Submission No 454

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: Centre for Rural and Remote Mental Health

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

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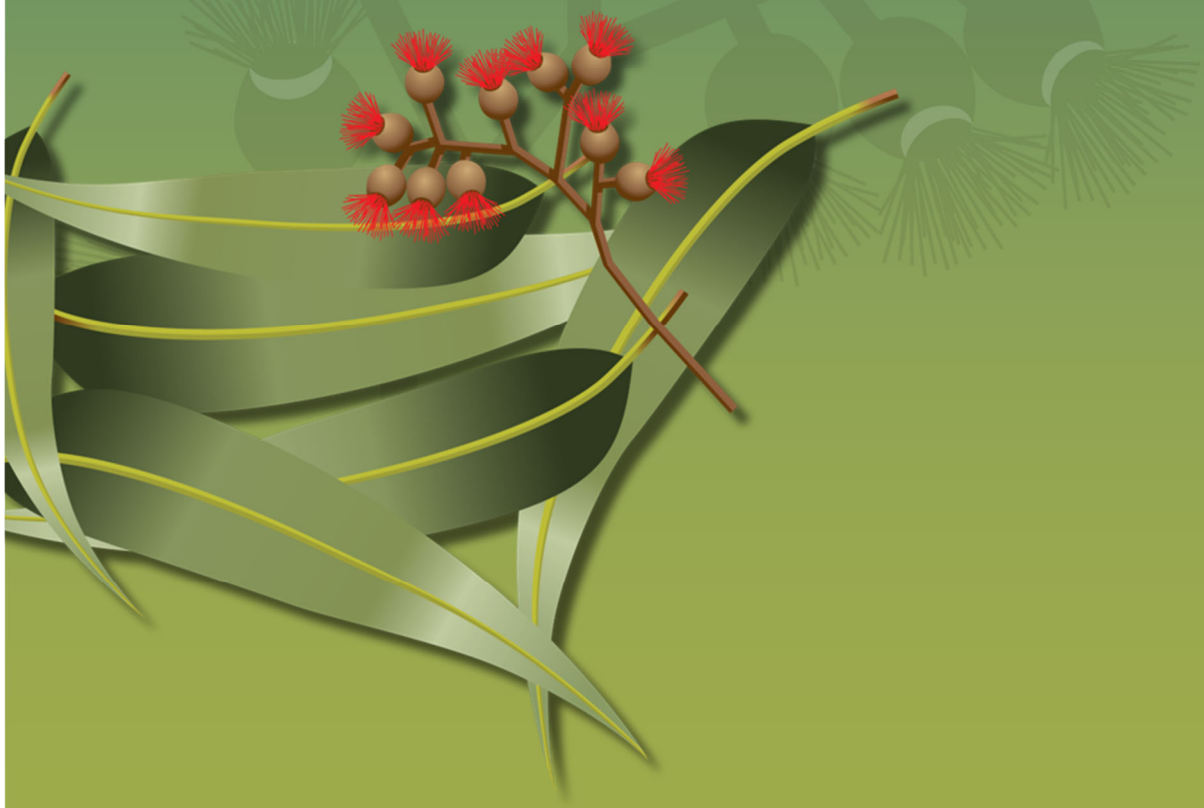

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About the CRRMH

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

Proudly funded by NSW GOVERNMENT

Centre for Rural and Remote Mental Health (CRRMH): Response, Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote New South Wales

1. Introduction/Preamble

This response for the Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote New South Wales has been prepared by the University of Newcastle Centre for Rural and Remote Mental Health (CRRMH), Orange NSW. We will take a focus on mental health and suicide prevention in rural and remote areas. Firstly, we will present a general statement about the CRRMH, then we will address the terms of reference, in particular outcomes, access, care experience, planning, and workforce challenges (items - a, b, c, d, e, g).
We are very happy to discuss these issues further with the committee – please contact us via crrmh@newcastle.edu.au.

2. General Statement

The Centre for Rural and Remote Mental Health (CRRMH) is committed to improving the mental health, wellbeing and resilience of rural and remote residents. The CRRMH is based in Orange NSW and receives a major grant from the NSW Health Mental Health Branch and aims to provide evidence-based solutions to improve the mental health, wellbeing and resilience of rural and remote residents and to deliver high quality and relevant research, information, health promotion and education services that improve mental health and wellbeing.
We aim to make a significant contribution to:

- improving the mental health and wellbeing of rural and remote residents
- developing the mental health system to better meet the needs of those experiencing mental ill-health
- understanding and responding to rural and remote suicide and suicide-related behaviours

The CRRMH has a long history of supporting rural communities, for a more comprehensive overview of our projects visit - https://www.crrmh.com.au/research/our-research/
The CRRMH understand the cumulative impact that adversities have on rural resident's mental health, and that rural communities experience different adverse events and economical changes differently [1](Perkins, 2019). Rural communities do share some similarities, but they also have distinct differences specific to their context and community [2](Lawrence-Bourne et al., 2020). As such, rural communities are not a homogenous group and therefore, the CRRMH advocate that a whole of community and place-based approaches are most suitable when addressing mental health in rural communities (Perkins, 2019 – see https://www.crrmh.com.au/research/the-orange-declaration/).

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 (via NSW Health Mental Health Branch) for its research, infrastructure and rural service coordination through the Rural Adversity Mental Health Program (RAMHP).

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

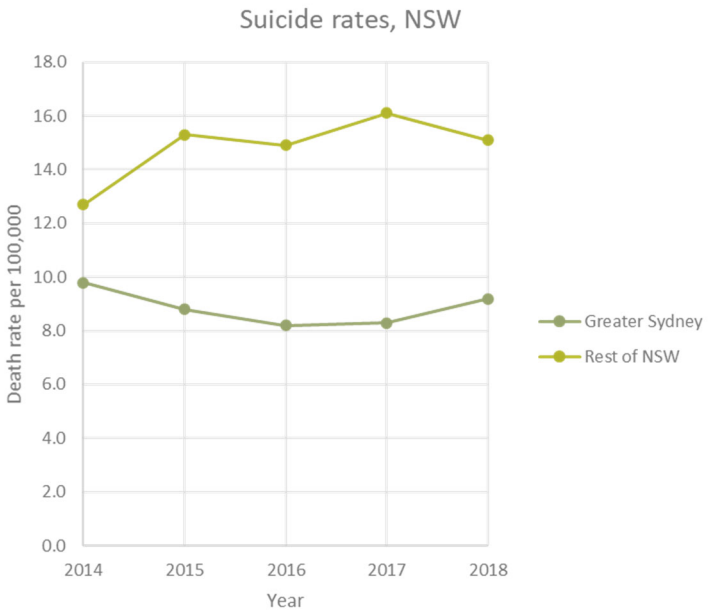
Mental health outcomes

The Australian Institute for Health and Welfare (AIHW) suggest the prevalence of mental and behavioural conditions (including alcohol and drug problems, mood (affective) disorders, anxiety-related disorders, organic mental disorders and other mental and behavioural conditions) are experienced at relatively similar levels from metropolitan areas to remote (21.4% metro, 25.7% inner regional and 22.3% outer regional and remote areas) [3]. Scores for high or very high for psychological distress were comparable for those living in major cities through to rural and remote areas (17.9% down to 15.6%) [4]. However, in rural and remote areas, we know that not all people experiencing clinically significant distress levels will recognise this. In the Australian Rural Mental Health Study (ARMHS), a third of these individuals did not report a mental health problem [5]. This represents undiagnosed/unmet need and an access gap due to poor mental health literacy and recognition.

For a proper understanding of the true prevalence and associated factors for mental ill-health in NSW, better community data sets are needed. Mental health outcome data for rural residents is limited, and often published data is not comparable. Current data presents issues related to reliability and its use to predict and plan for systems aiming to improve rural mental health is limited. Consideration of the variation due to location, socioeconomic status, access to services are all vital to bring a full picture. The last National mental health and wellbeing survey was conducted in 2007 and did not adequately sample rural areas. It is welcome that there is a new survey promised, but not yet conducted. The landmark Australian Rural Mental Health Study (ARMHS), delved much deeper into the social, environmental, economic and rural determinants of mental health – this data set is now ageing (ten years old) and the cohort sampled was of an older group overall [6]. Thus there is a great and pressing need for comprehensive data on the mental health of rural and remote NSW residents and the factors that impact this.

Measuring outcomes is more challenging – there is routinely collected data from NSW Health (which we anticipate will be provided by the Mental Health Branch or the Bureau of Health Information). Measures of outcomes from primary care and allied health are more challenging and not standardised as yet, though there are efforts to systematise and digitally enable primary care data collection and comparison.

In terms of outcomes relative to metropolitan settings that suicide rates in rural NSW have been consistently higher than Greater Sydney (see Figure). We acknowledge that suicide is a low prevalence event, which brings complications regarding measuring and predicting. And suicidal risk does vary with place as rural areas are diverse – population characteristics, amenity, employment stability and diversity, adversity risk profiles etc. In rural areas it becomes really difficult with small population numbers, but overall the aggregate numbers point to a persistent trend. Rural and remote areas also have higher prevalence of the social determinants of poor health including mental health – low socioeconomic status, higher



unemployment, lower educational attainment, higher domestic and family violence, higher prevalence of problematic alcohol and drug use etc. These both impact on mental health, and poor mental health can contribute to these building cycles of inequity (for more see work on Adverse Childhood Events – ACEs)[7, 8].

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

Access to health and hospital services depends on a variety of factors, both supply and demand-based. Rural and remote areas add unique and distinct challenges. A relatively small population unevenly spread across a large geographic area poses significant logistical challenges to the supply and provision of effective care. In terms of workforce, we see a loss of specialists as you go rural and a loss of generalists as you get to remote areas. A mix of drive-in/drive-out (DIDO), fly-in/fly-out (FIFO), telehealth and digital models and supports seek to fill the gaps. This leads to inconsistent, complex, sometimes duplicative, variable services which create waste and requires navigation support for consumers. There is also structural fragmentation which will be addressed in section (e).

It is really important to consider how to support and leverage the local resident health service capability – those who live and work in rural to enable them to work to their broadest scope of practice with appropriate local and clinical supervision. There are models which act as adjunct support to the resident services and health professionals – e.g. the visiting psychiatrist model in Broken Hill, the Mental Health Rural Access Program (MHEC-RAP) via the mental health line – which as a stable platform has great promise for future leverage and expansion, digital models such as This Way Up which provide effective tools to support resident health professionals (GPs, allied health, social workers) to provide evidence-based therapeutic support for their patients/clients.

Community Capacity Building – Mental Health Literacy

On the demand side of access, we must consider unrecognised and unmet need as a feature of rural and remote areas. Evidence suggests up to a third of rural residents with clinically diagnosable mental distress don't recognise that they are unwell [5], thus this would prevent help-seeking altogether. This is supported by the Rural Doctors Association of Australia who writes

> *"Improving utilisation of mental health services by rural and remote people will require: improving understanding of mental health and mental health literacy across Australia through community education mechanisms to allay fears and reduce stigma.".*

Mental health literacy is important at the individual level for self-recognition, but to support someone into active help-seeking, we need to ensure that the wider social support network is accepting and supportive. This requires the building of mental health literacy – knowledge and confidence to recognise the signs and symptoms of poor mental health, the confidence to offer support to seek help. To ensure that access occurs, another layer of help-getting is needed – this can come in the form of tailored advice to connect to locally relevant services, with contingencies when wait times and other disruptions impact the first choice of care. This is where RAMHP Coordinators can assist in connecting people to services. They are skilled gatekeepers who provide locally relevant, trustworthy and holistic advice on how to connect to the help needed, thus when help is sought for mental health a high degree of trust ensures a supported referral. Resident workforce ensures a local contextually rich understanding of what people are dealing with at the community as well as personal level.

Insufficient Support for Mild to Moderate (Developing) Mental Health Issues

- Services for mild to moderate (developing) mental health issues are not well resourced in rural areas. **General support and care for mild conditions** are 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) and PHN-funded services to address and not serious enough for state mental health service care and so these patients do not receive adequate care.

- Capacity and capability of General Practitioners (GPs) to adequately meet the mental health needs of their patients remains a challenge. Fluctuating locum services lead to instability in service provision, lack of trust from community, and lack of rapport. Many visiting or overseas trained GPs do not understand what mental health or psychosocial supports are available (e.g. not providing mental health care plans). Long waiting times for GPs are common in rural and remote NSW.
- Stable psychology services are lacking in rural towns. Many 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 particularly during drought) which becomes a prohibitive factor in accessing face to face services.
- **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.

Suggested Solution

- Mental health literacy and education initiatives for rural residents - 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 support etc. Put simply, a localised response needs to be built on a strong foundation of core services.

- The Orange Declaration 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/
- The Federally funded (via PHNs) New Access program provides a larger framework for the training and clinical support (via the CBT institute) of non-clinicians to provide coaching based support for those with mild to moderate mental health clinicians.

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

There is considerable structural fragmentation within the mental health system in Australia, including NSW. There are federal and state-funded services, with different governance, oversight, funding models, and output/outcome measures. There is provider variation across government (state and federal), NGO and private practitioner. There is variation between resident and visiting health professionals. All of these lead to greater complexity, inconsistency and inefficiency.

There are measures that seek to bring consistency and safety including clinical and professional governance and oversight, safeguards and governance within care systems, movement to consistent

measures (NOCC). Safety and consistency are coming in to other areas including digital mental health standards and accreditation for low-intensity mental health services to expand access and build trust and safety in these services that expand access, particularly at the low to moderate end of the spectrum.

At the policy level, the Fifth National Mental Health and Suicide Prevention Plan 2017-2022 has mandated joint regional planning between primary health networks and their corresponding local health districts. There are eight priority areas for collaborative government action, including:

- Achieving integrated regional planning and service delivery.
- Effective suicide prevention.
- Coordinated treatment and supports for people with severe and complex mental illness.
- Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.
- Improving the physical health of people living with mental illness and reducing early mortality.
- Reducing stigma and discrimination.
- Making safety and quality central to mental health service delivery.
- Ensuring that the enablers of effective system performance and system improvement are in place.

Primary health networks and local hospital networks are key to regional integration and are guided by the Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs). Joint regional planning is a huge opportunity for integration, however, it needs to be acknowledged that this is resource-intensive requiring skilled people, time and funding. There is a need to support and build capacity in this area and give it the stability it needs to mature into an effective planning system. The maturity across rural NSW is variable, this should be supported to improve, not judged as success/failure.
There are substantial challenges for NGOs to effectively collaborate and participate in co-design processes due to the market-driven competition-based approach for tendering for services. NGOs compete for opportunities to provide services commissioned by NSW LHDs, PHNs and via the NDIS. Short-term funding contracts also inhibit effective service provision with long lead times to hiring staff and staff moving amongst rural providers close to contract end-dates.

Market-Driven Responses are Not Sufficient in Rural Areas

The CRRMH submission to the Productivity Commission Issues Paper: The Social and Economic Benefits of Improving Mental Health asserts that market-driven responses are not suitable for rural areas.
While reforms have placed a strong emphasis on introducing funding mechanisms that drive efficiencies through a market-driven response, this approach assumes that rural areas have a well-functioning and mature market of mental health services. Rather, rural areas:

- Have a small number of service providers that can effectively service rural areas, creating a non-competitive market environment.
- The ability for PHNs to commission services in an effective manner relies on PHNs having a solid understanding of the evidence behind interventions and the outcomes achievable. There is a paucity of evidence surrounding 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 are highly variable 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 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.

Planning – special considerations

There are groups and settings for which special considerations are needed – support for Aboriginal and Torres Strait Islander peoples, children and young people, older persons, veterans groups, etc.

For Aboriginal people in NSW, holistic concepts of health, consideration and understanding of social and emotional wellbeing are crucial to providing appropriate support and care. With trust an issue, coupled with high unmet need – stable long-term investments in Aboriginal Controlled Community Health Services represents a great opportunity to meet care needs. This does not preclude the need for general services to deliver culturally safe and responsive services. There is substantial policy advice in this space, e.g. see the Health in Culture – Policy Concordance for an overview.

For children and young people – recognise that adverse childhood events are likely to impact long term trajectories in health, including mental health. Systematically addressing these and providing effective trusted support is key. Having services that go beyond assessment into effective support is crucial. As are the supports in social care – e.g. Triple P parenting programs, relationship counselling, etc.

There are key supports in the digital space that can act as adjuncts to on the ground services, including Emerging Minds for children, ReachOUT and eHeadspace for young people.

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

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 in the workforce to fill vacancies severely impacts the ability to provide a consistent level of service provision.
- **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 the 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 and 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 ensured RAMHP Coordinators have both the qualifications and experience to make appropriate decisions for their rural communities but 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.

- 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 across mental health nurse, psychologist and community nurse roles in rural and remote Australia.

Suggested Solution

The CRRMH believe a whole of community approach is needed for equitable rural workforce, and we acknowledge that the effective use, support and development of the allied health workforce is essential to improve equitable access to care and rural health outcomes [9]. Further, Cosgrave [10] argue that for a sustainable rural allied health workforce the *"rural public sector health services must be efficient and demonstrate strategic leadership and vision".* In particular, improved recruitment and retention including career progression and a whole of community approach towards allied health professionals adjusting into a new community.

Additionally, 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.

- 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 simply financial remuneration. Diversity in scope of practice, access to learning opportunities and adequate professional development support are critical and under-recognised elements of staff retention.

- Workforce retention strategies and practices need to take account of local factors since place-based social processes affect retention in rural and remote areas. 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 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 and 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 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.
- A suggestion to alleviate at least one of the above-mentioned market failures is the provision of longer-term contracts to both PHNs, NGOs and State-wide programs that deliver mental health services in rural areas (minimum contract term 3 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.

Terms of Reference

1. That Portfolio Committee No. 2 - Health inquire into and report on health outcomes and access to health and hospital services in rural, regional and remote NSW, and in particular:

(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;
(c) access to health and hospital services in rural, regional and remote NSW including service availability, barriers to access and quality of services;
(d) patient experience, wait-times and quality of care in rural, regional and remote NSW and how it compares to metropolitan NSW;
(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;
(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;
(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;
(h) the current and future provision of ambulance services in rural, regional and remote NSW;
(i) the access and availability of oncology treatment in rural, regional and remote NSW;
(j) the access and availability of palliative care and palliative care services in rural, regional and remote NSW;
(k) an examination of the impact of health and hospital services in rural, regional and remote NSW on indigenous and culturally and linguistically diverse (CALD) communities; and
(l) any other related matters.

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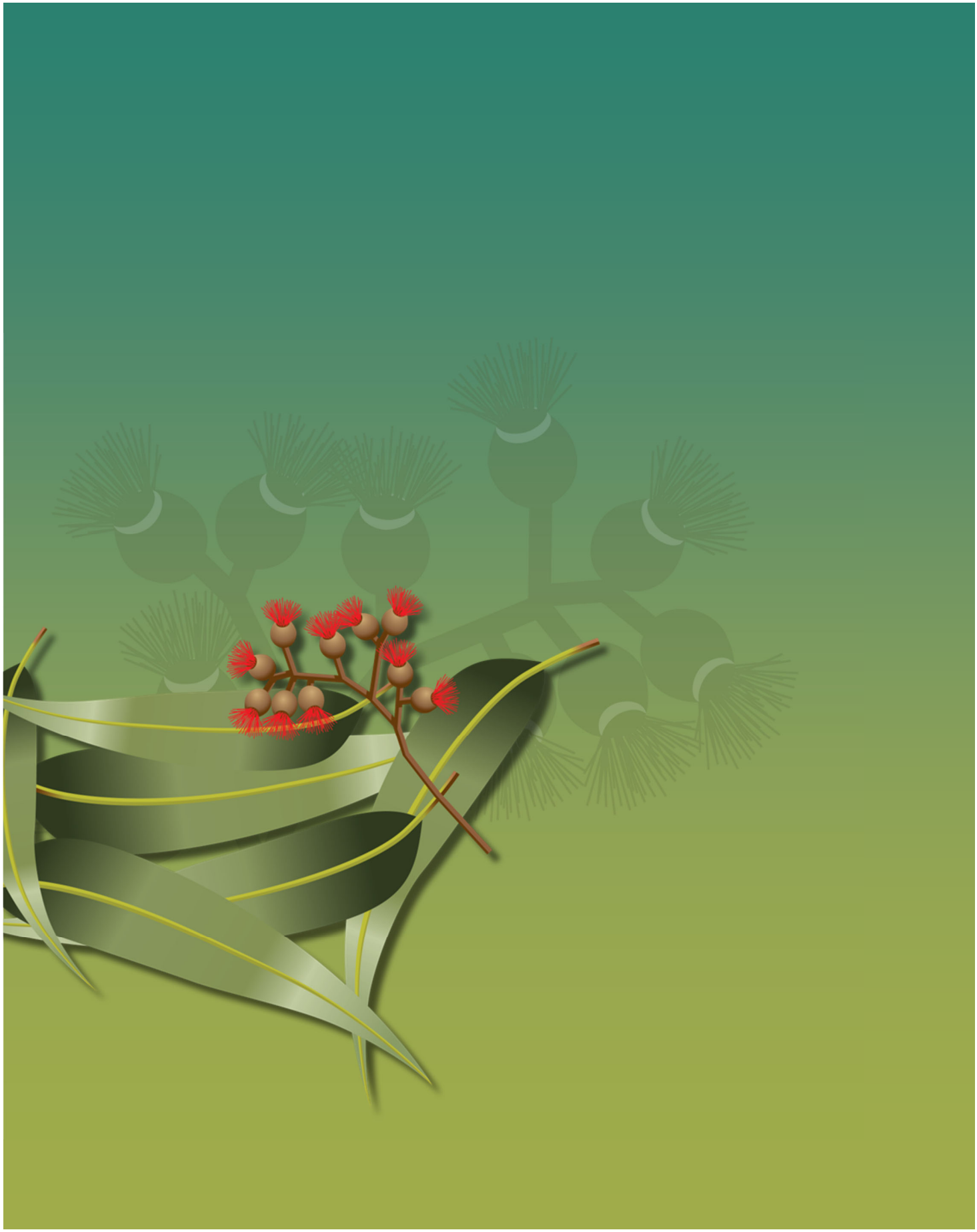

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