatient setting

It is well-established that there is a severe shortage of psychiatrists in rural and remote areas. Issues are complex but include lack of flexibility in NSW Government awards and no capacity to provide incentives in hard to recruit to locations, like the growth regions.

We know, as we have said lots of times in our submission, that one of the most significant reasons for low access rates and the attendant problems this causes (e.g. self-harm or suicide) lies in the lack of mental health professionals within reasonable distance of the homes of rural and remote population. The simple truth is that without people, there is no service, and people who depend on these must make to do with different models of care that are very different to those that can be offered in more urban settings. Patients are reliant on their GP, and for more specialised help, locums, visiting medial officers, fly-in fly-out doctors where these are available. The extent of this situation is made evident in Table A (in appendix) where we see, for example, LHDs like Western NSW, Southern NSW and Murrumbidgee delivering psychiatry services almost entirely through VMOs.

Recommendation 4

NSW Health, with input from our Branch, is working on a psychiatry workforce plan to support a sustainable psychiatry workforce and to meet the needs of people living with a

mental illness and their families. We should like to recommend that the Committee note this work and support its implementation once completed.

Appendix - Data table

TABLE A – Current and projected population, hospital admissions (mental disorders) number of public sector psychiatrists per 100,000 by LHD[16]

LHD	2019	2036	Change	% + or -	Admissions mental disorders 2018-19	Admission rate per 100,000 population	#self harm (rate per 100,000)	# Suicide (rate per 100,000)[17]	# of public sector psychiatrists (headcount) as July 2019[18]			Psychiatrist /population size	Per 100,000 population 2019
									Staff specialists	VMOs	Total		
City/metropolitan areas													
Sydney	686,694	895,790	209,096	30%	17,091	2365.9	461 (66)	67 (9.4)	71	5	76	9,035	11
Northern Sydney	945,497	1,121,810	176,313	19%	23,563	2474.3	610 (69)	73 (7.7)	71	17	88	10,744	9
South Eastern Sydney	947,829	1,124,960	177,131	19%	19,120	1924.4	396 (86)	100 (10.1)	60	8	68	13,939	7
South Western Sydney	1,019,985	1,402,810	382,825	38%	14,709	1479.5	595 (61)	92 (9.4)	29	34	63	16,190	6
Western Sydney	1,027,226	1,482,480	455,254	44%	17,712	1773.1	546 (56)	69 (7)	59	5	64	16,050	6
Total	**4,627,231**	**6,027,850**	**1,400,619**	**30%**	**92,195**	**1992**	**2608 (56.4)**	**401 (8.6)**	**290**	**69**	**359**	**12,889**	**7.75**
Regional and rural areas													
Far West	30,060	27,780	-2,280	-8%	408	1448.4	54 (222)	NA	0	8	8	3,758	26[19]
Southern NSW	214,124	250,170	36,046	17%	2,452	1195.5	256 (142)	36 (16.6)	0	20	20	10,706	9
Mid North Coast	223,355	251,910	28,555	13%	4,418	1943.4	284 (157)	33 (15.2)	5	15	20	11,168	9
Murrumbidgee	243,309	244,740	1,431	1%	2,356	971.4	306 (146)	41 (17.7)	0	21	21	11,586	9
Western NSW	283,615	301,690	18,075	6%	3,448	1281.1	272 (110)	41 (15.3)	4	41	45	6,303	16
Northern NSW	306,903	344,060	37,157	12%	3,349	1115.1	376 (141)	53 (18.2)	8	18	26	11,804	8
Central Coast	348,472	415,060	66,588	19%	9,213	2631.5	376 (120)	50 (14.8)	14	13	27	12,906	8
Nepean Blue Mountains	385,180	466,660	81,480	21%	8,358	2230.4	353 (98)	50 (13.6)	17	10	27	14,266	7
Illawarra Shoalhaven	416,091	471,700	55,609	13%	8,253	1978.3	110 (100)	54 (14.1)	18	18	36	11,558	9
Hunter New England	942,374	1,063,870	121,496	13%	18,994	2046.9	1,232 (145)	147 (16.0)	46	20	66	14,278	7
Total	**3,393,483**	**3,837,640**	**444,157**	**13%**	**61,249**	**1804**	**3619 (107)**	**505 (14.9)**	**112**	**184**	**296**	**11,464**	**9.4**
Justice	NA	NA	NA	NA	NA				43	19	62	NA	NA
Sydney Children's Network	NA	NA	NA	NA	NA				15	5	20	NA	NA
Grand total	**8,022,733**	**9,867,526**	**1,844,793**	**23%**	**153,444**	**1912**	**6227 (78)**	**906[20] (10.1)**	**505 (14.9)**	**277**	**737**	**10885**	**9.2**

[16] NSW HealthStats Population by Local Health District [Accessed 20 November 2019] Available at http://www.healthstats.nsw.gov.au/Indicator/dem_pop_lhnmap

[17] NSW Suicides 2018, HealthStats NSW, [Accessed 20 November 2019] http://www.healthstats.nsw.gov.au/Indicator/men_suidth/men_suidth_lhn

[18] Figures provided by NSW Health, Hospitalisation by category of cause [Accessed 21 November 2019] Available at http://www.healthstats.nsw.gov.au/Indicator/bod_hos_cat/bod_hos_cat_lhn_snap

[19] Assumes a population of 100,000 people.

[20] 8 were not stated

TABLE B – Psychiatry – MBS Medicare-subsidised mental health-specific services, by provider type (psychiatry), remoteness area, 2007–08 to 2016–17[21]

Remoteness area	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17	2017-18	2018-19	Average annual change (per cent) 2014–15 to 2018–19"
All areas	1,949,702	1,967,222	1,983,481	2,009,411	2,058,777	2,136,042	2,216,848	2,302,742	2,355,319	2,390,788	2,422,166	2,453,810	3.0
Major cities	1,661,431	1,673,339	1,684,357	1,704,398	1,749,890	1,802,990	1,830,321	1,917,112	1,944,437	1,964,350	1,993,929	2,013,524	4.9
Inner regional	231,001	233,630	237,281	241,196	242,915	261,450	273,101	292,227	307,704	317,891	324,958	331,524	4.0
Outer regional	49,240	51,496	53,064	55,178	56,347	61,087	71,631	81,953	91,744	96,246	91,379	95,257	8.4
Remote	4,396	5,160	5,211	5,187	5,538	5,904	7,016	7,460	7,918	8,769	8,788	98,847	1.7
Very remote	1,961	1,670	1,568	1,620	2,191	2,422	2,601	2,941	3,517	3,480	3,075	3,658	3.0
NSW	N/A	91,012	94,460	97,870	101,633	107,937	113,548	118,687	121,239	123,788	128,334	132,655	2.8

[21] The number of services reported for each remoteness area may not sum to the total due to missing or not reported data.

TABLE C - NSW Emergency Department mental health presentations: year to date 22 Sep 2020

Local Health District	Age groups:													
	0-11		12-17		18-25		25-34		35-64		65+		All ages	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
City LHDs														
Northern Sydney	43	-16%	793	25%	718	-9%	737	-7%	1,351	1%	269	2%	3,911	1%
South Eastern Sydney	40	74%	496	-7%	1,027	8%	1,281	-6%	2,315	-6%	480	-2%	5,639	-3%
South Western Sydney	129	40%	1,072	5%	1,452	3%	1,910	0%	2,954	-8%	520	2%	8,037	-1%
St Vincent's	2		52	37%	343	1%	629	9%	1,232	7%	128	2%	2,386	7%
Sydney	17	-37%	245	10%	656	-8%	937	-5%	1,885	7%	303	-15%	4,043	-1%
Sydney Children's Hospitals	243	-2%	1,113	31%	0	0	1	-	1,357	24%	243	-2%	1,113	31%
Western Sydney	15	-32%	508	30%	1,066	19%	1,228	21%	1,861	7%	333	22%	5,014	16%
Inner regional/rural LHDs														
Central Coast	79	-12%	543	24%	690	6%	647	5%	1,095	-5%	354	-15%	3,408	1%
Far West	2	-78%	44	26%	79	16%	114	23%	204	7%	32	-33%	475	7%
Hunter New England	190	27%	1,811	24%	1,864	-1%	1,846	-6%	3,301	-14%	612	-2%	9,624	-3%
Illawarra Shoalhaven	66	-20%	584	20%	868	6%	777	7%	1,589	-10%	385	2%	4,270	0%
Mid North Coast	52	-15%	433	17%	555	-3%	584	0%	1,127	-10%	256	-16%	3,007	-4%
Murrumbidgee	45	-35%	351	6%	592	-2%	698	-1%	1,067	-9%	286	-15%	3,039	-6%
Nepean Blue Mountains	71	31%	376	4%	542	4%	595	-4%	1,128	6%	243	12%	2,958	4%
Northern NSW	72	18%	506	2%	741	-4%	923	6%	1,679	-14%	405	1%	4,326	-5%
Southern NSW	52	73%	277	5%	400	8%	410	0%	796	-13%	218	-3%	2,153	-3%
Western NSW	92	2%	648	1%	797	-5%	731	-16%	1,403	0%	257	-10%	3,928	-5%
NSW	1,210	4%	9,852	15%	12,390	2%	14,047	0%	24,988	-5%	5,081	-3%	67,575	0%

Increased by 5% or more compared to same period in 2019
Reduced by 5% or more compared to same period in 2019

TABLE D - NSW Emergency Department self-harm or suicidal ideation presentations: year to date 22 Sep 2020

Local Health District	Age groups:													
	0-11		12-17		18-25		25-34		35-64		65+		All ages	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
City LHDs														
Northern Sydney	8	-53%	778	33%	608	-11%	468	-3%	759	-8%	117	3%	2,738	1%
South Eastern Sydney	5	-38%	378	-13%	728	1%	728	-6%	1,103	0%	186	-8%	3,130	-3%
South Western Sydney	35	35%	1,022	12%	1,137	2%	1,178	10%	1,474	-12%	178	-13%	5,024	0%
St Vincent's	0		35	30%	207	5%	304	-7%	496	8%	63	62%	1,105	5%
Sydney	1	-86%	236	-1%	570	2%	573	-14%	940	-7%	100	2%	2,420	-6%
Sydney Children's Hospitals	64 12%	879	49%	64 12%	0		0						943	46%
Western Sydney	3	50%	528	28%	965	14%	938	20%	1,250	3%	165	7%	3,855	13%
Inner regional and rural LHDs														
Central Coast	22	4	550	27%	653	11%	508	5%	830	-7%	163	-17%	2,727	4%
Far West	0		47	52%	52	13%	59	31%	96	13%	9	29%	263	22%
Hunter New England	64	60%	1,318	18%	1,171	4%	868	-6%	1,358	-12%	218	25%	4,997	1%
Illawarra Shoalhaven	15	-6%	414	17%	558	23%	345	5%	692	-4%	133	-11%	2,157	7%
Mid North Coast	9	-25%	431	32%	421	5%	296	-3%	555	-8%	112	-10%	1,824	3%
Murrumbidgee	10	-50%	328	9%	456	-2%	388	4%	583	-1%	111	-10%	1,876	0%
Nepean Blue Mountains	16 129	16 129	368	22%	476	31%	394	11%	639	13%	105	11%	1,999	18%
Northern NSW	21	200%	461	6%	559	7%	494	24%	793	-4%	167	15%	2,495	7%
Southern NSW	14	100%	266	16%	275	5%	249	19%	404	-10%	65	-16%	1,273	3%
Western NSW	27	23%	596	15%	582	1%	380	-12%	724	10%	97	8%	2,406	5%
NSW	314	13%	8,635	19%	9,418	5%	8,170	3%	12,696	-4%	1,989	0%	41,232	4%

Increased by 5% or more compared to same period in 2019
Reduced by 5% or more compared to same period in 2019

TABLE E - Australian Government Medicare expenditure on mental health-specific services per capita ($), constant prices, by provider type, remoteness area, 2006–07 to 2018–19

Remoteness area	Provider	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19	Average annual change (per cent) 2014/15-2018/19
Major cities	Psychiatrist	16.67	16.82	16.40	16.29	16.44	16.67	16.88	17.13	17.20	17.01	16.83	16.65	16.52	-1.0
Major cities	General practitioner	n.p.	7.96	9.61	10.34	11.77	9.92	9.38	10.08	10.89	11.78	12.22	12.56	12.50	3.5
Major cities	Clinical psychologist	1.45	4.91	6.59	7.78	9.01	9.62	10.64	11.26	11.89	12.49	12.92	13.34	13.60	3.4
Major cities	Other psychologist	2.15	5.93	7.41	8.63	9.59	9.27	9.42	9.22	9.69	10.38	10.74	11.20	11.43	4.2
Major cities	Other allied health	0.09	0.40	0.62	0.79	0.90	0.89	0.95	0.97	1.07	1.16	1.23	1.29	1.34	5.9
Major cities	**All providers**	**24.6**	**36.**	**40.6**	**43.8**	**47.7**	**46.4**	**47.3**	**48.7**	**50.7**	**52.8**	**53.9**	**55.0**	**55.4**	**2.2**
Inner regional	Psychiatrist	7.73	7.84	7.72	7.87	7.99	8.12	8.62	9.22	9.75	10.22	10.49	10.86	11.31	3.8
Inner regional	General practitioner	n.p.	8.24	10.12	11.03	12.33	10.16	9.63	10.04	11.11	12.17	12.50	12.50	12.31	2.6
Inner regional	Clinical psychologist	0.88	3.15	4.33	5.16	5.99	6.39	7.16	7.73	8.40	9.23	9.75	10.20	10.57	5.9
Inner regional	Other psychologist	1.85	5.50	6.93	8.20	9.03	8.91	9.50	9.09	9.73	10.37	10.16	10.07	10.02	0.7
Inner regional	Other allied health	0.09	0.40	0.57	0.82	0.99	0.98	1.08	1.16	1.32	1.54	1.72	1.84	1.99	10.8
Inner regional	**All providers**	**14.7**	**25.1**	**29.66**	**33.1**	**36.3**	**34.6**	**36**	**37.2**	**40.3**	**43.5**	**44.6**	**45.5**	**46.2**	**3.5**
Outer regional	Psychiatrist	3.16	3.38	3.49	3.62	3.87	4.02	4.30	5.57	6.29	7.03	7.24	7.15	7.79	5.5
Outer regional	General practitioner	n.p.	5.21	6.56	7.37	8.28	6.94	6.67	7.41	8.39	9.42	9.70	9.81	9.79	3.9
Outer regional	Clinical psychologist	0.40	1.35	1.95	2.37	2.92	3.26	3.56	4.20	4.72	5.16	5.41	5.77	5.99	6.1
Outer regional	Other psychologist	0.99	2.89	3.86	4.67	5.19	5.03	5.43	5.29	5.90	6.48	6.68	6.72	6.58	2.7
Outer regional	Other allied health	0.05	0.26	0.40	0.57	0.69	0.71	0.82	0.96	1.00	1.13	1.21	1.17	1.41	8.9
Outer regional	**All providers**	**7.3**	**13.1**	**16.3**	**18.6**	**21.0**	**20.0**	**20.8**	**23.4**	**26.30**	**29.2**	**30.2**	**30.6**	**31.5**	**4.7**
Remote	Psychiatrist	1.98	1.91	2.11	2.14	2.21	2.37	2.52	3.32	3.40	3.90	4.26	4.44	5.26	11.5
Remote	General practitioner	n.p.	2.73	3.58	4.16	4.59	3.78	3.54	3.81	4.47	5.05	5.41	5.99	6.03	7.8
Remote	Clinical psychologist	0.19	0.81	0.94	1.22	1.33	1.58	1.99	1.96	2.27	2.33	2.39	3.00	3.25	9.4
Remote	Other psychologist	0.35	1.11	1.37	1.63	1.89	1.85	1.88	1.76	1.91	2.41	2.43	3.23	3.31	14.7
Remote	Other allied health	—	0.06	0.09	0.20	0.29	0.21	0.19	0.25	0.33	0.39	0.51	0.58	0.62	17.2
Remote	**All providers**	**3.89**	**6.61**	**8.09**	**9.35**	**10.31**	**9.79**	**10.12**	**11.10**	**12.38**	**14.08**	**15.00**	**17.24**	**18.47**	**10.5**
Very remote	Psychiatrist	1.33	1.44	1.15	1.13	1.12	1.42	1.59	2.06	2.14	2.69	2.59	2.31	2.73	6.2
Very remote	General practitioner	n.p.	1.49	1.81	2.05	2.30	1.98	1.75	2.10	2.32	2.60	2.85	2.83	2.93	5.9
Very remote	Clinical psychologist	0.10	0.38	0.46	0.78	0.82	0.72	0.77	0.86	0.97	1.18	1.44	1.29	1.50	11.5
Very remote	Other psychologist	0.17	0.59	0.81	0.93	1.03	1.10	0.99	0.96	1.06	1.30	1.45	1.51	1.48	8.7
Very remote	Other allied health	0.00	—	—	0.08	0.09	0.06	0.08	0.27	0.27	0.23	0.18	0.21	0.17	-10.6
Very remote	**All providers**	**2.34**	**3.91**	**4.24**	**4.96**	**5.36**	**5.28**	**5.18**	**6.24**	**6.76**	**8.00**	**8.52**	**8.14**	**8.80**	**6.8**