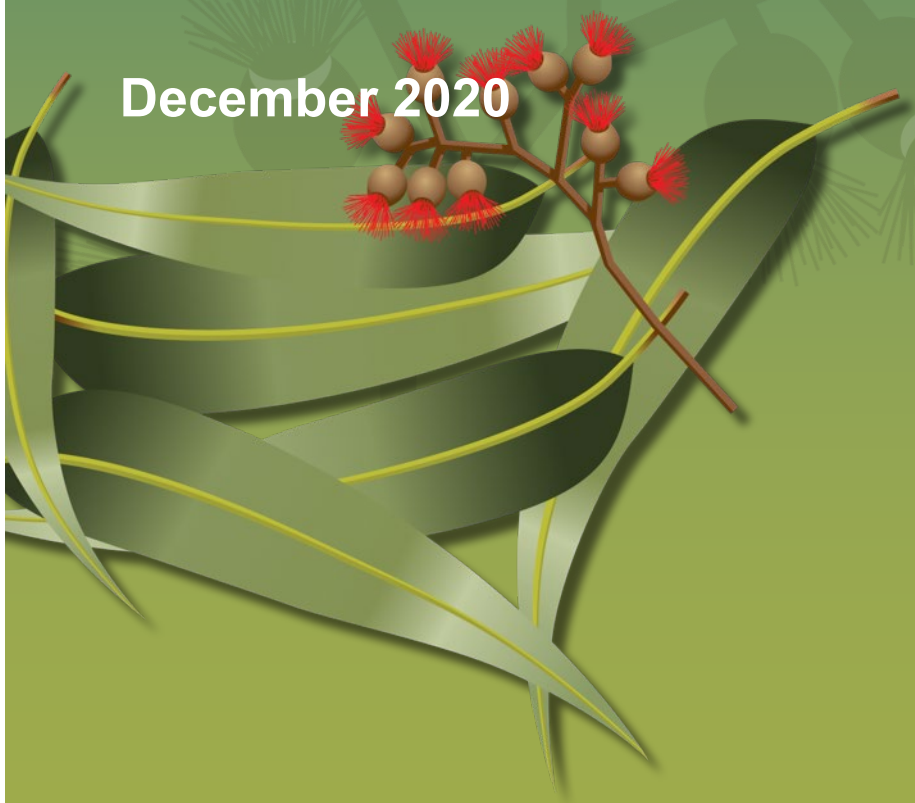
Centre for Rural and Remote Mental Health

Committee on Investment, Industry and Regional Development on the Impact of Drought on Mental Health: Response to six questions posed by the Committee

December 2020



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About the CRRMH

The Centre for Rural and Remote Mental Health (CRRMH) is based in Orange NSW and is a major rural initiative of the University of Newcastle and the NSW Ministry of Health. Our staff are located across rural and remote NSW.

The Centre is committed to improving mental health and wellbeing in rural and remote communities. We focus on the following key areas:

- the promotion of good mental health and the prevention of mental illness;
- developing the mental health system to better meet the needs of people living in rural and remote regions; and
- understanding and responding to rural suicide.

As the Australian Collaborating Centre for the International Foundation for Integrated Care, we promote patient-centred rather than provider-focused care that integrates mental and physical health concerns.

As part of the University of Newcastle, all of our activities are underpinned by research evidence and evaluated to ensure appropriateness and effectiveness.

Centre for Rural & Remote Mental Health
ramhp RURAL ADVERSITY MENTAL HEALTH PROGRAM
THE UNIVERSITY OF NEWCASTLE AUSTRALIA
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Contents

Introduction

This paper follows oral evidence presented by Ms Tessa Cummins, Dr Hazel Dalton and Ms Vanessa Delaney to the Committee on 28 September 2020. The committee forwarded six supplementary questions on 12 November 2020. Our response is based on a combination of rural experience and published evidence from research conduct by our team and by other reputable research groups. Each regional community is different and so there will always be exceptions to these responses both positive and negative.

Declaration of interests

The Centre for Rural and Remote Mental Health is part of the University of Newcastle and receives funds from the NSW Government for its research, infrastructure and rural service coordination through the Rural Adversity Mental Health Program.

1. From your work and research what are the gaps in mental health services in regional communities and are there areas in NSW which need more services?

Service gaps in regional communities

- Services for **mild to moderate (developing) mental health issues** are not well resourced in rural areas. General support and care for **mild conditions** is crucial as an early intervention option. **Peer workers** and **counsellors** play a vital yet underappreciated role. Further, there remains significant variation in the level of access to these services across rural NSW.
- In many places there is a so-called **missing middle**. Patient needs are too serious for General Practitioners (GPs) to address and not serious enough for state mental health service care and so these patients do not receive adequate care.
- **The capacity and capability of GPs** to meet the mental health needs of their patients adequately remains a challenge. Fluctuating locum services lead to instability in service provision, lack of trust from community, and lack of rapport. Some visiting or overseas trained GPs do not understand what mental health or psychosocial supports services are available (e.g. not providing mental health care plans). Long waiting times for a GP appointment are common in rural and remote NSW.
  More generally, GPs are time poor and have a broad range of professional areas to keep up to date with and time pressures in care delivery (time-limited MBS payments and high demand for services). Those who do have an interest in mental health struggle to prioritise the time for mental health upskilling even with PHN and College support (competing with other CPD priorities – chronic disease management etc).
- **Stable psychology services** are scarce in rural towns. Many towns are serviced by larger centres such as Tamworth, Dubbo, Orange or Wagga Wagga, with fluctuating service delivery and staffing. Remote towns experience severe access problems when vacancies or workforce shortages occur in regional centres. We know that the proportion of people who access Medicare-subsidised mental health-specific psychological services decreases with remoteness (2.7% in metropolitan to 0.4% in very remote, AIHW).

Socioeconomic Barriers to Access Remain

- **The cost** of accessing psychology services is prohibitive for those in the lower social economic groups (even with MBS subsidies).
- **The opportunity cost** of accessing services includes **time** away from work (**lost income**) and **transport** costs (i.e. fuel or public transport) which becomes a prohibitive factor in accessing face to face services, particularly during drought.
- **Telehealth** is widely promoted as the answer to most rural access issues. Access to **reliable internet**, adequate **digital literacy** and the **availability of technological devices** are key challenges experienced by the most vulnerable members of rural communities. **Telehealth** is not the entire solution, rather one component of the overall response – it should be an adjunct to, not a replacement of, local primary care and mental health services.

Rural Workforce Challenges are Significant

- **Recruitment and retention issues remain** for mental health professionals in public and NGO services (Psychologists, Mental Health Nurses, Social Workers, Counsellors etc). This lack of trained and willing people to fill vacancies severely limits the provision of consistent services.
- **Wellbeing supports for frontline workforce are variable**. Rural mental health workers often experience the same adversities/ stressors as their clients (e.g. Drought). Efforts to increase workforce capacity are often not implemented until workers reach a crisis point or burnout. For many, Employee Assistance Program (EAP) services are insufficient or EAP providers are metropolitan based, do not fully understand the rural environment and are not considered an effective or appropriate form of support.

- **Adequate professional development opportunities** are not provided to mental health professionals employed by government or NGO agencies. This limited opportunity for support and growth impacts negatively on staff retention.
- Substantial workforce shortages exist in Mental Health Nurse, Psychologist and Community Nurse roles in rural and remote Australia.
- In rural areas, with small, widely scattered populations staff need in- **depth skills and a broad scope of practice.** The best decisions are made by someone that truly understands the situation and environment. For example, The Rural Adversity Mental Health Program (RAMHP) has recognised this need and ensures RAMHP Coordinators have both the qualifications and experience to make appropriate decisions for their rural communities and are also empowered to do so. RAMHP Coordinators' jobs are well designed and well supported through peer networks and experienced management. Such well designed jobs are attractive and relatively easy to fill and staff retention is good.

Suggested Solutions

- We conducted a major review of workforce issues for the National Mental Health Commission in 2014. We do not believe that the numbers have changed significantly since review.
- Our broad recommendations were as follows:
  - Retrain general Nurses as Mental Health Nurses
  - Undertake a study of the psychologist workforce
  - Build capacity of Primary Care services to increase access to mental health care and promote prevention and early intervention
  - Co-locate a proportion of Community Mental Health Staff within Primary Care
  - Support the development of the peer-support mental health workforce
  - Establish the infrastructure for competency-based workforce planning and development for mental health services.
- Consider rural workforce incentives beyond simple financial remuneration, though stability of employment is a factor. Diversity in scope of practice, access to learning opportunities and adequate professional development support are critical and under-used elements of staff retention.
- Workforce retention strategies and practices should take local factors into account since place-based social processes affect retention in rural and remote areas (Cosgrave et al. 2019) Thus, incentives need to provide local management support, appropriate clinical support , training and skills-retention opportunities, including the provision of locums to back-fill for off-site training, and education and when vacancies occur.
- There is currently substantial variability in how peer workers are used alongside the clinical mental health workforce. Further consultation with the sector is required to agree on an appropriate scope of practice for peer workers across the inpatient, community and disabilities sectors. Due consideration needs to be given, including training and ongoing support for the peer workforce that exists now and into the future.
- There are locally developed rural models of care and support that address some of these gaps and highlight opportunities for sustainable approaches in other rural areas. For example:
  - Teen Clinic is in an integrated primary care nurse-led model wherein teens can attend the local primary care service at no cost, see a nurse who will assess their needs and prioritise free appointments with the GP and/or Psychologist. The main reasons for attendance are mental health and sexual health.
  - In Mudgee, an integrated primary mental health care model sees effective mental and physical health care for those with persistent mental illness in partnership with the local community mental health team.
  - Murrumbidgee Primary Health Network (PHN) have sought to bridge the service gaps across intensity of mental health need via geographically based service commissioning across the span of service need for mental health services, whilst retaining the stepped

care model. In line with the 5th National Mental Health Plan, this model was evidence-based and co-designed with the Murrumbidgee Mental Health and Drug and Alcohol Alliance.

- This Way Up provides an online platform and intervention for local rural-clinician supported CBT-based therapy (free to the clinician). This style of digital enhancement of local service provision provides a real opportunity to build and reinforce the skills and capabilities of local GPs, clinicians, allied health professionals and peer workers.
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Access for Children and Young People Varies

- **There are significant deficits in access to child and youth services** across all areas (government and non-government, mild, moderate and acute). Family Mental Health Support Services (federally funded) are not available in all LGAs, therefore some communities including Nyngan, Warren, Narromine and Gilgandra do not have family mental health supports.
- There is a shortage of **school counsellors** and their capacity to provide genuine intervention past initial assessment and referral is limited. This is particularly true in smaller, remote schools with small student numbers.
- Child and Youth Mental Health Services experience the same **workforce shortages** and challenges described above.

Lack of Consistent Support Provided for Social Events and Activities

- There is considerable **variation between State and Federally funded** programs for **social connectedness activities**, which leads to duplication and underserved communities.
- Activities delivered without community consultation are not effective in supporting the community, leading to frustration and a reluctance to engage or attend pre-organised events.

Suggested Solution

- All agencies involved in visiting communities or distributing funds to drought impacted communities for social or recovery style events must demonstrate knowledge and adherence to the principles similar to those included in the CRRMH's Respectfully Engaging Rural Communities Guideline as a condition of their funding.

Market Driven Responses are Not Sufficient in Rural Areas

- Over the past two decades, Australia's physical health, mental health and disability sectors have undergone considerable reforms, all with the ultimate objective of improving the efficiency and effectiveness of achieving health outcomes for Australians. All reforms, including the most recent reforms to the mental health system, have placed a strong emphasis on the introduction of funding mechanisms that drive efficiencies through a market-driven/competitive response. The major structural weakness which has been overlooked is that this approach to reform assumes that a well-functioning and mature market of mental health services exists in rural areas.
- Unfortunately, rural mental health services are exposed to a number of market failures:
    - There are small numbers of service providers that can effectively service rural

areas, this creates a non-competitive market environment.
    - Service providers operate within a pseudo-competitive environment and this can inhibit the collaboration and cooperation needed to effectively enable service users to access and be cross-referred to different providers.
    - Efficiency gains can lead to system fragility, wherein gaps are common and there is no slack in the system to accommodate fluctuations in demand, nor cover over temporary staff turnover (common in contracted roles).
    - The ability of PHNs to commission services in an effective manner relies on them having a solid understanding of the evidence behind interventions and the outcomes achievable. There is limited evidence about the effectiveness of many mental health interventions in rural areas. Simply assuming interventions that work in metropolitan areas will be effective in rural areas is not sufficient for making value for money commissioning decisions (this is particularly pertinent when commissioning interventions to support mental health in times of drought or severe adversity).
    - PHNs vary in their maturity and ability to commission mental health services effectively and on a value for money basis. Many rural PHNs have found it difficult to recruit the skills needed to lead regional mental health planning and this recruitment is not made easier by short term funding.
- The end result of overlooking these market failures, and simply assuming a market-driven response will work in rural areas is significant fragmentation and duplication of rural mental health services. This creates substantial confusion amongst community members on where, when and how they can access mental health services. This confusion is further exacerbated in times of severe adversity, such as drought.
- The provision of **drought related interventions and services** are prone to the same **market failures experienced in the wider rural mental health services sector**.

Suggested Solution

- A suggestion to alleviate at least one of the above-mentioned market failures is the provision of longer-term contracts to PHNs, NGOs and State-wide programs that deliver mental health services in rural areas (minimum contract term three years). This will provide some consistency and certainty to service providers, enabling them to build trust with community members and make investments which allow them to deliver services efficiently in rural areas and do the necessary preparation work with communities to handle severe or prolonged adversity when it occurs.

2. The Committee has heard that mental health strategies and solutions aimed at regional communities need to be localised and what works for one community may not work for another. What are your thoughts and experience on this issue and can you point to any examples of local communities that have worked together to provide a localised solution?

- The CRRMH understand the cumulative impact drought and other adversities have on rural resident's mental health. While rural communities share some similarities, they also have distinct differences specific to their context and community (Lawrence-Bourne et al., 2020). As such, variability exists and rural communities are thus, not a homogenous group.

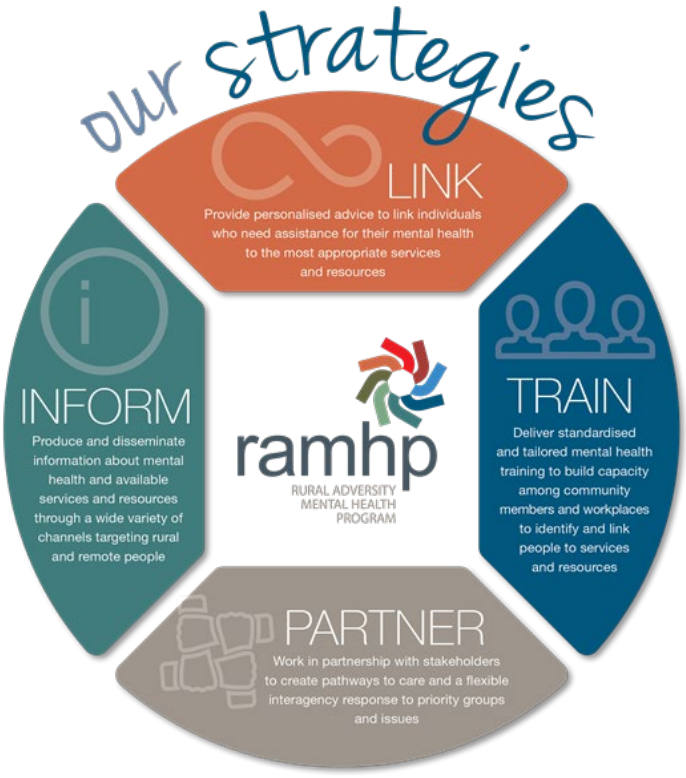
- Rural communities experience diverse adverse events, economic changes and also experience them differently (Perkins, 2019). Thus, whole of community and place-based approach are most suitable when addressing mental health in rural communities (Perkins, 2019).
- As an advocacy tool for system review and change, The Orange Declaration (led by the CRRMH) recognises that rural residents experience a series of interconnected geographical, demographic, social, economic and environmental challenges which are not addressed adequately by the current mix of services. The Declaration provides ten problems and ten solutions to explore these issues and advocate for change. The Orange Declaration can be viewed here: https://www.crrmh.com.au/research/the-orange-declaration/
- Taking a localised and tailored approach for each community is key, however there needs to be equal recognition and effort given to ensuring that community has stable access to core services such as GPs, community mental health teams, and family and carers supports etc. Put simply, a localised response needs to be built on a strong foundation of core services.

Examples of communities or programs that provide a localised solution

Rural Adversity Mental Health Program

- The Rural Adversity Mental Health Program (RAMHP) is an early intervention and mental health promotion program that has been operating in rural NSW since 2007. The RAMHP program was specifically developed for the unique needs of rural people and is evidenced based.
- RAMHP is managed by the Centre for Rural and Remote Mental Health in partnership with the nine rural Local Health Districts.
- The aim of RAMHP is to ensure rural and remote people who are struggling with their mental health are connected with appropriate services and support. Recognising that successful early intervention programs in rural areas need to go well beyond service access information, RAMHP provides four main strategies. These strategies of link, train, inform and partner are outlined in Figure 1.

Figure 1 Overview of RAMHP's Strategies



- Much of RAMHP's success stems from the fact our 19 RAMHP Coordinators live, work and genuinely understand the needs of their communities, and tailor their approach accordingly. Furthermore, our most recent funding contract spans five years. This has provided employment certainty and the ability for RAMHP Coordinators to build and gain the trust of their rural communities. Trust is an essential element of any rurally based intervention program and to achieving a truly localised solution.
- A comprehensive evaluation framework measures the outcomes achieved by the program, builds the evidence base and enables continuous quality improvement and refinement of RAMHPs activities.
- **Community Wellbeing Initiatives** - The CRRMH was supported by the Mental Health Commission of NSW to conduct a review of collaborative community wellbeing initiatives, which entailed a review of the literature, case study approaches and the development of support resources. The model for such approaches that we have drawn together involves a public health approach that is community-led and supported by local government and services.

Muswellbrook HEALTHY & WELL

OUR HEALTHY CLARENCE

MINDFUL MARGARET RIVER

- This has involved working with the following communities Our Healthy Clarence (Grafton – see case study), Muswellbrook Healthy & Well, Lithgow, Mindful Margaret River, and various Act-Belong-Commit initiatives to learn from their experience.
- We believe these are effective evidenced-based examples of communities working together to create a localised response.

NALAG 'Our Shout' Program (Western NSW)

- **Our Shout** is funded by the NSW Government to provide social events and activities to local communities. Through thorough and ongoing consultation with community members and other stakeholders, a significant number of events and activities are held to boost social engagement and skills.

Leverage Existing Local Networks or Inter-agencies

- **Western Rural Support Network (WRSN) Dubbo** - is a network of over 30 providers from western NSW working together to deliver projects, events, training and services. WRSN has identified gaps, made linkages to effective support options, provided stronger advocacy, and shared resources, skills and funding. It has advocated for a Drought Support Team model which has proved effective in supporting communities, collaborated in applications for Western PHN Empowering Communities funding to deliver shared projects with significant outcomes.
- **Suicide Prevention Networks** – Grenfell and Cowra have developed their own Suicide Prevention Networks headed by local community members who know the community and have access to knowledge about local needs and resources. These established networks can be further leveraged in times of severe adversity.
- **Respectful, comprehensive and long-term local consultation is critical –** There are a number of well-respected local professionals who have a wealth of local knowledge including Community Development Officers, Rural Resilience Workers and RAMHP Coordinators. Ongoing consultation with experienced local staff such as these is key. We note that in the interim inquiry report, there is a recommendation for 'resilience officers (drought and recovery)' to be employed - this is the existing role of the Department of Primary Industries (DPI) Rural Resilience Program and it is important not to duplicate or reinvent this well-respected workforce, but rather support and strengthen this team, which can be scaled up during adversity.

3. How can we promote the use of local skills and leadership to build support networks in regional communities?

- **Local Councils** have several significant roles that can assist such as Community Engagement Officers and Youth Support Officers. Elected should be identifiable as leaders or at least be able to identify key leaders.
- **Rural Support Networks and Interagency Groups** are important in sharing scarce information, skills and resources. The value of these networks is currently under recognised/ underutilised. There is a need to provide clearer pathways for communicating issues, concerns, and suggestions to Government for action (e.g. clearer links with the Department for Regional NSW for reporting). Further, it is important to improve the consistency and clarity about what information is needed. This should always involve local community members, not just Government/service providers.
- It should be noted that there is considerable **variability in the capacity and capability of Rural Support Networks and Interagency Groups** across rural NSW, the current model is largely dependent on the capacity and motivation of local individual workers. There is significant potential for learnings to be shared between these rural networks.
- DPI's Rural Resilience Workers and RAMHP Coordinators play an integral part in supporting capacity building activities in local communities. Providing **clarity and long-term** security for this workforce (and similar roles) is crucial for sustainable resilience building.

Suggested Solutions

- Providing rural leaders with reasonable job security and opportunities for career progression are simple yet critical elements to enhancing the support networks in regional communities.
- Development of simple yet standardised reporting mechanisms to collect the information, emerging risks and advice from local inter-agencies and/or rural networks.

4. From your work and research how long does it take for communities to recover from drought and get back to where they started? How long should support programs be offered after drought conditions ease?

- Communities never fully regain or recover from drought as they move from one adversity to another - drought, bushfire, floods, locusts - it is on-going, persistent and cumulative.
- Adaption to drought (and other adversities) is essential as drought is a reoccurring pervasive element of Australia's climate (Austin et al. 2020). Hence, the focus should be on **assisting and empowering communities to adapt to drought** or other forms of adversity rather than setting the goal/ expectation of full recovery.
- Vulnerability, and resilience to drought differs across locations and populations, with socio-demographics, health and financial position contributing to an individual's adaptive capacity and ability to cope and adapt to drought (Austin et al. 2020). Research has shown that **individual adaptive capacity improves with age, financial security and reduced psychological distress** (Austin et al 2020).
- Programs must **be adaptable** to future adversities. Developing locally informed and lead strategies is a critical component in achieving this along with taking a **holistic view of adversity** (Lawrence-Bourne et al. 2020).
- **Recovery or adaption is complex** and includes many different facets of an individual or community's experience, including economic, business, social, emotional and environmental recovery.
- What is observed on the ground is that the environment tends to recover first and priority is given to financial or economic recovery, with the **psychological, social and emotional impacts remaining for years**, and in some cases indefinitely
- Support for individuals to address loss and grief includes personal and financial counselling, and assistance to navigate services, which are often offered by outsiders for a limited period of time and funded by government agencies. These support services are often unconnected with, or unaware of, local resources such as primary care and other providers (Lawrence-Bourne et al. 2020).

Suggested Solutions

- Individual and community adaptive capacity is an essential consideration when responding to the impacts of drought. There is a need to develop a stronger understanding of the relationship between adaptive capacity and wellbeing, and therefore increase opportunities for interventions which effectively improve adaptability to drought (Austin et al. 2020).
- There needs to be equitable consideration and resource distribution for supports across all facets of recovery/ adaption - economic, business, social, environmental and emotional. Further, this needs to go well beyond agricultural businesses, and narrow definitions of primary producers (i.e. viticulturists, apiarists and fishers and similar).
- Investments which support communities to build resilience or cope with adversities such as droughts should not be subject to short-term or episodic investments. Rather, long term investments (5+ years) which assist communities to build a strong foundation of support for current and future adversities are needed.

5. The Committee has heard about the impact of drought on the wellbeing of children and young people in regional communities. What is your experience of the impact of drought on children and young people in regional communities and are there any specific responses needed for children and young people?

- When children are in a stressed environment (parental stress, deteriorating land around them, fear of future) there is the risk of ongoing negative impacts. Rural youth are more likely to study agriculture and primary industry courses but do this with fear that there will be no roles for them in the future.
- Anecdotally, we know they often put off talking to their parents about the current situation for fear of upsetting them. Many parents who have had better academic and social opportunities are not able to provide tertiary level education due to cost and yet are unable to provide long term employment to children within the family business.
- We know that concerns **about future employment prospects** are one of the leading causes of emotional distress amongst rural youth (Ivanic et al. 2018).
- Similarly to many adult services, there is a need to provide more **stable mental health service provision for children and young people** (see previous points). Current systems remain understaffed, disjointed and highly variable across rural NSW. These system challenges are further exacerbated when severe or prolonged adversity occurs.

Suggested Solutions

- Map the current availability and appropriateness of child and youth mental health services in each rural community to inform a more consistent distribution of child and youth mental health services across rural NSW e.g., providing the Family Mental Health Support Service across all communities
- Similar workforce challenges exist for the child and youth mental health workforce. Consider further upskilling or professional development for clinicians and school staff. This should include a review of the role and adequacy of School-Link Coordinators in providing support and linkage between schools and health services.
- Involve youth in the consultation and design process when determining the specific needs of children and young people during drought. Refer to the approach and results from The NSW Youth Drought Summit on Living with Drought, convened by Unicef.

6. From your work and research what policy response would you recommend the Government consider to address the impact of drought on the mental health and wellbeing of people in regional communities?

Suggested solutions have been provided throughout this document, however, the CRRMH believes the following are the most important considerations when designing a policy response:

- Adopt a **holistic understanding of adversity** when designing support services and measures. Recognition of **rural adversity as a complex determinant of mental health and wellbeing** implies that integrated and collaborative approaches are needed to develop and implement combinations of interventions that are tailored to local needs, based on evidence and driven by data, with local leadership and community support wherever possible. In Australia, this might imply a new emphasis on integrated regional mental health and suicide prevention planning in defined populations alongside attempts to mitigate future adverse events and build community capital and resilience.
- **Scale up these existing, established and known teams** such as Support Workers, Rural Resilience Officers, RAMHP, Rural Financial Counselling Services, counselling and psychological support as needed rather than creating new teams, services and models.
- **Invest in whole of community resilience and capacity building** activities helping locals to build skills and identify their local assets – community development to build more local community champions and capacity who can act when adversity occurs.
- **Longer term funding support**. Consider service models with a core/skeleton of long term, ongoing programs across the stepped care framework which can then be scaled up when adversity occurs.
- Support rurally based research and evaluation to ensure a better understanding of the impact of adverse events and the effectiveness of service and community responses.

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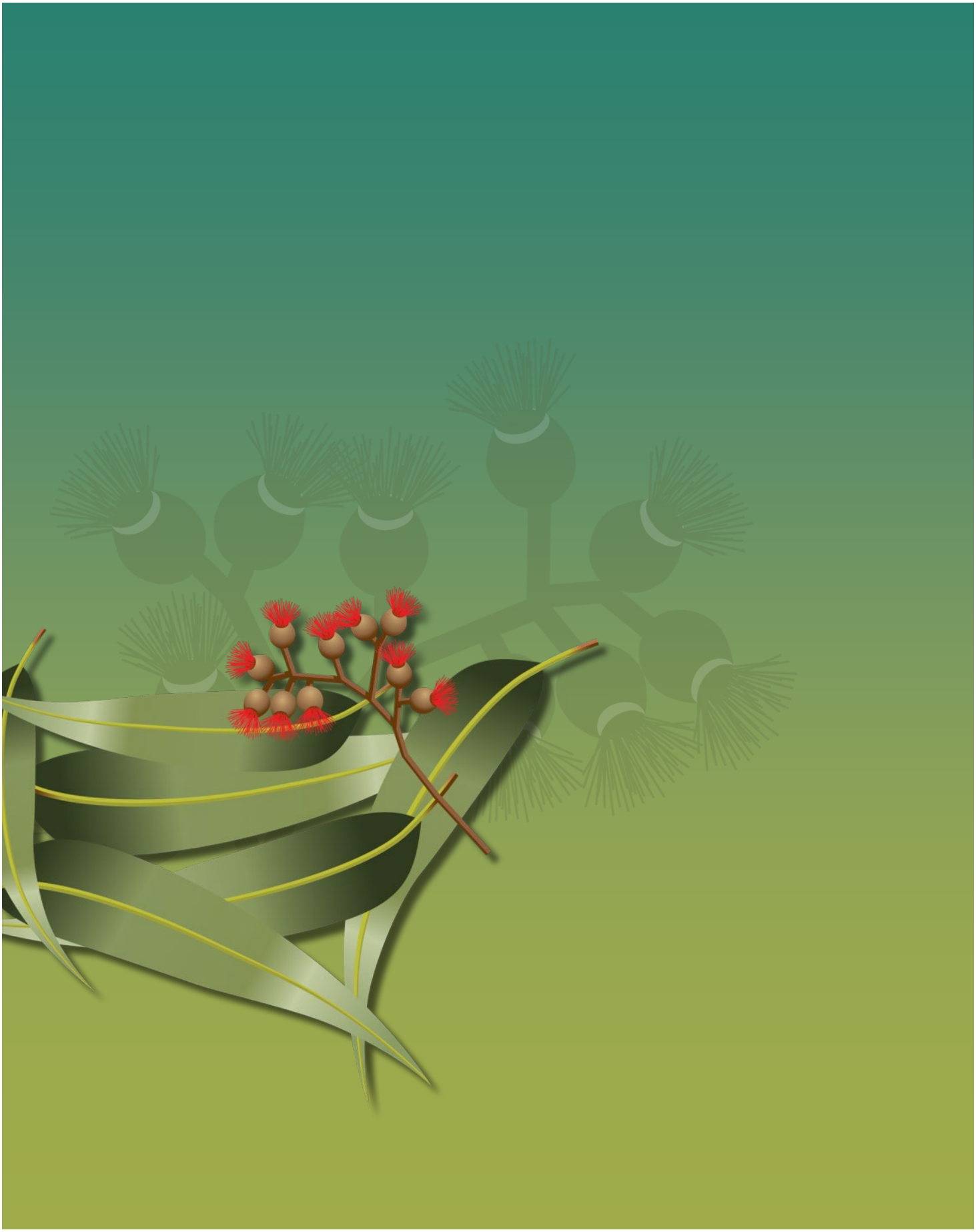

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