11 May 2018

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

By online submission

Dear Sir/Madam

Re: Accessibility and quality of mental health services in rural and remote Australia

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP has more than 5500 members including over 4000 fully qualified psychiatrists and around 1400 members who are training to qualify as psychiatrists.

The RANZCP is pleased to provide this submission to the Senate Community Affairs References Committee. In developing this submission, the RANZCP consulted with a variety of Fellows and internal committees, including the Section of Rural Psychiatry, Branch Committees in Australia and the Aboriginal and Torres Strait Islander Mental Health Committee, to ensure that priority areas identified reflect clinical experience, community input and mental health expertise.

This submission provides an overview of some of the issues relating to psychiatry in rural and remote Australia, recognising the distinctive context for psychiatric practice in rural and remote areas of Australia and the poorer mental health indicators in non-urban areas.

There is a severe shortage of psychiatrists in rural and remote Australia, and a paucity of incentives to support recruitment of retention of health professionals in areas of need. Higher rates of suicide are an unacceptable reflection of gaps in Australia's health system. For many people in rural and remote Australia, mental health services are simply out of reach.

In addition, across rural and remote Australia, there is an acute shortfall in treatment and recovery services for misuse of alcohol and other drugs. To improve health outcomes for people with mental illness, remote and regional areas of Australia need additional funding and better integration of services.
If you would like to discuss any of the points raised in this letter, please contact Rosie Forster, Executive Manager, Practice, Policy and Partnerships via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours faithfully

Dr Kym Jenkins
President

Ref: 1110o
Senate Community Affairs
References Committee

Submission to the Inquiry into
accessibility and quality of mental
health services in rural and remote
Australia

May 2018
About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has more than 5500 members including more than 4000 fully qualified psychiatrists and around 1400 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care and use a range of evidence-based treatments to support a person in their journey to recovery. In developing this submission, the RANZCP consulted with a variety of Fellows and internal committees, including the Section of Rural Psychiatry, Branch Committees in Australia and the Aboriginal and Torres Strait Islander Mental Health Committee, to ensure that priority areas identified reflect clinical experience, community input and mental health expertise.

Summary

The RANZCP is pleased to provide this submission to the Senate Community Affairs References Committee regarding the Inquiry into the accessibility and quality of mental health services in rural and remote Australia (the Inquiry). The RANZCP recognises the distinctive context for psychiatric practice in rural and remote areas of Australia, including poorer mental health indicators in non-urban areas.

There is a severe shortage of psychiatrists in rural and remote Australia, and a paucity of incentives to support recruitment of retention of health professionals in areas of need. Higher rates of suicide are an unacceptable reflection of gaps in Australia’s health system. For many people in rural and remote Australia, mental health services are simply out of reach. Across rural and remote Australia, there is an acute shortfall in treatment and recovery services for misuse of alcohol and other drugs. To improve health outcomes for people with mental illness, remote and regional areas of Australia need additional funding and better integration of services.

This submission provides an overview of some of the issues relating to psychiatry in rural and remote Australia. Additional detail is provided in the RANZCP Position Statement on Rural Psychiatry and related practice documents. Content for this submission has been shaped around the six areas identified in the Inquiry’s Terms of Reference.

RECOMMENDATIONS

1. Fund and develop targeted programs to focus on prevention of suicide among rural, remote and Aboriginal and Torres Strait Islander communities.
2. Provide assistance for transport costs for individuals that need to travel for treatment.
3. Increase funding and support systems for telepsychiatry, including upgrades to technology and enhanced referral systems.
4. Support and expand training programs designed to address workforce shortages in rural and remote programs, such as the Specialist Training Program, the Integrated Rural Training Pipeline and initiatives like the Hunter New England Training Network.
5. Improve and expand treatment and recovery services for alcohol and other drugs in rural and remote areas.
Nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate

People living in rural and remote areas face significant challenges in accessing appropriate mental health care and treatment. National Medicare data from 2007 to 2011 shows that increasing remoteness is consistently associated with lower service activity per 1,000 population (Meadows, 2015). With a strong commitment to providing high quality mental health services to Australians in rural and remote areas, the RANZCP has developed initiatives to support trainees and Fellows and promoted evidence-based programs and services for people in more isolated settings.

The reasons for the lower rate of mental health service access by rural and remote Australians are multifaceted. In many cases appropriate services are not available or affordable. The 2014 National Review of Mental Health Programmes and Services found that rural and remote mental health services are transient, understaffed and facing rising demand in a number of areas (National Mental Health Commission, 2014). This, along with inadequate funding for the additional demand and costs that accompany service delivery in rural and remote areas, decreases the capacity and quantity of mental health services available to rural and remote Australians.

There is a severe shortage of consultant psychiatrists in rural Australia (NMTAN, 2016) and most mental health care is delivered by primary care workers, such as GPs. Often rural towns may be too small to support a specialist mental health service and services that are community-based have difficulty recruiting and retaining specialists. This can lead to rural communities being less able to access mental health services provided by psychiatrists and this presents a major service gap for people with severe mental illness. In addition, the unique issues associated with practicing in rural and remote communities means that GPs can be limited in their ability to provide mental health services and diagnosis, which are often complex and time consuming.

The shortage of consultant psychiatrists in rural and remote Australia – as well as the growing use of flexible models of service provision – means there is a need for better coordination between existing medical services and psychiatry services. This is particularly relevant considering the collaborative partnerships required to treat mental illness concurrently with physical illness (Lambert et al., 2017). Issues with communication can be exacerbated by distance, leaving rural and remote communities at a disadvantage when seeking coordinated and collaborative care from a number of health professionals and service providers.

People living in rural and remote areas also face substantial social and physical challenges. These include long distance travel to services, stigma and discrimination around seeking help and cultural barriers to seeking help. Studies report barriers such as a lack of knowledge about, and a negative view of, mental health problems and practitioners impacting those living in rural areas (Jackson et al., 2007). A recent survey from the Australian Institute of Health and Welfare (AIHW) found that 3 in 5 people in remote and very remote areas said not having a specialist nearby stopped them from seeing one (AIHW, 2018).

Several therapies commonly prescribed by psychiatrists require attendance at a hospital or medical centre for safe treatment. One example is electroconvulsive therapy (ECT), which is administered to over 7,500 Australians each year and is only available in hospitals. ECT requires a number of sessions in each treatment course, with a few days between sessions. This can impose a substantial burden for
those in rural or remote areas, and requires travel for long periods of time and payment for additional living costs such as accommodation (RANZCP, 2016b).

Recent private health insurance reforms, effective 1 April 2018, mandated insurers to expand hospital insurance to cover travel and accommodation benefits for people in regional and rural areas that need to travel for treatment. This will be particularly useful for rural and remote Australians requiring ECT.

**Higher rate of suicide in rural and remote Australia**

Data collected by the AIHW shows that between 2001 and 2011 suicide rates were consistently higher in all remoteness areas compared to major cities (Harrison & Henley, 2014). The higher rate of suicide in rural and remote Australia is an unacceptable reflection of gaps in Australia’s health system and is a serious concern. Rural and remote communities facing a number of issues and challenges that may contribute to a higher rate of suicide. Commonly identified factors include economic and financial hardship (particularly for those working in farming), social isolation, stigma around help seeking, stressors relating to changing climatic conditions, reduced access to support services, easier access to means that lead to immediate death. For many in rural and remote areas, risk factors combine.

Greater funding and resources for mental health services and professionals in rural and remote Australia is urgently needed. Investments should be targeted at increasing the number of specialists available in rural and remote areas and providing more evidence-based support programs for at-risk groups. Evidence for restricting access to lethal means for the prevention of suicide is also strong (Zalsman et al., 2016), and this should be a priority for all levels of government.

The RANZCP acknowledges that all Australians 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. Studies show that farmers, young men, older people, and Indigenous Australians in remote areas, are at greatest risk of suicide (Arnautovska et al., 2015; Harrison & Henley, 2014). The individual stressors and factors vary across these groups, indicating a need for more specialised support and approaches tailored for different communities.

Farmers face a number of distinctive pressures and stressors, with studies highlighting occupational considerations as a key factor in the higher rate of suicide for this group. The workload associated with running a farm, including dealing with financial stresses and challenging living conditions, as well as a perceived lack of control over success, contributes to a feeling of powerlessness and may contribute to suicide rates (Kõlves, 2012). The RANZCP believes that psychiatrists, in collaboration with other health professionals, are well placed to provide greater support to communities in rural and remote Australia through targeted and specialised care and support.

The RANZCP 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. The RANZCP provides a number of resources and training modules to ensure psychiatrists have relevant knowledge of Aboriginal and Torres Strait Islander history, culture and practices. Ongoing funding for learning and development programs to encourage culturally secure assessment and treatment is critical. The RANZCP is committed to increasing competency among Fellows and trainees and has adopted initiatives to increase the number of Aboriginal and Torres Strait Islander mental health professionals.
and support them in their practice. The RANZCP’s own Psychiatry Interest Forum and work with the Australian Indigenous Doctors’ Association provide good models. Much more needs to be done, but resources are sparse.

There are massive challenges faced by rural and remote communities with regard to seeking help for alcohol and other drug use. The 2016 National Drug Strategy Household Survey found that people living in remote and very remote areas were more likely to smoke, drink at risky levels, and use cannabis and meth/amphetamines (AIHW, 2017). People in remote and very remote areas were 2.5 times as likely to use meth/amphetamines as those in major cities. The strong association between illicit drug use and mental health issues (although not a simple causative relationship) demonstrates that rural and remote communities require significant support in this area (AIHW, 2017; Loxley et al. 2004).

However, rural and remote communities currently face an acute shortfall in services for those seeking assistance for alcohol and other drug related issues. Alcohol and other drug services that are particularly limited in rural areas include opioid pharmacotherapy (such as methadone programs), withdrawal and detoxification services as well as needle and syringe programs. In addition, the issues around inadequate services are compounded by the lack of specialist medical expertise to manage these issues. Telephone and online service options do exist for alcohol and other drug issues (including counsellingonline.org.au, Directline, Hello Sunday Morning), but there are critical issues with capacity, coverage and continuity. When combined, these circumstances can lead to increasingly poor outcomes, with substantial repercussions for individuals in rural and remote areas, and their communities.

Nature of the mental health workforce

The recruitment and retention of health professionals in rural and remote communities continues to be a major barrier for providing equal access to mental health services. As mentioned previously, there is a severe shortage of consultant psychiatrists in rural Australia. Most trainee psychiatrists also report a clear and continuing inclination to practice in urban centres (RANZCP, 2016a; NMTAN, 2016; RANZCP, 2014), as there are fewer opportunities for career development and supervision in rural and remote areas. The most recent data shows that major cities in Australia have approximately 15.1 full-time equivalent (FTE) employed psychiatrists per 100,000 population, while that figure was 5.8 for inner regional areas, 3.4 in outer regional areas, 5.0 in remote areas and only 1.4 in very remote areas (NMTAN, 2016). Generally, the more remote the location, the worse the access is to psychiatric services (HWA, 2012; Meadows et al., 2015).

Psychiatrists that practice ruraly can face a number of challenges, including professional isolation, social and family factors (including difficulties with spouses obtaining employment), limited career opportunities, size of patient base, burden of travel to outreach services, risks of litigation, lack of specialist positions at regional hospitals, and remuneration (HWA, 2012; DoHA, 2008; Dunbabin, 2003). Factors associated with professional isolation may relate to deficits in after hours and sickness cover, peer support and review, access to Continuing Professional Development (CPD), opportunities to train registrars and to have junior medical staff backup, collegiality, and the impact of chronic shortages on sustainable workloads.

Rural psychiatrists are required to have broad knowledge and special skills across a range of areas of expertise, working with patients across all age ranges and treating a wider array of issues than psychiatrists in urban areas. This occurs where there are fewer clinical supports and leads to increased responsibilities. It can be harder for psychiatrists in rural areas to collaborate with other clinicians, they often have to assume different supervisory roles, but still maintain a heavy patient load. There is an
expectation for rural psychiatrists to liaise with other services and to work in multidisciplinary teams in a more broad and flexible way than is required in urban centres. Working in rural psychiatry may involve travelling to more remote areas and/or transferring patients to larger centres for treatments unavailable in the local region, which leads to increased administration and delays. Heightened workload pressures must be taken into account in planning and budgeting to ensure health services are adequately staffed to manage these pressures.

Rural and remote settings are almost inevitably areas of unmet need, leading to a situation where a significant number of International Medical Graduates (IMGs) are employed. This can introduce additional cultural and language issues, and can accentuate problems of professional and social isolation for practitioners. IMGs need support to adapt to new work contexts, support which health facilities in rural and remote locations are often not well resourced to provide.

In order to manage these challenges, it is important that all psychiatrists are provided with adequate support and incentives when practicing in rural areas. This may include locum support to allow for breaks, time off or attendance of professional development activities, as well as financial support to cover the cost of relocation. Priority should be given to long-term solutions, through initiatives that encourage health professionals to move to rural and remote areas.

The impact of these issues varies between different areas, as do the initiatives funded to improve outcomes and the models of mental health service delivery. One example is the New South Wales Rural Psychiatry Project, funded by NSW Department of Health and delivered by RANZCP, for workforce development, priority filling of rural training places, enhancing experiences for rural trainees, and support for IMGs in rural settings. The outcomes of the project demonstrated that, with the commitment of government funding and support, better access to psychiatry can be delivered in rural areas (RANZCP, 2010). Programs like this should be adapted in other contexts.

Initiatives such as the Specialist Training Program (STP) have also made significant gains and require ongoing support. Through STP, Australian Government funding is provided to the RANZCP and other Colleges to expand opportunities for specialist trainees. Support for regional, rural and remote areas are one of three priority areas identified for the program for 2018–2020. Critically, this program requires concurrent efforts to address rural workload pressures, such as travel times, lack of alternative services and appropriate staffing levels to properly support and supervise such training posts. The Integrated Rural Training Pipeline (IRTP) also addresses an important need, and provides funding to enable doctors to complete most of their training in a rural area. The RANZCP believes that guaranteed ongoing funding for these initiatives will help to ensure that the ratio of psychiatrists in rural to urban areas improves over time.

**Challenges of delivering mental health services in the regions**

As explained in previous sections, distance, resource shortages and the nature of mental health challenges in rural and remote areas can create additional challenges for service delivery. Psychiatrists work in multidisciplinary teams and rely on referrals from GPs. Importantly, these networks need to be strong, with trained and supported professionals in allied health roles. In mental health nursing and other professions – particularly in rural and remote areas – there tends to be high rates of turnover which can add to pressure on the system and impacts outcomes for people with mental illness.

Innovative models of service delivery are required to meet the needs of rural communities and provide access to quality mental health care. In communities without adequate numbers of resident psychiatrists
or where subspecialist services are unavailable, flexible models such as fly-in, fly-out services or telehealth solutions, have been developed. These services should not be seen as permanent solutions and in the interests of good, consistent patient care, there needs to be more effort to encourage psychiatrists to relocate, rather than visit.

The misuse of alcohol and other drugs is a significant issue in remote and very remote communities (AIHW, 2017). Better service planning and resourcing is required for services to treat the misuse of alcohol and other drugs. Initiatives such as the Royal Flying Doctors Service Wellbeing Centres in Queensland, which provide innovative and culturally appropriate services addressing drug and alcohol misuse, as well as other issues, are a valuable example of targeted and community minded service delivery in this area (Bishop et al., 2017).

**Attitudes towards mental health services**

As outlined earlier in this submission, rural and remote communities face a number of barriers to accessing mental health services. A particularly influential factor for some groups is the stigma associated with help-seeking behaviour, as well as cultural factors influencing attitudes towards mental health services. The RANZCP notes that the Australian Government has taken positive steps to build awareness of suicide and reduce stigma associated with seeking help. Ongoing work is required to continually reduce stigma around mental health services. As public awareness increases, so does demand for services and there is a risk in some areas that expectations and mental health care needs will not be met.

Stigma, along with rural stoicism, is well known to make it more likely for rural people to withdraw rather than access mental health services (Hoolahan, 2002). Issues around stigma are often exacerbated in rural communities due to reduced levels of privacy and fewer options when selecting health professionals. The highly integrated nature of rural communities can result in the exclusion of people who are seen as different or who are new to the community. A number of these groups may be influenced by attitudes towards mental health services and seeking help.

Studies indicate that resistance to help-seeking may be more articulated by men, which has been linked to social factors such as traditional rural masculinity (Alston, 2010; Alston & Kent, 2008). This may contribute to higher rates of male farmers and young men completing suicide.

**Opportunities that technology presents for improved service delivery**

Technology provides useful tools for training and supervision opportunities for rural psychiatrists who would ordinarily be isolated and hard-to-reach. Increasingly, webinar-style training and supervision from a distance are helping to connect psychiatrists in rural and remote areas to training and professional development.

The RANZCP supports the use of telepsychiatry in augmenting the delivery of mental health services and notes its practical application in reaching people in rural and remote areas. Studies have demonstrated that telepsychiatry can be as effective as face-to-face consultations in achieving improved health outcomes (García-Lizana & Muñoz-Mayorga, 2010). As in any psychiatric consultation, it is important to provide sufficient information to enable patients and carers to make informed decisions regarding their care.
The RANZCP notes that telepsychiatry should never be seen as a stand-alone service; the implementation of telepsychiatry requires a planned and coordinated approach. For psychiatric emergencies, the telepsychiatry practice should work in coordination with local services, and these services should be resourced and prepared appropriately. Local, cultural and technological factors including groups with special needs must be taken into consideration. Complex and often regionally-specific issues in rural areas need to be carefully considered with regards to community needs. Also of note, ‘oversight responses’ involving metropolitan services such as telehealth or fly-in specialist services, while being valuable to address gaps in some cases, can disrupt networks and de-skill local clinicians in others.

Concerns remain for privacy and confidentiality when using telepsychiatry. It is important that such services are delivered through appropriate channels, which allow for secure and confidential consultations. This is noted within the RANZCP professional practice standards for telepsychiatry, which were developed with Australian Government support in 2013 (RANZCP, 2013). Investments in purpose-built systems may be necessary to guarantee privacy.

The RANZCP notes there is an ever-growing range of online applications and websites which provide mental health advice to consumers. As this content grows, there is potential for consumers to feel confused or misled by information that is not based on the best evidence. Initiatives such as Head to Health, have been designed to help Australians find the right mental health resource and should be supported as part of a commitment to improving the quality of information available to the public on mental health care.

References

• Hoolahan B (2002) ‘The Tyranny of Distance’. Issues that impact on mental health care in rural NSW. NSW Centre for Rural and Remote Mental Health, Orange, NSW.