Fact Sheet 3 – What this means for regional, rural and remote Australia

Key issues
- People living in regional, rural and remote areas of Australia make up 30 per cent of the population, but do not receive anywhere near 30 per cent of funding and services for mental health.
- The Review found high levels of unmet mental health need in rural and regional communities which requires immediate attention.
- Further, this inequity compounds the mental health challenges facing the significant numbers of Aboriginal and Torres Strait Islander people living in these areas.
- Given the persistent difficulty in expanding face-to-face services and workforces in these areas, we need innovative, local ways of mitigating this situation in the short term, while adopting a long-term focus to improve quality and outcomes. These should be locally targeted to take into account community-specific issues.
- Over the years, rural incentive programmes for professionals have had mixed success. Expansion of the current workforce mix in regional, rural and remote areas for mental health care will require ongoing efforts.

Key responses
- A fundamental key design feature of the Review recommendations is to develop a regional model of service delivery based around the proposed Primary and Mental Health Networks (PMHN) as the key regional architecture for equitable planning and purchasing of place-based mental health programmes, services and integrated care pathways.
- In particular, this approach should take into account the mental health and social and emotional needs of Aboriginal and Torres Strait Islander peoples.
- A weighted population-based funding model, with funds bundled-up at a regional level, will lead to greater equity in distribution of Commonwealth funding across Australia.
- PMHNs should have responsibilities as core system and service integrators of both physical and mental health services for people with mental health problems, and as facilitators and purchasers of mental health and suicide prevention services and programmes.
- They need to develop mechanisms to regularly engage with people with lived experience and service providers, involving inclusion of mental health clinicians and people with mental health difficulties on their formal advisory bodies – Clinical Councils and Community Advisory Committees – and establishment of a specific mental health advisory group.
- PMHNs, in partnership with State Local Health Networks (LHNs or their equivalent), should conduct comprehensive mapping of mental health services, programmes and supports.
available in regional, rural and remote areas through Commonwealth, state and territory and local governments, private and not-for-profit sectors.

- Nationally, we need to develop a regional mental health and suicide prevention strategy, based on the mapping of local services.

- PMHNs should build on what exists and what works in frontline service delivery by engaging with local services, people with lived experience, their families and support people, and drawing on research and evidence bases. Existing arrangements which make a positive contribution to mental health outcomes should be supported.

- Where change occurs, there needs to be a smooth, seamless transition for service recipients.

- Workforce supply issues also need to be urgently addressed, in particular, by implementing a range of changes to the Commonwealth’s Better Access programme. Figure 1 shows the disparity in workforce coverage between remoteness areas. We need to enhance access to the Better Access programme for those who need it most through changed eligibility and payment arrangements and a more equitable geographical distribution of psychological services.

**Figure 1 Employed (full-time equivalent) general practitioners, psychiatrists, psychologists and mental health nurses, by remoteness, 2012**

<table>
<thead>
<tr>
<th>Remoteness Area</th>
<th>FTE general practitioners</th>
<th>FTE psychiatrists</th>
<th>FTE mental health nurses</th>
<th>FTE psychologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cities</td>
<td>163</td>
<td>15.3</td>
<td>79.5</td>
<td>47.8</td>
</tr>
<tr>
<td>Inner regional</td>
<td>6.2</td>
<td>3.9</td>
<td>47.8</td>
<td>34.3</td>
</tr>
<tr>
<td>Outer regional</td>
<td>4.8</td>
<td>3.9</td>
<td>47.8</td>
<td>34.3</td>
</tr>
<tr>
<td>Remote and Very remote</td>
<td>-10.0</td>
<td>10.0</td>
<td>30.0</td>
<td>50.0</td>
</tr>
</tbody>
</table>

Source: AIHW National Health Workforce Data Set 2012

- Throughout this Review, two further responses have been repeatedly advocated to overcome the persistent challenges to improving mental health in regional, rural and remote areas.
  - The first is improving access to services using technology. It is now possible to provide much needed assistance and interventions in real time via telephone or over the internet.
- The second solution is to better train community members to provide services and supports in these areas.

- The National Disability Insurance Scheme (NDIS) rollout needs to be adapted for more remote areas. In these areas, agencies funded by Commonwealth programmes often are the only organisations with expertise in recovery support and psychosocial rehabilitation.

- PMHNs and LHNs should work together to build on the Multipurpose Service Programme model, to integrate and collocate mental and other health services in smaller rural communities, supported by telehealth services.
Rural, regional and remote Australia

The availability of specialised mental health care in hospitals and Medicare-subsidised mental health services is significantly worse in more remote areas of Australia than in major cities.

**Major Cities**

- For every 1,000 people, there were 6.5 hospitalisations for mental health reasons with specialised psychiatric care, but 3.5 without specialised care.

- For every 100 people, 8 received MBS-subsidised mental health services. Each of these people received 5.2 consultations.

**Remote/Very Remote**

- For every 1,000 people, there were 3.5 hospitalisations for mental health reasons with specialised psychiatric care, but 8.2 without specialised care.

- For every 100 people, 3 received MBS-subsidised mental health services. Each of these people received 3.0 consultations.

In major cities, the per person Medicare funding for mental health services was $43.44:

- Psychiatrists: $15.51
- Other allied health providers: $0.87
- Other psychologists: $8.66
- Clinical psychologists: $9.78
- General practitioners: $8.62

In remote and very remote areas the per person Medicare funding for mental health services was $7.46:

- Psychiatrists: $1.96
- Other allied health providers: $0.13
- Other psychologists: $1.40
- Clinical psychologists: $1.38
- General practitioners: $2.59